



**News Flash** – The revised *Ambulance Fee Schedule Fact Sheet* (January 2010), which provides general information about the Ambulance Fee Schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html> on the CMS website.

MLN Matters Number: MM6347

Related Change Request (CR) #: 6347

Related CR Release Date: March 6, 2009

Effective Date: April 1, 2009

Related CR Transmittal #: R1696CP

Implementation Date: April 6, 2009

**Note:** This article was updated on December 17, 2012, to reflect current Web addresses. All other information remains unchanged.

## Updates to the Medicare Claims Processing Manual (Publication 100-04), Chapter 15, Ambulance Services

### Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ambulance services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on CR6347 which implements significant changes to the Internet Only Manual Publication 100-04, Chapter 15. Most of the changes in CR 6347 have already been communicated via prior change requests and related MLN Matters articles. The key purpose of CR 6347 is to eliminate references to the reasonable charge payment methodology and the transition to the Ambulance Fee Schedule, which took place from April 2002 until December 2006, in the actual Medicare manual. Please make sure your staff is familiar with these changes.

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## Background

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Medicare has revised the Medicare Claims Processing Manual, Chapter 15 – Ambulance section. Some sections have been added and other sections have been renumbered. Most of the added information has been conveyed in prior MLN Matters articles related to ambulance services.

## Key Points:

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The most important changes for providers of ambulance services are listed as follows:

### **References to statutes and regulations have been updated as follows:**

Section 1861(s) (7) of the Social Security Act (Act) establishes an ambulance service as a Medicare Part B service. Payment for ambulance services is addressed at Section 1834(l) of the Act. Coverage rules are addressed at 42 Code of Federal Regulations (CFR), Section 410.40. Additional rules, including rules regarding vehicular and staffing requirements, are specified at 42 CFR 410.41. Payment rules under the fee schedule established in 2002 are specified at 42 CFR Part 414, Subpart H (414.601 et seq.). Payment rules for ambulance services furnished by a critical access hospital (CAH) or by an entity owned and operated by a CAH are specified at 42 CFR 413.70(b) (5). Other general Medicare provisions apply to ambulance services. See Title XVIII of the Act and 42 CFR Parts 400 to 429 to determine applicability.

### **References to Centers for Medicare & Medicaid Services (CMS) manual instructions for ambulance providers have been updated as follows:**

Coverage: Manual instructions regarding coverage of ambulance services, including specifications for vehicular and staffing requirements, are specified in the Medicare Benefit Policy Manual, Chapter 10, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf> on the CMS website.

Medical Review: Manual instructions regarding medical review for ambulance services are specified in the Medicare Program Integrity Manual, Chapter 6 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf> on the CMS website.

### **A summary of the ambulance services benefit has been provided in the revised manual as follows:**

Ambulance services are covered under Medicare Part B. However, a Part B payment for an ambulance service furnished to a Medicare beneficiary is available only if the following, fundamental conditions are met:

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- Actual transportation of the beneficiary occurs.
- The beneficiary is transported to an appropriate destination.
- The transportation by ambulance must be medically necessary, i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated.
- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements.
- The transportation is not part of a Part A service.

Other requirements specified in CR6347 or in the above-cited CMS Manuals may also apply to the provider/supplier or to a particular transport or billing.

**New and revised definitions related to ambulance claims processing have been added as follows:**

- **A/MAC** - For the purposes of Chapter 15 of the Medicare Claims Processing Manual only, the term refers to those Medicare contractors that process claims for institutionally-based ambulance providers billed on CMS-1450 Form (UB04) and/or a Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant ANSI X12N 837I electronic transaction.
- **B/MAC** - For the purposes of Chapter 15 of the Medicare Claims Processing Manual only, the term refers to those Medicare contractors that process claims for ambulance suppliers billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction.
- **Date of Service** - The date of service (DOS) of an ambulance service is the date that the loaded ambulance vehicle departs the point of pickup (POP). In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the DOS is the date of the vehicle's dispatch. In the case of an air transport, if the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary, the DOS is the date of the vehicle's takeoff.
- **Provider** - For the purposes of this Chapter 15 of the Medicare Claims Processing Manual only, the term "provider" is used to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e) of the Act, a fund.
- **Supplier** - For the purposes of Chapter 15 of the Medicare Claims Processing Manual only, the term supplier is defined as any ambulance service that is not institutionally based. A supplier can be an independently owned and operated

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ambulance service company, a volunteer fire and/or ambulance company, a local government run firehouse based ambulance, etc., that provides Part B Medicare covered ambulance services and is enrolled as an independent ambulance supplier.

### **Claims Jurisdiction**

Claims jurisdiction for suppliers is considered to be where the ambulance vehicle is garaged or hangared. Claims jurisdiction for institutional based providers is based on the primary location of the institution.

Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the Medicare beneficiary. In this, as in most instances, Medicare pays only for the level of service provided, and then only when the service provided is medically necessary.

### **Adjustments for Fee Schedule (FS) Payment Rates for Ground Ambulance Transports**

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006 as well as July 1, 2008 through December 31, 2009. For ground ambulance transport services furnished where the POP is urban, the rates are increased by 1 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2009 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. For ground ambulance transport services furnished where the POP is rural, the rates are increased by 2 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2009 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors.

### **Billing Instruction Reminder Information**

Independent ambulance suppliers may bill on CMS-1500 Form or the ANSI X12N 837P data set. These claims are processed using the Multi-Carrier System (MCS).

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Institution based ambulance providers may bill on CMS-1450 Form or the ANSI X12N 837I. These claims are processed using the Fiscal Intermediary Shared System (FISS).

Institutional providers and suppliers must report an origin and destination modifier for each ambulance trip provided in Healthcare Common Procedure Coding System (HCPCS)/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

- D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
- E = Residential, domiciliary, custodial facility (other than 1819 facility);
- G = Hospital based end stage renal disease (ESRD) facility;
- H = Hospital;
- I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
- J = Freestanding ESRD facility;
- N = Skilled nursing facility;
- P = Physician's office;
- R = Residence;
- S = Scene of accident or acute event;
- X = Intermediate stop at physician's office on way to hospital (destination code only)

In addition, institutional providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

- QM - Ambulance service provided under arrangement by a provider of services; or
- QN - Ambulance service furnished directly by a provider of services.

While combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code, the reported modifiers can only indicate origin/destination.

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## Additional Information

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The official instruction, CR 6347, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1696CP.pdf> on the CMS website. The revised portions of Chapter 15 of the Medicare Claims Processing Manual are attached to CR6347.

A version of the Ambulance Fee Schedule is also posted to the CMS website (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html>) for public consumption.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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