



News Flash – The revised Ambulance Fee Schedule Fact Sheet (January 2010), which provides general information about the Ambulance Fee Schedule including how payment rates are set for ground and air ambulance services, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbulanceFeeSched_508.pdf on the CMS website. It is also available in printed format. To place your order, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

MLN Matters® Number: MM6896

Related Change Request (CR) #: 6896

Related CR Release Date: April 2, 2010

Effective Date: May 3, 2010

Related CR Transmittal #: R1942CP

Implementation Date: May 3, 2010

Note: This article was updated on November 30, 2012, to reflect current Web addresses. All other information remains unchanged.

Update to the Medicare Claims Processing Manual (Publication 100-04, Chapter 15, Section 40)

Provider Types Affected

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

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 6896 which updates the Medicare Claims Processing Manual (Chapter 15 (Ambulance), Section 40 (Medical Conditions List and Instructions)).

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**CAUTION – What You Need to Know**

CR 5442 (Transmittal 1185, February 23, 2007) provided for an update to the Ambulance Fee Schedule Medical Conditions List and Instructions found in the Medicare Claims Processing Manual. Subsequently, CR 6347 (Transmittal 1696, March 6, 2009) communicated many revisions and updates to most of Chapter 15 of the Medicare Claims Processing Manual. However, the updated Section 40 (Medical Conditions List and Instructions) was not updated properly to reflect the updates made by CR 5442. Therefore, CR 6896 updates Section 40, Chapter 15, of the Medicare Claims Processing Manual.

**GO – What You Need to Do**

CR 6896 is issued primarily for educational guidance and to help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

CR 6896 is being issued to reflect the updates and revisions to the Medicare Claims Processing Manual (Chapter 15 (Ambulance), Section 40 (Medical Conditions List and Instructions)), and the following includes the revised Section 40. These updates and revisions will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service.

Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the Healthcare Common Procedure Coding System (HCPCS) code or the condition code by themselves. All current Medicare ambulance policies remain in place.

The Centers for Medicare & Medicaid Services (CMS) issued the Medical Conditions List as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded

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from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act (HIPAA)) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some Medicare Contractors have Local Coverage Determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the Medical Conditions List in CR 6896 is available for those who do find it helpful in justifying that services are reasonable and necessary. (CR 6896 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1942CP.pdf> on the CMS website.

The Medical Conditions List in CR 6896 is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and can be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "PLUS." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "PLUS") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "PLUS"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes.

Example:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)). In

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addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "PLUS any other code" requirement when using the alternative list for this condition (abnormal vital signs)). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the Medicare contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an Advanced Life Support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a Basic Life Support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code

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corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when medical review is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Medicare Contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Information on appropriate use of transportation indicators:

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

• **Air and Ground Transportation Indicators**

- 'C1': Transportation indicator "C1" indicates an interfacility transport (to a higher level of care) determined necessary by the originating facility based upon the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.
- 'C2': Transportation indicator "C2" indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
- 'C3': Transportation indicator "C3" may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this

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modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.

- 'C4': Transportation indicator "C4" indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.
- **Ground Only Transportation Indicators**
 - 'C5': Transportation indicator "C5" has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year old beneficiary who has undergone cataract surgery at the Eye Surgery Center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes mellitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

- 'C6': Transportation indicator "C6" has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for

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service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

- 'C7': Transportation indicator "C7" is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.
- **Air Only**
 - All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.
 - '**D1' Long Distance**: patient's condition requires rapid transportation over a long distance.
 - '**D2**': Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
 - '**D3**': Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.
 - '**D4**': Pick up point not accessible by ground transportation.

The revised Medicare Claims Processing Manual (Chapter 15, Section 40) is included as an attachment to CR 6896, and in the attachment you can review the

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Medical Conditions List which is set up as a series of tables divided into the following principal sections:

- Emergency Conditions – Non-Traumatic;
- Emergency Conditions – Trauma;
- Non-Emergency;
- Transportation Indicators; and
- Air Ambulance Transportation Indicators.

Additional Information

The official instruction, CR 6896, 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/R1942CP.pdf> on the CMS website.

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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