

Medicare Claims Processing Manual

Chapter 15 - Ambulance

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10 - Overview

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

10.1 - Authorities

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

10.1.1 - Statutes and Regulations

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

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 §1834(l) of the Act. Coverage rules are addressed at 42 Code of Federal Regulations (CFR) §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.

10.1.2 - Other References to Ambulance Related Policies in the CMS Internet Only Manuals (IOM)

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Coverage: Manual instructions regarding coverage of ambulance services, including specifications for vehicular and staffing requirements, are specified in the Internet-Only Manual (IOM), Pub. 100-02, Medicare Benefit Policy Manual, chapter 10.

Medical Review: Manual instructions regarding medical review for ambulance services are specified in the IOM, Pub.100-08, Medicare Program Integrity Manual, chapter 6.

Payment and Claims Processing: This chapter restates previously issued instructions to Medicare fee-for-service claim processing contractors for processing claims under the Part B ambulance fee schedule (FS). For historical reference, refer to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html> on the CMS website to view the previous version of this chapter.

10.2 - Summary of the Benefit

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

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:

- 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 this chapter or in the above-cited CMS Manuals may also apply to the provider/supplier or to a particular transport or billing.

10.3 - Definitions

(Rev. 3076, Issued: 09-24-14, Effective: Upon Implementation of ICD-10 ASC X12: 01-01-12, Implementation: ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Most of the definitions previously found in this chapter can now be found in IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services. Other definitions pertaining to payment and claims processing follow.

A/B MAC (A)

Definition: For the purposes of this chapter only, the term refers to those contractors that process claims for institutionally-based ambulance providers billed on the ASC X12 837 institutional claim transaction or Form CMS-1450.

A/B MAC (B)

Definition: For the purposes of this chapter only, the term refers to those contractors that process claims for ambulance suppliers billed on the ASC X12 837 professional claim transaction or a CMS-1500 form.

Date of Service

Definition: The date of service (DOS) of an ambulance service is the date that the loaded ambulance vehicle departs the point of pickup. 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.

Point of Pickup (POP)

Definition: Point of pickup is the location of the beneficiary at the time he or she is placed on board the ambulance.

Application: The ZIP Code of the POP must be reported on each claim for ambulance services so that the correct Geographic Adjustment Factor (GAF) and Rural Adjustment Factor (RAF) may be applied, as appropriate.

Provider

Definition: For the purposes of this chapter 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), a fund.

Supplier

Definition: For the purposes of this chapter, the term supplier is defined as any ambulance service that is not institutionally based. A supplier can be an independently owned and operated 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.

10.4 - Additional Introductory Guidelines

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

Since April 1, 2002 (the beginning of the transition to the full implementation of the ambulance fee schedule), payment for a medically necessary ambulance service is based on the level of service provided, not on the vehicle used.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered “patient transportation” and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building. See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 10.3.3 - Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service for further details. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing, section 10.5 - Hospital Inpatient Bundling for additional

information on hospital inpatient bundling of ambulance services. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing for the definitions of an inpatient for the various inpatient facility types. All Prospective Payment Systems (PPS) have a different criteria for determining when ambulance services are payable (i.e., during an interrupted stay, on date of admission and date of discharge).

NOTE: The cost of oxygen and its administration in connection with and as part of the ambulance service is covered. Under the ambulance FS, oxygen and other items and services provided as part of the transport are included in the FS base payment rate and are NOT separately payable.

The A/B MAC (A) is responsible for the processing of claims for ambulance services furnished by a hospital based ambulance or for ambulance services provided by a supplier if provided under arrangements for an inpatient. The A/B MAC (B) is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. See section 10.2 below for further clarification of the definition of Providers and Suppliers of ambulance services.

Effective December 21, 2000, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH are paid on a reasonable cost basis, but only if the CAH or entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH or entity. Beginning February 24, 1999, ambulance transports to or from a non-hospital-based dialysis facility, origin and destination modifier "J," satisfy the program's origin and destination requirements for coverage.

Ambulance supplier services furnished under arrangements with a provider, e.g., hospital or SNF are typically not billed by the supplier to its A/B MAC (B), but are billed by the provider to its A/B MAC (A). The A/B MAC (A) is responsible for determining whether the conditions described below are met. In cases where all or part of the ambulance services are billed to the A/B MAC (B), the A/B MAC (B) has this responsibility, and the A/B MAC (A) shall contact the A/B MAC (B) to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the A/B MAC (A) should accept the A/B MAC (B)'s determination without pursuing its own investigation.

Where a provider furnishes ambulance services under arrangements with a supplier of ambulance services, such services can be covered only if the supplier's vehicles and crew meet the certification requirements applicable for independent ambulance suppliers.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, if ambulance claims submitted with a code(s) that is/are not separately billable the payment for the code(s) is included in the base rate.

Contractors shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO
CARC: 97
RARC: N390
MSN: 1.6

This is true whether the primary transportation service is allowed or denied. When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

Payment for ambulance services may be made only on an assignment related basis.

Prospective payment systems, including the Ambulance Fee Schedule, are exempt from Inherent Reasonableness provisions.

20 - Payment Rules

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
B3-4115, 5116, PM AB-02-131

Medicare covered ambulance services are paid based on the Medicare ambulance fee schedule.

The following subsections describe how contractors calculate the payment amount. Section 20.1 and its subsections describe how the payment amount is calculated for the fee schedule. The other subsections in §20 provide information on certain components of the payment amount (e.g., mileage) or specialized payment amounts (e.g., air ambulance).

20.1 - Payment Under the Ambulance Fee Schedule

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

20.1.1 - General

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Payment under the fee schedule for ambulance services:

- Includes a base rate payment plus a separate payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Does not include a separate payment for items and services furnished under the ambulance benefit.

Payment for items and services is included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing (e.g., ancillary services) - but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit.

For additional information on the fee schedule, contractors may refer to the “Ambulance Services Center” on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html>

20.1.2 - Jurisdiction

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

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.

20.1.3 - Services Provided

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

AB-03-106

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.

20.1.4 - Components of the Ambulance Fee Schedule

(Rev. 3800, Issued: 06-23-17, Effective: 07-25-17, Implementation: 07-25-17)

The mileage rates provided in this section are the base rates that are adjusted by the yearly ambulance inflation factor (AIF). The payment amount under the fee schedule is determined as follows:

- **For ground ambulance services**, the fee schedule amount includes:
 1. A money amount that serves as a nationally uniform base rate, called a “conversion factor” (CF), for all ground ambulance services;
 2. A relative value unit (RVU) assigned to each type of ground ambulance service;
 3. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (geographic practice cost index (GPCI));
 4. A nationally uniform loaded mileage rate;
 5. An additional amount for certain mileage for a rural point-of-pickup; and

6. For specified temporary periods, certain additional payment amounts as described in section 20.1.4A, below.

- **For air ambulance services**, the fee schedule amount includes:

1. A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
2. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (GPCI);
3. A nationally uniform loaded mileage rate for each type of air service; and
4. A rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup.

A. Ground Ambulance Services

1. Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF is updated annually by the ambulance inflation factor and for other reasons as necessary.

2. Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, e.g., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

The RVUs are as follows:

Service Level	RVU
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

3. Geographic Adjustment Factor (GAF)

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services. The GAF for the ambulance FS uses the non-facility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the ambulance FS are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance (POP) establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the POP establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70 percent of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the ground mileage rate.

4. Mileage

In the context of all payment instructions, the term “mileage” refers to loaded mileage. The ambulance FS provides a separate payment amount for mileage. The mileage rate per statute mile applies for all types of ground ambulance services, except Paramedic Intercept, and is provided to all Medicare contractors electronically by CMS as part of the ambulance FS. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

5. Adjustment for Certain Ground Mileage for Rural Points of Pickup (POP)

The payment rate is greater for certain mileage where the POP is in a rural area to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period.

If the POP is a rural ZIP Code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. For loaded miles 1-17, the rural adjustment for ground mileage is 1.5 times the rural mileage allowance.

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).

The following chart summarizes the above information:

Service	Dates of Service	Bonus	Calculation
Loaded miles 1-17, Rural POP	Beginning 4/1/02	50%	FS Rural mileage * 1.5

Service	Dates of Service	Bonus	Calculation
Loaded miles 18-50, Rural POP	4/1/02 - 12/31/03	25%	FS Rural mileage * 1.25
All loaded miles (Urban or Rural POP) 51+	7/1/04 - 12/31/08	25%	FS Urban or Rural mileage * 1.25

The POP, as identified by ZIP Code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the ZIP Code of the POP establishes whether a rural adjustment applies to such second (or subsequent) transport.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service (USPS) ZIP Code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or in New England, a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the “Goldsmith modification.” (The Goldsmith modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;
- It is located outside of an MSA or NECMA; or
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.

See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 30.1.1 - Ground Ambulance Services for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable FS amount for mileage. Thus, when rural mileage is involved, the contractor compares the calculated FS rural mileage payment rate to the provider’s/supplier’s actual charge for mileage and pays the lesser amount.

The CMS furnishes the ambulance FS files to claims processing contractors electronically. 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/afspuf.html>) for public consumption. To clarify whether a particular ZIP Code is rural or urban, please refer to the most recent version of the Medicare supplied ZIP Code file.

6. Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground ambulance transports is subject to a minimum amount. This minimum amount depends upon the area of the country in which the service is furnished. The country is divided into 9 census divisions and each of the census divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national rate and the regional rate in accordance with the following schedule:

Year	National FS Percentage	Regional FS Percentage
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 - CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. Note that this provision affects only the FS portion of the blended transition payment rate. This floor amount is calculated by CMS centrally and is incorporated into the FS amount that appears in the FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the MAC in order to implement this provision.

7. Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2010, the base rate portion of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by a percentage amount determined by CMS. Section 3105 (c) and 10311 (c) of the Affordable Care Act amended section 1834 (1) (13) (A) of the Act to extend this rural bonus for an additional year through December 31, 2010. This increase applies if the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. CMS will determine this bonus amount and the designated POP rural ZIP Codes in which the bonus applies. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a “B” indicator on the national ZIP Code file. Contractors must apply the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP Codes.

Subsequently, section of 106 (c) of the MMEA again amended section 1843 (l) (13) (A) of the Act to extend the rural bonus an additional year, through December 31, 2011.

8. Adjustments for 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, 2010. 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 2003 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. 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 2003 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. Subsequently, section 106 (a) of the Medicare and Medicaid Extenders Act of 2010 (MMEA) again amended section 1834 (1) (12) (A) of the Act to extend the payment increases for an additional year, through December 31, 2011. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the MAC in order to implement this provision.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that became effective on July 1, 2004 as well as the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 changes that became effective July 1, 2008 and were extended by the Patient Protection and Affordable Care Act of 2010 and the Medicare and Medicaid Extenders Act of 2010 (MMEA).

Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA, MIPPA and MMEA

Service	Effective Dates	Payment Increase*
All rural miles	7/1/04 - 12/31/06	2%
All rural miles	7/1/08 - 12/31/11	3%
Rural miles 51+	7/1/04 - 12/31/08	25% **
All urban miles	7/1/04 - 12/31/06	1%
All urban miles	7/1/08 - 12/31/11	2%
Urban miles 51+	7/1/04 - 12/31/08	25% **
All rural base rates	7/1/04 - 12/31/06	2%
All rural base rates	7/1/08 - 12/31/11	3%
Rural base rates (lowest quartile)	7/1/04 - 12/31/11	22.6 % **
All urban base rates	7/1/04 - 12/31/06	1%
All urban base rates	7/1/08 - 12/31/11	2%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

NOTES: * All payments are percentage increases and all are cumulative.

**Contractor systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file.

B. Air Ambulance Services

1. Base Rates

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services.

2. Geographic Adjustment Factor (GAF)

The GAF, as described above for ground ambulance services, is also used for air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50 percent of each of the base rates (fixed and rotary wing).

3. Mileage

The FS for air ambulance services provides a separate payment for mileage.

4. Adjustment for Services Furnished in Rural Areas

The payment rates for air ambulance services where the POP is in a rural area are greater than in an urban area. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted FS amount, e.g., the applicable air service base rate multiplied by the GAF plus the mileage amount or, in other words, 1.5 times both the applicable air service base rate and the total mileage amount.

The basis for a rural adjustment for air ambulance services is determined in the same manner as for ground services. That is, whether the POP is within a rural ZIP Code as described above for ground services.

20.1.5 - ZIP Code Determines Fee Schedule Amounts

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

The POP determines the basis for payment under the FS, and the POP is reported by its 5-digit ZIP Code. Thus, the ZIP Code of the POP determines both the applicable GPCI and whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the ZIP Code of the POP of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the ZIP Code of the POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment. Part B contractors must report the POP ZIP Code, at the line item level, to

CWF when they report all other ambulance claim information. CWF must report the POP ZIP Code to the national claims history file, along with the rest of the ambulance claims record.

A. No ZIP Code

In areas without an apparent ZIP Code, it is the provider's/supplier's responsibility to confirm that the POP does not have a ZIP Code that has been assigned by the USPS. If the provider/supplier has made a good-faith effort to confirm that no ZIP Code for the POP exists, it may use the ZIP Code nearest to the POP.

Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the POP does not have an assigned ZIP Code and annotate the claim to indicate that a surrogate ZIP Code has been used (e.g., "Surrogate ZIP Code; POP in No-ZIP"). Providers and suppliers should maintain this documentation and provide it to their contractor upon request.

Contractors must request additional documentation from providers/suppliers when a claim submitted using a surrogate ZIP Code does not contain sufficient information to determine that the ZIP Code does not exist for the POP. They must investigate and report any claims submitted with an inappropriate and/or falsified surrogate ZIP Code.

If the ZIP Code entered on the claim is not in the CMS-supplied ZIP Code File, manually verify the ZIP Code to identify a potential coding error on the claim or a new ZIP Code established by the U.S. Postal Service (USPS). ZIP Code information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP Code information may be consulted.

- If this process validates the ZIP Code, the claim may be processed. All such ZIP Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural, unless the contractor exercises its discretion to designate the ZIP Code as rural. (See Section §20.1.5.B – New ZIP Codes)
- If this process does not validate the ZIP Code, the claim must be rejected as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two

Group Code: CO
CARC: 16
RARC: N53
MSN: N/A

B. New ZIP Codes

New ZIP Codes are considered urban until CMS determines that the ZIP Code is located in a rural area. Thus, until a ZIP Code is added to the Medicare ZIP Code file with a rural designation, it will be considered an urban ZIP Code. However, despite the default designation of new ZIP Codes as urban, contractors have discretion to determine that a new ZIP Code is rural until designated otherwise. If the contractor designates a new ZIP Code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment.

Providers and suppliers should annotate claims using a new ZIP Code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP Code and provide it to their contractor upon request.

If the provider or supplier believes that a new ZIP Code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare FS regulation), it may request an adjustment from the A/B MAC (A) or appeal the determination with the A/B/MAC (B), as applicable, in accordance with standard procedures.

When processing a claim with a POP ZIP Code that is not on the Medicare ZIP Code file, contractors must search the USPS Web site at <http://www.usps.com/>, other governmental Web sites, and commercial Web sites, to validate the new ZIP Code. (The Census Bureau Web site located at <http://www.census.gov/> contains a list of valid ZIP Codes.) If the ZIP Code cannot be validated using the USPS Web site or other authoritative source such as the Census Bureau Web site, reject the claim as unprocessable.

C. Inaccurate ZIP Codes

If providers and suppliers knowingly and willfully report a surrogate ZIP Code because they do not know the proper ZIP Code, they may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP Code on a claim when not appropriate to do so for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

D. Claims Outside of the U.S.

The following policy applies to claims outside of the U.S.:

- Ground transports with pickup and drop off points within Canada or Mexico will be paid at the fee associated with the U.S. ZIP Code that is closest to the POP;
- For water transport from the territorial waters of the U.S., the fee associated with the U.S. port of entry ZIP Code will be paid;
- Ground transports with pickup within Canada or Mexico to the U.S. will be paid at the fee associated with the U.S. ZIP Code at the point of entry; and

- Fees associated with the U.S. border port of entry ZIP Codes will be paid for air transport from areas outside the U.S. to the U.S. for covered claims.

As discussed more fully below, CMS will provide contractors with a file of ZIP Codes that will map to the appropriate geographic location and, where appropriate, with a rural designation identified with the letter “R” or “B.” Urban ZIP Codes are identified with a blank in this position.

20.1.5.1 - CMS Supplied National ZIP Code File and National Ambulance Fee Schedule File

(Rev. 2703, Issued: 05-10-13, Effective: 10-01-13, Implementation: 10-07-13)

CMS will provide each contractor with two files: a national ZIP Code file and a national Ambulance FS file.

A. The national ZIP5 Code file is a file of 5-digit USPS ZIP Codes that will map each ZIP Code to the appropriate FS locality. Every 2 months, CMS obtains an updated listing of ZIP Codes from the USPS. On the basis of the updated USPS file, CMS updates the Medicare ZIP Code file and makes it available to contractors.

The following is a record layout of the ZIP5 file effective January 1, 2009

ZIP5 CODE to LOCALITY RECORD LAYOUT

Field Name	Position	Format	COBOL Description
State	1-2	X(02)	Alpha State Code
ZIP Code	3-7	X(05)	Postal ZIP Code
A/B MAC (B)	8-12	X(05)	A/B MAC (B) Number
Pricing Locality	13-14	X(02)	Pricing Locality
Rural Indicator	15	X(01)	Effective 1/1/07 Blank = urban, R=rural, B=super rural
Beneficiary Lab CB Locality	16-17	X(02)	Lab competitive bid locality; Z1= CBA1 Z2= CBA2 Z9= Not a demonstration locality

Field Name	Position	Format	COBOL Description
Rural Indicator 2	18	X(01)	What was effective 12/1/06 Blank=urban, R=rural, B=super rural
Filler	19-20	X(02)	
Plus Four Flag	21	X(01)	0 = no +4 extension 1 = +4 extension
Filler	22-75	X(54)	
Year/Quarter	76-80	X(05)	YYYYQ

NOTE: Effective October 1, 2007, claims for ambulance services will continue to be submitted and priced using 5-digit ZIP Codes. Contractors will not need to make use of the ZIP9 file for ambulance claims.

Beginning in 2009, contractors shall maintain separate ZIP Code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP Code file based on the date of service submitted on the claim.

A ZIP Code located in a rural area will be identified with either a letter “R” or a letter “B.” Some ZIP Codes will be designated as rural due to the Rural Urban Commuting Area (RUCA) Score even though the ZIP Code may be located, in whole or in part, within an MSA or Core Based Statistical Area (CBSA).

A “B” designation indicates that the ZIP Code is in a rural county (or RUCA area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. Effective for claims with dates of service between July 1, 2004 and December 31, 2010, contractors must apply a bonus amount to be determined by CMS to the base rate portion of the payment under the FS for ground ambulance services with a POP “B” ZIP Code. This amount is in addition to the rural bonus amount applied to ground mileage for ground transports originating in a rural POP ZIP Code.

Each calendar quarter beginning October 2007, CMS will upload updated ZIP5 and ZIP9 ZIP Code files to the Direct Connect (formerly the Network Data Mover). Contractors shall make use of the ZIP5 file for ambulance claims and the ZIP9 file as appropriate per IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 1 -General Billing Requirements , section 10.1.1 - Payment Jurisdiction Among A/B MACs (B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services and the additional information found in Transmittal 1193, Change Request 5208, issued March 9, 2007. The updated files will be available for downloading on approximately November 15th for the January 1 release, approximately February 15th for the April 1 release, approximately May 15th for the July 1 release, and approximately August 15th for the October 1 release.

Contractors are responsible for retrieving the ZIP Code files upon notification and must implement the following procedure for retrieving the files:

1. Upon quarterly Change Requests communicating the availability of updated ZIP Code files, go to the Direct Connect and search for the files. Confirm that the release number (last 5 digits) corresponds to the upcoming calendar quarter. If the release number (last 5 digits) does not correspond to the upcoming calendar quarter, notify CMS.
2. After confirming that the ZIP Code files on the Direct Connect corresponds to the next calendar quarter, download the files and incorporate the files into your testing regime for the upcoming model release.

The names of the files will be in the following format:

MU00.AAA2390.ZIP5.LOCALITY.Vyyyyr and MU00.AAA2390.ZIP9.LOCALITY.Vyyyyr where “yyyy” equals the calendar year and “r” equals the release number with January =1, April =2, July =3, and October =4. So, for example, the names of the file updates for October 2007 are MU00.AAA2390.ZIP5.LOCALITY.V20074 and MU00.AAA2390.ZIP9.LOCALITY.V20074. The release number for this file is 20074, release 4 for the year 2007.

When the updated files are loaded to the Direct Connect, they will overlay the previous ZIP Code files.

NOTE: Even the most recently updated ZIP Code files will not contain ZIP Codes established by the USPS after CMS compiles the files. Therefore, for ZIP Codes reported on claims that are not on the most recent ZIP Code files, follow the instructions for new ZIP Codes in **§20.1.5(B)**.

B. CMS will also provide contractors with a national Ambulance FS file that will contain payment amounts for the applicable HCPCS codes. The file will include FS payment amounts by locality for all FS localities. The FS file will be available via the CMS Mainframe Telecommunications System. Contractors are responsible for retrieving this file when it becomes available. The full FS amount will be included in this file. CMS will notify contractors of updates to the FS and when the updated files will be available for retrieval. CMS will send a full-replacement file for annual updates and for any other updates that may occur.

The following is a record layout of the Ambulance Fee Schedule file:

AMBULANCE FEE SCHEDULE FILE RECORD DESCRIPTION

Field Name	Position	Format	Description
HCPCS	1-5	X(5)	Level 2 HCPCS code number for the service.
A/B MAC (B) Number	6-10	X(5)	Contractor Number
Locality Code	11-12	X(2)	Identification of Pricing Locality

Field Name	Position	Format	Description
RVU	13-18	9(4)V2	Relative Value Units set a numeric value for ambulance services relative to the value of a base level ambulance service.
GPCI (PE)	19-22	9V3	The GPCI for the practice expense portion of the Medicare physician fee schedule is used to adjust payment to account for regional differences.
Base Rate	23-29	9(5)V2	A nationally uniform “base” amount used to calculate each HCPCS’ payment amount.
Urban Rate	30-36	9(5)V2	Urban Ground/Air mileage rate.
Rural Rate	37-43	9(5)V2	Rural Ground/Air mileage rate.
Current Year	44-47	x(4)	4 digit current effective year.
Current Quarter	48-48	x(1)	1 digit current effective quarter: 1=January, 2=April, 3=July, 4 =October.
Current Date	49-56	x(8)	Current Effective Start Date.
Filler	57-80	X(26)	Future use

20.1.6 - Contractor Determination of Fee Schedule Amounts
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

The FS amount is determined by the FS locality, based on the POP of the ZIP Code. Use the ZIP Code of the POP to electronically crosswalk to the appropriate FS amount. All ZIP Codes on the ZIP Code file are urban unless identified as rural by the letter “R” or the letter “B.” Contractors determine the FS amount as follows:

- If an urban ZIP Code is reported with a ground or air HCPCS code, the contractors determine the amount for the service by using the FS amount for the urban base rate. To

determine the amount for mileage, multiply the number of reported miles by the urban mileage rate.

- If a rural ZIP Code is reported with a ground HCPCS code, the contractor determines the amount for the service by using the FS amount for the rural base rate. To determine the amount for mileage, contractors must use the following formula:
 - For services furnished on or after July 1, 2004, for rural miles 1-17, the rate equals 1.5 times the rural ground mileage rate per mile. Therefore, multiply 1.5 times the rural mileage rate amount on the FS to derive the appropriate FS rate per mile;
 - For services furnished during the period July 1, 2004 through December 31, 2008, for all ground miles greater than 50 (i.e., miles 51+), the FS rate equals 1.25 times the applicable mileage rate (urban or rural). Therefore, multiply 1.25 times the urban or rural, as appropriate, mileage rate amount on the FS to derive the appropriate FS rate per mile.
- If a rural ZIP Code is reported with an air HCPCS code, the contractor determines the FS amount for the service by using the FS amount for rural air base rate. To determine the amount allowable for the mileage, multiply the number of loaded miles by the rural air mileage rate.

20.2 - Payment for Mileage Charges

**(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
B3-5116.3, PM AB-00-131**

Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to his/her arrival at destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes his basic charge for ambulance services and his rate for loaded mileage. Suppliers should be notified that separate charges for unloaded mileage will be denied.

Instructions on billing mileage are found in §30.

20.3 - Air Ambulance

(Rev. 3380, Issued: 10-23-15, Effective: 01-01-16, Implementation: 01-04-16)

Refer to IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 10.4 – Air Ambulance Services, and section 30.1.2 – Definitions of Air Ambulance Services for additional information on the coverage and definitions of air ambulance services. Under certain circumstances, transportation by airplane or helicopter may qualify as covered ambulance services. If the conditions of coverage are met, payment may be made for the air ambulance services.

Air ambulance services are paid at different rates according to two air ambulance categories:

- **AIR** ambulance service, conventional air services, transport, one way, **fixed wing** (FW) (HCPCS code A0430)
- **AIR** ambulance service, conventional air services, transport, one way, **rotary wing** (RW) (HCPCS code A0431)

Covered air ambulance mileage services are paid when the appropriate HCPCS code is reported on the claim:

- HCPCS code A0435 identifies FIXED WING AIR MILEAGE
- HCPCS code A0436 identifies ROTARY WING AIR MILEAGE

Effective for claims with dates of service on or after January 1, 2011, air mileage must be reported in fractional numbers of loaded statute miles flown. Contractors must ensure that the appropriate air transport code is used with the appropriate mileage code.

Air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician's office, or a patient's home may not be paid air ambulance. The destination is identified by the use of an appropriate modifier as defined in Section 30(A) of this chapter.

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing. Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions;
- Hazardous weather; or
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 – Intermediary MR Guidelines for Specific Services contains instructions for Medical Review of Air Ambulance Services.

20.4 - Ambulance Inflation Factor (AIF)

(Rev. 3625, Issued: 10-14-16, Effective: 01-01-17, Implementation; 01-03-17)

Section 1834(l)(3)(B) of the Social Security Act (the Act) provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the Ambulance Inflation Factor (AIF). These updated percentages are issued via Recurring Update Notifications.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Following is a chart tracking the history of the AIF:

<u>CY</u>	<u>AIF</u>
2003	1.1
2004	2.1
2005	3.3
2006	2.5
2007	4.3
2008	2.7
2009	5.0
2010	0.0
2011	-0.1
2012	2.4
2013	0.8
2014	1.0
2015	1.5
2016	-0.4
2017	0.7

20.5 - Documentation Requirements

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the contractor. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

IOM Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4 - Physician Certifications and Recertification of Services, contains specific information on supplier requirements for ambulance certification.

IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services contains information on medical review instructions of ambulance services.

20.6 - Payment for Non-Emergency Trips to/from ESRD Facilities (Rev. 2703, Issued: 05-10-13, Effective: 10-01-13, Implementation: 10-07-13)

Section 637 of the American Taxpayer Relief Act of 2012 requires that, effective for transports occurring on and after October 1, 2013, fee schedule payments for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment be reduced by 10%. The payment reduction affects transports (base rate and mileage) to and from hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. Non-emergency BLS ground transports are identified by Healthcare Common Procedure Code System (HCPCS) code A0428.

Ambulance transports to and from renal dialysis treatment are identified by modifier codes “G” (hospital-based ESRD) and “J” (freestanding ESRD facility) in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier. (See Section 30 (A) for information regarding modifiers specific to ambulance.)

Effective for claims with dates of service on and after October 1, 2013, the 10% reduction will be calculated and applied to HCPCS code A0428 when billed with modifier code “G” or “J”. The reduction will also be applied to any mileage billed in association with a non-emergency transport of a beneficiary with ESRD to and from renal dialysis treatment. BLS mileage is identified by HCPCS code A0425.

The 10% reduction will be taken after calculation of the normal fee schedule payment amount, including any add-on or bonus payments, and will apply to transports in rural and urban areas as well as areas designated as “super rural”.

Payment for emergency transports is not affected by this reduction. Payment for non-emergency BLS transports to other destinations is also not affected. This reduction does not affect or change the Ambulance Fee Schedule.

Note: The 10% reduction applies to beneficiaries with ESRD that are receiving non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, contractors have discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.

30 - General Billing Guidelines

(Rev. 3076, Issued: 09-24-14, Effective: Upon Implementation of ICD-10 ASC X12: 01-01-12, Implementation: ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Independent ambulance suppliers may bill on the ASC X12 837 professional claim transaction or the CMS-1500 form. These claims are processed using the MCS system.

Institution based ambulance providers may bill on the ASC X12 837 institutional claim transaction or Form CMS 1450. These claims are processed using the FISS system.

A. Modifiers Specific to Ambulance Service Claims

For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in 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 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-based 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.

B. HCPCS Codes

The following codes and definitions are effective for billing ambulance services on or after January 1, 2001.

AMBULANCE HCPCS CODES AND DEFINITIONS

HCPCS Code	Description of HCPCS Codes
A0425	BLS mileage (per mile)
A0425	ALS mileage (per mile)

HCPCS Code	Description of HCPCS Codes
A0426	Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
A0427	Ambulance service, ALS, emergency transport, Level 1
A0428	Ambulance service, Basic Life Support (BLS), non-emergency transport
A0429	Ambulance service, basic life support (BLS), emergency transport
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers.
A0433	Ambulance service, advanced life support, level 2 (ALS2)
A0434	Ambulance service, specialty care transport (SCT)
A0435	Air mileage; FW, (per statute mile)
A0436	Air mileage; RW, (per statute mile)

NOTE: PI, ALS2, SCT, FW, and RW assume an emergency condition and do not require an emergency designator.

Refer to IOM Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10 - Ambulance Service, section 30.1 - Definitions of Ambulance Services, for the definitions of levels of ambulance services under the fee schedule.

30.1 - Multi-Carrier System (MCS) Guidelines

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

B3-5116

Payment under the fee schedule for ambulance services:

- Includes a base rate payment plus a payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Precludes a separate payment for items and services furnished under the ambulance benefit.

Payment for items and services is included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing - but only when

such items and services are both medically necessary and covered by Medicare under the ambulance benefit.

30.1.1 - MCS Coding Requirements for Suppliers **(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)** **PM AB-00-88**

The ambulance fee schedule contains the following HCPCS coding logic:

- Seven categories of ground ambulance services;
- Two categories of air ambulance services;
- Payment based on the condition of the beneficiary, not on the type of vehicle used;
- Payment is determined by the point of pickup (as reported by the 5-digit ZIP Code);
- Increased payment for rural services; and
- Services and supplies included in base rate.

30.1.2 - Coding Instructions for Paper and Electronic Claim Forms **(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)**

Except as otherwise noted, beginning with dates of service on or after January 1, 2001, the following coding instructions must be used.

Origin

Electronic billers should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup). Beginning with the early implementation of version 5010 of the ASC X12 837 professional claim format on January 1, 2011, electronic billers are required to submit, in addition to the loaded ambulance trip's origin information (e.g., the ZIP Code of the point of pickup), the loaded ambulance trip's destination information (e.g., the ZIP code of the point of drop-off). Refer to the appropriate Implementation Guide to determine how to report the destination information. Only the ZIP Code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off. However, the point of drop-off is an additional reporting requirement on version 5010 of the ASC X12 837 professional claim format.

Where the CMS-1500 Form is used the ZIP code is reported in item 23. Since the ZIP Code is used for pricing, more than one ambulance service may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP Code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP Codes.

Claims without a ZIP Code in item 23 on the CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N53
MSN: N/A

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

Mileage

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

Beginning with dates of service on or after January 1, 2011, mileage billed must be reported as fractional units in the following situations:

- Where billing is by ASC X12 claims transaction (professional or institutional), and
- Where billing is by CMS-1500 paper form.

Electronic billers should see the appropriate Implementation Guide to determine where to report the fractional units. Item 24G of the Form CMS-1500 paper claim is used.

Fractional units are not required on Form CMS-1450

For trips totaling up to 100 covered miles suppliers must round the total miles up to the nearest tenth of a mile and report the resulting number with the appropriate HCPCS code for ambulance mileage. The decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, suppliers must report mileage rounded up to the next whole number mile without the use of a decimal (e.g., 998.5 miles should be reported as 999).

For trips totaling less than 1 mile, enter a “0” before the decimal (e.g., 0.9).

For mileage HCPCS billed on the ASC X12 837 professional transaction or the CMS-1500 paper form only, contractors shall automatically default to “0.1” units when the total mileage units are missing.

30.1.3 - Coding Instructions for Form CMS-1491
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Effective April 2, 2007, Form CMS-1491 will no longer be a valid format for submitting claims. Suppliers who wish to submit a paper claim must use CMS-1500 Form.

30.1.4 - CWF Editing of Ambulance Claims for Inpatients
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay (see IOM Pub. 100-04, Medicare Claims Processing, chapter 3 - Inpatient Hospital Billing, Section 10.4 - Payment of Nonphysician Services for Inpatients). CWF performs reject edits to incoming claims from suppliers of ambulance services.

Upon receipt of a hospital inpatient claim at the CWF, CWF searches paid claim history and compares the period between the hospital inpatient admission and discharge dates to the line item service date on an ambulance claim billed by a supplier. The CWF will generate an unsolicited response when the line item service date falls within the admission and discharge dates of the hospital inpatient claim.

Upon receipt of an unsolicited response, the A/B MAC (B) will adjust the ambulance claim and recoup the payment.

Ambulance services with a date of service that are the same as an admission or discharge date on an inpatient claim are separately payable and not subject to the bundling rules.

30.2 - Fiscal Intermediary Shared System (FISS) Guidelines
(Rev. 3076, Issued: 09-24-14, Effective: Upon Implementation of ICD-10 ASC X12: 01-01-12, Implementation: ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 6 - SNF Inpatient Part A Billing, Section 20.3.1 - Ambulance Services, for additional information on SNF consolidated billing and ambulance transportation.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing, section 10.5 - Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

In general, the A/B MAC (A) processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill A/B

MACs (A) using only Method 2.

The provider must furnish the following data in accordance with A/B MAC (A) instructions. The A/B MAC (A) will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. General

The reasonable cost per trip of ambulance services furnished by a provider of services may not exceed the prior year's reasonable cost per trip updated by the ambulance inflation factor. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997, and September 30, 1998). Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

The following instructions provide billing procedures implementing the above provisions.

B. Applicable Bill Types

The appropriate type of bill (13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.

C. Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance in the Value Code field. The value code is defined as “ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.” Providers report the number in dollar portion of the form location right justified to the left of the dollar/cents delimiter.

More than one ambulance trip may be reported on the same claim if the ZIP Codes of all points of pickup are the same. However, since billing requirements do not allow for value codes (ZIP Codes) to be line item specific and only one ZIP Code may be reported per claim, providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different ZIP Codes.

For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

NOTE: Information regarding the claim form locator that corresponds to the Value Code field is found in Pub.100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

D. Revenue Code/HCPCS Code Reporting

Providers must report revenue code 054X and, for services **provided before January 1, 2001**, one of the following CMS HCPCS codes for each ambulance trip provided during the billing period:

A0030 (discontinued 12/31/2000); A0040 (discontinued 12/31/2000);
A0050 (discontinued 12/31/2000); A0320 (discontinued 12/31/2000); A0322 (discontinued 12/31/2000); A0324 (discontinued 12/31/2000); A0326 (discontinued 12/31/2000); A0328, (discontinued 12/31/2000); or A0330 (discontinued 12/31/2000).

In addition, providers report one of A0380 or A0390 for mileage HCPCS codes. No other HCPCS codes are acceptable for reporting ambulance services and mileage. Providers report one of the following revenue codes:

0540;
0542;
0543;
0545;
0546; or
0548.

Do not report revenue codes 0541, 0544, or 0547.

For claims with **dates of service on or after January 1, 2001**, providers must report revenue code 540 and one of the following HCPCS codes for each ambulance trip provided during the billing period:

A0426; A0427; A0428; A0429; A0430; A0431; A0432; A0433; or A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly. In addition, all providers report one of the following mileage HCPCS codes: A0380; A0390; A0435; or A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, providers must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

However, in the case where the beneficiary was pronounced dead after the ambulance is called but before the ambulance arrives at the scene: Payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing base rate, as applicable, if an air ambulance is dispatched. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Providers report the A0428 (BLS) HCPCS code. Providers report modifier QL (Patient pronounced dead after ambulance called) in "HCPCS/Rates" instead of the origin and destination modifier. In addition to the QL modifier, providers report modifier QM or QN.

NOTE: Information regarding the claim form locator that corresponds to the HCPCS code is found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

E.Modifier Reporting

See the above Section 30 (A) (Modifiers Specific to Ambulance Service Claims) for instructions regarding the usage of modifiers.

F. Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in the Service Date field.

NOTE: Information regarding the claim form locator that corresponds to the Service Date is

found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

G. Service Units Reporting

For line items reflecting HCPCS code A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001**) or code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**services on and after January 1, 2001**), providers are required to report in Service Units each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, the number of loaded miles must be reported. (See examples below.)

Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, A0435, or A0436, the number of loaded miles must be reported.

H. Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434;

Providers are required to report in Total Charges the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS code A0380, A0390, A0435, or A0436, report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units as a separate line item. For the related charges, providers report \$1.00 in FL48 for non-covered charges. A/B MACs (A) should assign remittance adjustment Group Code OA to the \$1.00 non-covered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

Prior to submitting the claim to CWF, the A/B MAC (A) will remove the entire revenue code line containing the mileage amount reported in Non-covered Charges to avoid non-acceptance of the claim.

NOTE: Information regarding the claim form locator that corresponds to the Charges fields is found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

EXAMPLES: The following provides examples of how bills for Part B ambulance services

should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by providers. Ambulance services provided under arrangement between the provider and an ambulance company are reported in the same manner except providers report a QM modifier instead of a QN modifier.

EXAMPLE 1: Claim containing only one ambulance trip:

Providers report as follows:

Revenue Code	HCPCS/Modifiers	Date of Service	Units	Total Charges
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2: Claim containing multiple ambulance trips:

Providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00
0540	A0330	RH	QN	082901	1 (trip)	400.00
0540	A0390	RH	QN	082901	3 (mileage)	6.00

EXAMPLE 3: Claim containing more than one ambulance trip provided on the same day:

Providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
0540	A0429	RH	QN	090201	1 (trip)	100.00
0540	A0380	RH	QN	090201	2 (mileage)	4.00
0540	A0429	HR	QN	090201	1 (trip)	100.00

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
0540	A0380	HR	QN	090201	2 (mileage)	4.00

I. Edits

FISS edits to assure proper reporting as follows:

- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes - A0435, A0436 or for claims with dates of service on or after April 1, 2002, A0425;
- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;
- The units field is completed for every line item containing revenue code 0540;
- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;
- Service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal "1"

For claims with dates of service on or after July 1, 2001, each 1-way ambulance trip, line- item dates of service for the ambulance service, and corresponding mileage are equal.

30.2.1 - A/B MAC (A) Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation

(Rev. 3076, Issued: 09-24-14, Effective: Upon Implementation of ICD-10 ASC X12: 01-01-12, Implementation: ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 6 - SNF Inpatient Part A Billing, Section 20.3.1 - Ambulance Services for additional information on SNF consolidated billing and ambulance transportation.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing, section 10.5 - Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

In general, the A/B MAC (A) processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill A/B MACs (A) using only Method 2.

The provider must furnish the following data in accordance with A/B MAC (A) instructions. The A/B MAC (A) will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. Revenue Code Reporting on Form CMS-1450

Providers report ambulance services under revenue code 540 in FL 42 “Revenue Code.”

B. HCPCS Codes Reporting on Form CMS-1450

Providers report the HCPCS codes established for the ambulance fee schedule. No other HCPCS codes are acceptable for the reporting of ambulance services and mileage. The HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used.

Providers must report one of the following HCPCS codes in FL 44 “HCPCS/Rates” for each base rate ambulance trip provided during the billing period:

A0426;
A0427;
A0428;
A0429;
A0430;
A0431;
A0432;
A0433; or
A0434.

These are the same codes required effective for services January 1, 2001.

In addition, providers must report **one** of HCPCS mileage codes:

A0425;
A0435; or
A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, providers must report revenue code 540 (ambulance) on two separate and consecutive line items to accommodate both the ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

For Form CMS-1450 claims submission prior to August 1, 2011, providers code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

Beginning with dates of service on or after January 1, 2011, for Form CMS-1450 hard copy claims submissions August 1, 2011 and after, mileage must be reported as fractional units. When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling less than 1 mile, enter a “0” before the decimal (e.g., 0.9).

For electronic claims submissions prior to January 1, 2011, providers code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

Beginning with dates of service on or after January 1, 2011, for electronic claim submissions only, mileage must be reported as fractional units for trips totaling up to 100 covered miles.

When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, providers must report mileage rounded up to the nearest whole number mile (e.g., 999) and not use a decimal when reporting whole number miles over 100 miles.

For trips totaling less than 1 mile, enter a “0” before the decimal (e.g., 0.9).

C. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided and either a QM (Ambulance service provided under arrangement by a provider of services) or QN (Ambulance service furnished directly by a provider of services) modifier in FL 44 “HCPCS/Rates”.

D. Service Units Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in “Service Units” for each ambulance trip provided. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0425, A0435, or A0436, providers must also report the number of loaded miles.

E. Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in Total Charges the actual charge for the ambulance service including all supplies used for the ambulance trip, but excluding the charge for mileage.

For line items reflecting HCPCS codes A0425, A0435, or A0436, providers are to report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units. For the related charges, providers report \$1.00 in non-covered charges. A/B MACs (A) should assign remittance adjustment Group Code OA to the \$1.00 non-covered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

F. Edits (A/B MAC (A) Claims with Dates of Service On or After 4/1/02)

For claims with dates of service on or after April 1, 2002, FISS performs the following edits to assure proper reporting:

- Edit to assure each pair of revenue codes 540 have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes - A0425, A0435, or A0436.
- Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540;
- Edit to assure that the unit's field is completed for every line item containing revenue code 540;
- Edit to assure that service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal "1"; and
- Edit to assure on every claim that revenue code 540, a value code of A0 (zero), and a corresponding ZIP Code are reported. If the ZIP Code is not a valid ZIP Code in accordance with the USPS assigned ZIP Codes, A/B MACs (A) verify the ZIP Code to determine if the ZIP Code is a coding error on the claim or a new ZIP Code from the USPS not on the CMS supplied ZIP Code File.
- Beginning with dates of service on or after April 1, 2012, edit to assure that only non-emergency trips (i.e., HCPCS A0426, A0428 [when A0428 is billed without modifier QL]) require an NPI in the Attending Physician field. Emergency trips do not require an NPI in the Attending Physician field (i.e., A0427, A0429, A0430, A0431, A0432, A0433, A0434 and A0428 [when A0428 is billed with modifier QL])

G. CWF (A/B MACs (A))

A/B MACs (A) report the procedure codes in the financial data section. They include revenue code, HCPCS code, units, and covered charges in the record. Where more than one HCPCS code procedure is applicable to a single revenue code, the provider reports each HCPCS code and related charge on a separate line, and the A/B MAC (A) reports this to CWF. Report the payment amount before adjustment for beneficiary liability in "Rate" and the actual charge in "Covered Charges."

30.2.2 - SNF Billing

(Rev. 3620; Issued: 10-07-16; Effective: 11-08-16, Implementation: 11-08-16)

The following ambulance transportation and related ambulance services for residents in Part A stays are not included in the PPS rate. For additional information, see Chapter 6, SNF Inpatient Part A Billing and SNF Consolidated Billing, § 20.3.1, Ambulance Services. They may be billed as Part B services by the supplier only in the following situations:

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS code modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.)
- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS code ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date, and the SNF patient status (FL 22) is other than 30.)
- The ambulance trip is to a hospital based or non-hospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility).
- The ambulance trip is from the SNF to another SNF (the first and second character (origin and destination) of any ambulance HCPCS code modifier is “N” (SNF)) and the beneficiary is not in a Part A stay.

Ambulance payment associated with the following outpatient hospital service exclusions is paid under the ambulance fee schedule:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRIs);
- Ambulatory surgery involving the use of an operating room, including the insertion, removal, or replacement of a percutaneous esophageal gastrostomy (PEG) tube in the hospital’s gastrointestinal (GI) or endoscopy suite;
- Emergency services;
- Angiography;
- Lymphatic and Venous Procedures; and
- Radiation therapy.

See Chapter 6, § 20.1.2, Other Excluded Services Beyond the Scope of a SNF Part A Benefit, for further information pertaining to the list of services that are excluded from SNF Part A payment referenced above.

The following ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and may not be billed as Part B services by the supplier. For additional information, see Chapter 6, § 20.3.1, In these scenarios, the services provided are subject to SNF CB and the first SNF is responsible for billing the services to the A/B MAC (A):

- A beneficiary's transfer from one SNF to another before midnight of the same day. The first and second characters (origin and destination) of any HCPCS code ambulance modifier are "N" (SNF).
- A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport. When billing for ambulance transports, suppliers should indicate whether the transport was part of a SNF Part A covered stay, using the appropriate origin/destination modifier (e.g., "NH" for a transport from a SNF to a hospital).
- Suppliers should bill with an "NN" origin/destination modifier when a SNF to SNF transport occurs. A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport.
 - Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.). The first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (Diagnostic or therapeutic site other than P or H), and the other modifier (origin or destination) is "N" (SNF).

30.2.3 - Indian Health Service (IHS)/Tribal Billing

(Rev. 2102, Issued: 11-19-10, Effective: 04-01-11, Implementation: 04-04-11)

Ambulance services furnished by IHS/Tribal hospitals including Critical Access Hospitals (CAHs) will be paid according to the appropriate payment methodology.

For dates of service on or after December 21, 2000 and prior to January 1, 2004, medically necessary ambulance services furnished by an IHS/Tribal CAH or by an entity that is owned and operated by an IHS/Tribal CAH are paid based on 100 percent of the reasonable cost if the 35 mile rule for cost-based payment is met. In order for the 35 mile rule to be met, the IHS/Tribal CAH or the entity that is owned and operated by the IHS/Tribal CAH, must be the only provider or supplier of ambulance services that is located within a 35 mile drive of the IHS/Tribal CAH or the entity. Those CAHs that meet the 35 mile rule for cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.

For dates of service on or after January 1, 2004, ambulance services furnished by an IHS/Tribal CAH or by an entity that is owned and operated by an IHS/Tribal CAH are paid based on 101 percent of the reasonable cost if the 35 mile rule for cost-based payment is met.

When the 35 mile rule for cost-based payment is not met, the IHS/Tribal CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the IHS/Tribal CAH is paid based on the ambulance fee schedule.

Other IHS/Tribal hospital based ambulance services are reimbursed based on the ambulance fee schedule.

30.2.4 - Non-covered Charges on Institutional Ambulance Claims (Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare law contains a restriction that miles beyond the closest available facility cannot be billed to Medicare. Non-covered miles beyond the closest facility are billed with HCPCS procedure code A0888 (“non-covered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility”). These non-covered line items can be billed on claims also containing covered charges. Ambulance claims may use the -GY modifier on line items for such non-covered mileage, and liability for the service will be assigned correctly to the beneficiary.

The method of billing all miles for the same trip, with covered and non-covered portions, on the same claim is preferable in this scenario. However, billing the non-covered mileage using condition code 21 claims is also permitted, if desired, as long as all line items on the claims are non-covered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories but excepting some points in Canada and Mexico in some cases, mileage is also statutorily excluded from Medicare coverage. Such billings are more likely to be submitted on entirely non-covered claims using condition code 21. This scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

Another scenario in which billing non-covered mileage to Medicare may occur is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. The -QL modifier should be used on the base rate line in this scenario, in place of origin and destination modifiers, and the line is submitted with covered charges. The -QL modifier should also be used on the accompanying mileage line, if submitted, with non-covered charges. Submitting this non-covered mileage line is optional for providers.

Non-covered charges may also apply if there is a subsidy of mileage charges that are never charged to Medicare. Because there are no charges for Medicare to share in, the only billing option is to submit non-covered charges, if the provider bills Medicare at all (it is not required in such cases). These non-covered charges are unallowable, and should not be considered in settlement of cost reports. However, there is a difference in billing if such charges are subsidized, but otherwise would normally be charged to Medicare as the primary payer. In this latter case, CMS examination of existing rules relating to grants policy since October 1983, supported by Federal regulations (42CFR 405.423), generally requires providers to reduce their costs by the amount of grants and gifts restricted to pay for such costs. Thereafter, section 405.423 was deleted from the regulations.

Thus, providers were no longer required to reduce their costs for restricted grants and gifts, and charges tied to such grants/gifts/subsidies should be submitted as covered charges. This is in keeping with Congress's intent to encourage hospital philanthropy, allowing the provider receiving the subsidy to use it, and also requiring Medicare to share in the unreduced cost. Treatment of subsidized charges as non-covered Medicare charges serves to reduce Medicare payment on the Medicare cost report contrary to the 1983 change in policy.

Medicare requires the use of the -TQ modifier so that CMS can track the instances of the subsidy scenario for non-covered charges. The -TQ should be used whether the subsidizing entity is governmental or voluntary. The -TQ modifier is not required in the case of covered charges submitted when a subsidy has been made, but charges are still normally made to Medicare as the primary payer.

If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider covered charges occurring in the subsidy case, since Medicare had previous billing instructions that stated all charges in the case of a subsidy, not just charges when the entity providing the subsidy never charges another entity/primary payer, should be submitted as non-covered charges, they may contact their A/B MAC (A) about reopening the reports in question for which the time period in 42 CFR 405.1885 has not expired. A/B MACs (A) have the discretion to determine if the amount in question warrants reopening. The CMS does not expect many such cases to occur.

Billing requirements for all these situations, including the use of modifiers, are presented in the chart below:

Mileage Scenario	HCPCS	Modifiers*	Liability	Billing	Remit. Requirements	MSN Message
STATUTE: Miles beyond closest facility, OR **Pick up point outside of U.S.	A0888 on line item for the non-covered mileage	-QM or -QN, origin/destination modifier, and -GY unless condition code 21 claim used	Beneficiary	Bill mileage line item with A0888 -GY and other modifiers as needed to establish liability, line item will be denied; OR bill service on condition code 21 claim, no -GY required, claim will be denied	Group code PR, reason code 96	16.10 “Medicare does not pay for this item or service”; OR, “Medicare no paga por este artículo o servicio”
Beneficiary dies after ambulance is called	Most appropriate ambulance HCPCS mileage code (i.e., ground, air)	-QL unless condition code -21 claim	Provider	Bill mileage line item with -QL as non-covered, line item will be denied	Group Code CO, reason code 96	16.58 “The provider billed this charge as non-covered. You do not have to pay this amount.” OR, “El proveedor facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”

Mileage Scenario	HCPCS	Modifiers*	Liability	Billing	Remit. Requirements	MSN Message
Subsidy or government owned Ambulance, Medicare NEVER billed***	A0888 on line item for the non-covered mileage	-QM or -QN, origin/destination modifier, and -TQ must be used for policy purposes	Provider	Bill mileage line item with A0888, and modifiers as non-covered, line item will be denied	Group Code CO, reason code 96	16.58 “The provider billed this charge as non-covered. You do not have to pay this amount.” OR, “El proveedor facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”

* Current ambulance billing requirements state that either the -QM or -QN modifier must be used on services. The -QM is used when the “ambulance service is provided under arrangement by a provider of services,” and the -QN when the “ambulance service is provided directly by a provider of services.” Line items using either the -QM or -QN modifiers are not subject to the FISS edit associated with FISS reason code 31322 so that these lines items will process to completion. Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination, and are not non-covered by definition.

** This is the one scenario where the base rate is not paid in addition to mileage, and there are certain exceptions in Canada and Mexico where mileage is covered as described in existing ambulance instructions.

***If Medicare would normally have been billed, submit mileage charges as covered charges despite subsidies.

Medicare systems may return claims to the provider if they do not comply with the requirements in the table.

40 - Medical Conditions List and Instructions

(Rev. 3240, Issued: 04-24-15, Effective: 07-27-15, Implementation: 07-27-15)

See <http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html> for a medical conditions list and instructions to assist 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.

In addition to reporting one of the medical conditions on the claim, one of the transportation indicators 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. Information on the appropriate use of transportation indicators is also available at <http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html>

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R3800CP	06/23/2017	Internet Only Manual Update to Pub. 100-04, Chapter 15	07/25/2017	10143
R3625CP	10/14/2016	Ambulance Inflation Factor for CY 2017 and Productivity Adjustment	01/03/2017	9811
R3620CP	10/07/2016	Update to Pub 100-04, Medicare Claims Processing Manual, Chapter 15: Ambulance	11/08/2016	9791
R3481CP	03/18/2016	Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages	06/20/2016	9562
R3380CP	10/23/2015	Ambulance Inflation Factor for CY 2016 and Productivity Adjustment	01/04/2016	9412
R3240CP	04/24/2015	Medicare Claims Processing Manual - Chapter 15, Section 40, Ambulance - Medical Conditions List	07/27/2015	9142
R3090CP	10/07/2014	Ambulance Inflation Factor for CY 2015 and Productivity Adjustment	01/05/2015	8895
R3076CP	09/24/2014	Update to Pub. 100-04, Chapter 15 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractors (MAC) Implementation	09/16/2014	8604
R3057CP	08/29/2014	Ambulance Inflation Factor for CY 2015 and Productivity Adjustment – Rescinded and replaced by Transmittal 3090	01/05/2015	8895
R3027CP	08/14/2014	Update to Pub. 100-04, Chapter 15 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractors (MAC) Implementation – Rescinded and replaced by Transmittal 3076	09/16/2014	8604
R2908CP	03/14/2014	Update to Pub. 100-04, Chapter 15 to Provide Language-Only Changes for Updating ICD-10 and ASC X12 – Rescinded and replaced by Transmittal	10/01/2014	8604

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		3027		
<u>R2788CP</u>	09/20/2013	Ambulance Inflation Factor for CY 2014 and Productivity Adjustment	01/06/2014	8452
<u>R2703CP</u>	05/10/2013	Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities	10/07/2013	8269
<u>R2620CP</u>	12/21/2012	Ambulance Inflation Factor CY 2013 and Productivity Adjustment	01/07/2013	8156
<u>R2383CP</u>	01/12/2012	FISS Claims Processing Updates for Ambulance Services	04/02/2012	7557
<u>R2336CP</u>	10/28/2011	FISS Claims Processing Updates for Ambulance Services – Rescinded and replaced by Transmittal 2383	04/02/2012	7557
<u>R2318CP</u>	10/13/2011	Update to the Internet Only Manual Pub. 100-04, Chapter 15 - Ambulance, to Include the Medicare and Medicaid Extenders Act of 2010 (MMEA) Provisions	01/03/2012	7558
<u>R2313CP</u>	09/30/2011	Update to the Internet Only Manual Pub. 100-04, Chapter 15 - Ambulance, to Include the Medicare and Medicaid Extenders Act of 2010 (MMEA) Provisions – Rescinded and replaced by Transmittal 2318	01/03/2012	7558
<u>R2310CP</u>	09/23/2011	Ambulance Inflation Factor for CY 2012	01/03/2012	7546
<u>R2162CP</u>	02/22/2011	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set	03/21/2011	7018
<u>R2124CP</u>	12/23/2010	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set - Rescinded and replaced by Transmittal 2162	01/25/2011	7018

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<u>R2104CP</u>	11/19/2010	Ambulance Inflation Factor for CY 2011 and Productivity Adjustment	01/03/2011	7042
<u>R2103CP</u>	11/19/2010	Fractional Mileage Units Submitted on Ambulance Claims	01/03/2011	7065
<u>R2102CP</u>	11/19/2010	Systems Changes Necessary to Implement “Technical Correction Related to Critical Access Hospital Services”, Section 3128 of the Affordable Care Act, Pub. 118-148	04/04/2011	7219
<u>R2074CP</u>	10/25/2010	Ambulance Inflation Factor (AIF) for CY 2011 and Productivity Adjustment – Rescinded and replaced by Transmittal 2104	01/03/2011	7042
<u>R2069CP</u>	10/15/2010	Ambulance Inflation Factor (AIF) for CY 2011 and Productivity Adjustment – Rescinded and replaced by Transmittal 2074	01/03/2011	7042
<u>R2065CP</u>	10/15/2010	Fractional Mileage Units Submitted on Ambulance Claims – Rescinded and replaced by Transmittal 2103	01/03/2011	7065
<u>R2029CP</u>	08/13/2010	Fractional Mileage Units Submitted on Ambulance Claims – Rescinded and replaced by Transmittal 2065	01/03/2011	7065
<u>R1942CP</u>	04/02/2010	Update to the Medical Conditions List and Instructions	05/03/2010	6896
<u>R1921CP</u>	02/19/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010	6563
<u>R1894CP</u>	01/15/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1921	04/05/2010	6563
<u>R1861CP</u>	11/27/2009	Ambulance Inflation Factor for CY 2010	01/04/2010	6631
<u>R1840CP</u>	10/29/2009	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage	04/05/2010	6563

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		(ABNs) – Rescinded and replaced by Transmittal 1894		
<u>R1821CP</u>	09/25/2009	Billing for and Ambulance Transport with More Than One Patient Onboard	10/26/2009	6621
<u>R1696CP</u>	03/06/2009	Updates to the Medicare Claims Processing Manual, Publication 100-04, Chapter 15	04/06/2009	6347
<u>R1682CP</u>	02/13/2009	Clarification of Date of Service (DOS) of Ambulance Services	03/13/2009	6372
<u>R1607CP</u>	10/03/2008	Ambulance Inflation Factor for CY 2009	01/05/2009	6113
<u>R1591CP</u>	09/09/2008	ZIP Code Files by Date of Service - Replaced by Transmittal 1591	07/07/2008	5881
<u>R1472CP</u>	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
<u>R1463CP</u>	02/22/2008	ZIP Code Files by Date of Service - Replaced by Transmittal 1591	07/07/2008	5881
<u>R1421CP</u>	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
<u>R1375CP</u>	11/09/2007	Ambulance Inflation Factor for CY 2008	01/07/2008	5801
<u>R1333CP</u>	08/17/2007	Ambulance: New Remark Code for Denying Separately Billed Services	10/01/2007	5659
<u>R1318CP</u>	08/17/2007	Ambulance: New Remark Code for Denying Separately Billed Services - Replaced by Transmittal 1333	10/01/2007	5659
<u>R1249CP</u>	05/25/2007	Update to Publication 100-04, Chapters 1 and 15 for ZIP5 and ZIP9 Medicare Zip Code Files.	10/01/2007	5578
<u>R1185CP</u>	02/23/2007	Ambulance Fee Schedule-Medical Conditions List	04/02/2007	5442
<u>R1144CP</u>	12/29/2006	Elimination of CMS-1491 and CMS-1490U Forms	04/02/2007	5390

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<u>R1102CP</u>	11/03/2006	Ambulance Inflation Factor (AIF) for CY 2007	01/02/2007	5358
<u>R1100CP</u>	11/03/2006	Jurisdiction for Ambulance Supplier Claims	01/01/2008	5203
<u>R852CP</u>	02/10/2006	Corrected Ambulance Fee Schedule file for CY 2006	02/24/2006	4362
<u>R789CP</u>	12/23/2005	Ambulance Medical Conditions List	03/27/2006	4221
<u>R762CP</u>	11/25/2005	Ambulance Inflation Factor (AIF) for CY 2006	01/03/2006	4061
<u>R668CP</u>	09/02/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
<u>R622CP</u>	07/29/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
<u>R459CP</u>	02/04/2005	Change To CWF SNF Edits For Consolidated Billing for Ambulance Transport to or From Therapeutic Sites -- replaces R342CP	04/04/2005	3676
<u>R437CP</u>	01/21/2005	This instruction revises Section 30, Chapter 6 to include ICD-9-CM coding guidance for Skilled Nursing Facilities (SNFs) and removes Home Health Agency (HHA) Types of Bill from various sections of Chapter 15 to conform with existing policy.	02/22/2005	3664
<u>R425CP</u>	01/10/2005	Payment of Ambulance Services to Indian Health Service (IHS) or Tribal Hospitals Including (CAHs)	04/03/2005	3521
<u>R411CP</u>	12/23/2004	Ambulance Inflation Factor (AIF) for CY 2005	01/03/2005	3599
<u>R395CP</u>	12/15/2004	Ambulance Fee Schedule - Medical Conditions List	01/03/2005	3619
<u>R367CP</u>	11/12/2004	Replaced by <u>Revision 425CP</u>	04/04/2005	3521
<u>R342CP</u>	10/29/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site	04/04/2005	3427

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<u>R220CP</u>	06/25/2004	Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003	07/06/2004	3099
<u>R212CP</u>	06/18/2004	Replaced by <u>Revision 220CP</u>	07/06/2004	3099
<u>R185CP</u>	05/28/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Drugs and Electrocardiogram (EKG) Testing Provided During an Ambulance Transport	10/04/2004	3212
<u>R163CP</u>	04/30/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site Other than a Physician's Office or Hospital	10/04/2004	3196
<u>R088CP</u>	02/06/2004	Implementation of Changes to Payment for Ambulance Services Required by Section 414 of MMA	07/05/2004	3099
<u>R059CP</u>	01/02/2004	Corrects the "Ambulance HCPCS Codes Crosswalk and Definitions," makes technical corrections to the manual, and adds a new carrier requirement for HCPCS code A0800	01/05/2004	3035
<u>R056CP</u>	12/24/2003	Ambulance Inflation Factor (AIF) for CY 2004 including the 2004 AIF for determining the payment limit for ambulance services required by §1834(1) of the Social Security Act (the Act), the blending percentages applicable to CY 2004, and the address of the ambulance fee schedule file for CY 2004	01/05/2004	3000
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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