CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1333	**Date: AUGUST 17, 2007**
	Change Request 5659

This corrects Transmittal 1318, date August 17, 2007. The only change in this Business Requirement is to change BR 5659.2 to correct the Spanish translation of the MSN to match the manual section language. All other information remains the same.

Subject: Ambulance: New Remark Code for Denying Separately Billed Services

I. SUMMARY OF CHANGES: This instruction is to inform contractors to begin using the new Remittance Advice Remark Code message when denying an ambulance claim submitted with a code that is not separately billable and to begin using MSN message 16.45 for benficiary notification when a claim has been denied with a code thats not separately billable.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	15/10/General Coverage and Payment Policies

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1333	Date: September 6, 2007	Change Request: 5659

This corrects Transmittal 1318, date August 17, 2007. The only change in this Business Requirement is to change BR 5659.2 to correct the Spanish translation of the MSN to match the manual section language. All other information remains the same.

SUBJECT: Ambulance: New Remark Code for Denying Separately Billed Services

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night shift differential are no longer paid separately for ambulance services. This policy fully implemented the Ambulance Fee Schedule, wherein payment is based solely on the ambulance fee schedule amount as cited in 42 CFR § 414.615(e). According to 42 CFR § 414.610(7)(d), payment under the ambulance fee schedule represents payment in full for all services, supplies, and other costs for an ambulance service furnished to a Medicare beneficiary.

CMS has been made aware that some providers are continuing to submit claims with ancillary services that are included in the base rate. A clearer denial message is needed to explain the reason for the denial and to advise that this service is not separately billable and as a result, these claims/services should not be resubmitted. This policy applies whether the primary transportation service is allowed or denied.

Accordingly, this transmittal implements the new Remittance Advice Remark Code (RARC) message N390, "This service cannot be billed separately" must be used when denying a code that is not separately billable. This new RARC message is for claims processed on or after October 1, 2007 and in conjunction with an existing ANSI reason code 97, "Payment was adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated", as well as a second RARC code N185 "Do not re-submit this claim/service". When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

This transmittal also instructs contractors to use Medicare Summary Notice (MSN) message 16.45, "You cannot be billed separately for this item or service. You do not have to pay this amount" when denying any code that does not appear on the Ambulance Fee Schedule.

B. Policy: RARC N390 must be used along with existing RARC N185, "Do not re-submit this claim/service" in addition to Claim Adjustment Reason Code 97, "Payment was adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated". MSN message 16.45: "You cannot be billed separately for this item or service. You do not have to pay this amount", shall be used for beneficiary notification.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5659.1	For claims submitted by ambulance suppliers that are processed on or after October 1, 2007, Contractors shall use Remittance Advice Remark Code N390 and N185 with Claim Adjustment Reason Code 97, group code CO, when denying any code that does not appear on the Ambulance Fee Schedule.	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5659.2	For claims submitted by ambulance suppliers that are processed on or after October 1, 2007, Contractors shall use the following MSN message when denying ambulance claims with a code that is not separately billable. 16.45 – You cannot be billed separately for this item or service. You do not have to pay this amount. Spanish Translation: 16.45 – Usted no puede ser facturado separadamente por este artículo o servicio. Usted no tiene que pagar esta cantidad.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5659.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X							

IV. SUPPORTING INFORMATION: N/A

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Supplier Claims: Wendy Knarr, Wendy.Knarr@cms.hhs.gov or dial National Relay at #711 and have agent dial Wendy's number at 410-786-0843.

Post-Implementation Contact(s): Your appropriate Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.
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B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 15 - Ambulance

10 - General Coverage and Payment Policies

(Rev. 1333; Issued: 08-17-07; Effective/Implementation: 10-01-07)

These instructions apply to processing claims to contractors under the ambulance fee schedule (FS).

General rules for coverage of ambulance services are in the Medicare Benefit Policy Manual, Chapter 10. General medical review instructions for ambulance services are in Chapter 6 of the Medicare Program Integrity Manual.

In general, effective April 1, 2002, payment is based on the level of service provided, not on the vehicle used. However, two temporary Q codes (Q3019 and Q3020) are available for use during the transition period when an ALS vehicle is used for a Medicare-covered transport, but no ALS service is furnished.

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 section 10.3.3 of Chapter 10 of the Medicare Benefit Policy Manual for further details. Refer to section 10.5 of Chapter 3 of the Medicare Claims Processing Manual for additional information on hospital inpatient bundling of ambulance services.

Prior to the implementation of the FS, suppliers used one of four billing methods. Providers used only one billing method, method 2. The FS (effective April 1, 2002) has only one billing method, formerly method 2. This current billing method includes payment for all items and services in the ambulance FS base rate except for the cost of mileage, which is payable separate from the base rate.

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 generally NOT separately payable.

The intermediary is responsible for the processing of claims for ambulance services furnished by providers; i.e., hospitals and skilled nursing facilities. The carrier is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. 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 nonhospital-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 not billed by the supplier to its carrier, but are billed by the provider to its intermediary. The intermediary 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 carrier, the carrier has this responsibility, and the intermediary shall contact the carrier to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the intermediary should accept the carrier'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.

The ambulance FS is effective for claims with dates of service on or after April 1, 2002. The FS is phased in over a transition period through the end of 2005. During the transition period payment amounts are a blended amount: part ambulance FS, and part reasonable charge (for independent suppliers) or reasonable cost for providers. The percentages for the blended rate during the transition period are as follows:

Transition Year	**Reasonable Charge/ Cost Percent**	**FS Percent**
Year One (4/1/2002-12/2002)	80	20
Year Two (CY 2003)	60	40
Year Three (CY 2004)	40	60
Year Four (CY 2005)	20	80
Year Five (CY 2006)	0	100

When carriers receive a claim on which the submitted charge substantially exceeds the normal reasonable charge amount for waiting time, they shall send it to the utilization review unit for its review. Once the review unit has made a determination to pay an amount higher than the customary or prevailing charge, documentation to support the reason for this determination **must** accompany the claim.

NOTE: To bill mileage, providers and suppliers continue to use codes A0380 and A0390 for dates of service January 1, 2001 through March 31, 2002.

Suppliers using Method 3 or 4 may use supply codes A0382, A0384, and A0392 - A0999 as well as J-codes and codes for EKG testing during the transition period. These supply codes should be entered in item 22. Carriers deny claims for items from Method 1 and Method 2 billers.

The ZIP code of the point of pickup must be entered in item 12. If there is no ZIP code in item 12, or if there are multiple ZIP codes in item 12, carriers return the claim as unprocessable.

The ZIP code entered in item 12 shall be edited for validity.

The format for a ZIP code is five numerics. If the ZIP code in item 12 shows a 9-digit ZIP code, carriers validate only the first 5 digits. If the ZIP code entered into item 12 does not correspond to a USPS either 5- or 9-digit format, carriers reject the claim as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

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 shall be processed. All such ZIP codes are to be considered urban ZIP codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP code, the claim shall be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

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, therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, ambulance claims submitted with a code(s) that is/are not separately billable and is/are already included in the base rate, contractors shall use Remittance Advice Remark Code N390, "This service cannot be billed separately" and N185, "Do not re-submit this claim/service" with Claim Adjustment Reason Code 97, "Payment was adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 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.