CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal: 3027	**August 14, 2014**
	Change Request 8604

Transmittal 2908, dated March 14, 2014, is being rescinded and replaced by Transmittal 3027, dated August 14, 2014, to change the effective and implementation dates for ICD-10. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Chapter 15 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractors (MAC) Implementation

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10, ASC X12, and MAC language in Pub 100-04, Chapter 15. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE:

ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012

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

IMPLEMENTATION DATE:

ICD-10: Upon Implementation of ICD-10
ASC X12: September 16, 2014

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	Table of Contents
R	15/10.3/ Definitions
R	15/30/ General Billing Guidelines
R	15/30.1.2/ Coding Instructions for Paper and Electronic Claim Forms
R	15/30./2/ Fiscal Intermediary Shared System (FISS) Guidelines
R	15/30.2.1/ A/B MAC (A) Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation
R	15/40/ Medical Conditions List and Instructions

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3027	Date: August 14, 2014	Change Request: 8604

Transmittal 2908, dated March 14, 2014, is being rescinded and replaced by Transmittal 3027, dated August 14, 2014, to change the effective and implementation dates for ICD-10. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Chapter 15 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractor (MAC) Implementation

EFFECTIVE DATE:

ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012

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

IMPLEMENTATION DATE:

ICD-10: Upon Implementation of ICD-10
ASC X12: September 16, 2014

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 15.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8604.1	A/B MACs shall be aware of the updated language for ICD-10 and for ASC X12 in Pub. 100 - 04, Chapter 15.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not applicable

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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

Table of Contents

(Rev.3027, Issued: 08-14-14)

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

10.3 - Definitions

(Rev.3027, Issued: 08-14-14, Effective: Upon Implementation of ICD – 10 ASC-X12: 01-01-12, Implementation: ICD- 10: Upon Implementation of ICD – 20 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 837professional 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.

30 - General Billing Guidelines

(Rev.3027, Issued: 08-14-14, Effective: Upon Implementation of ICD – 10 ASC-X12: 01-01-12, Implementation: ICD- 10: Upon Implementation of ICD – 20 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 Multi-Carrier System (MCS).

Institution based ambulance providers may bill on *the ASC X12 837 institutional claim transaction or Form CMS 1450*. These claims are processed using the Fiscal Intermediary Shared System (FISS).

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)
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. 100-04, Medicare Benefit Policy Manual, chapter 10 – Ambulance Service, section 30.1 – Categories of Ambulance Services, for the definitions of levels of ambulance services under the fee schedule.

30.1.2 - Coding Instructions for Paper and Electronic Claim Forms

Rev.3027, Issued: 08-14-14, Effective: Upon Implementation of ICD – 10 ASC-X12: 01-01-12, Implementation: ICD- 10: Upon Implementation of ICD – 20 ASC X12: 09-16-14)

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). *R*efer to the appropriate Implementation Guide to determine how to report the destination information. *O*nly 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. *A/B MACs (B)* use message N53 on the remittance advice in conjunction with reason code 16.

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 a 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.

Multiple Patients on One Trip

Ambulance suppliers submitting a claim using *the ASC X12 professional format* or the CMS-1500 *paper form* for an ambulance transport with more than one Medicare beneficiary onboard must use the "GM" modifier ("Multiple Patient on One Ambulance Trip") for each service line item. In addition, suppliers are required to submit documentation to *A/B* MACs *(B)* to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim (HIC) numbers for each Medicare beneficiary. *A/B/MACs (B)* shall calculate payment amounts based on policy instructions found in Pub.100-02, Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.

Ambulance claims submitted on or after January 1, 2011 in version 5010 *of the ASC X12 837 professional* claim format require the presence of a diagnosis code and the absence of said diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. *T*he presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the presence (or absence) of a diagnosis code *but a diagnosis code is required on the* ASC X12 837 professional claim format.

30.2 - Fiscal Intermediary Shared System (FISS) Guidelines

(Rev.3027, Issued: 08-14-14, Effective: Upon Implementation of ICD – 10 ASC-X12: 01-01-12, Implementation: ICD- 10: Upon Implementation of ICD – 20 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 Form Locator (FL) 44 “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:

For the hard copy CMS-1450 Form, 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:

For the hard copy Form CMS-1450, 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:

For the hard copy CMS-1450, 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
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.3027, Issued: 08-14-14, Effective: Upon Implementation of ICD – 10 ASC-X12: 01-01-12, Implementation: ICD- 10: Upon Implementation of ICD – 20 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* perform*s* 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, intermediaries 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."

40 - Medical Conditions List and Instructions

(Rev.3027, Issued: 08-14-14, Effective: Upon Implementation of ICD – 10 ASC-X12: 01-01-12, Implementation: ICD- 10: Upon Implementation of ICD – 20 ASC X12: 09-16-14)

The following list is intended as primarily an educational guideline. This list was most recently updated by CMS Transmittal 1185, Change Request 5542 issued February 23, 2007. It will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the HCPCS code or the condition code by themselves. All current Medicare ambulance policies remain in place.

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

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the “PLUS any other code” requirement when using the alternative list for this condition (abnormal vital signs)). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just

as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

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

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

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

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

Information on appropriate use of transportation indicators:

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for

the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

• **Air and Ground**

• **Transportation Indicator "C1":** Transportation indicator "C1" indicates an interfacility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.

• **Transportation Indicator "C2":** Transportation indicator "C2" indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.

• **Transportation Indicator "C3":** Transportation indicator "C3" may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.

• **Transportation Indicator "C4":** Transportation indicator "C4" indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appear to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

• **Ground Only**

• **Transportation Indicator "C5"**: Transportation indicator "C5" has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

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

• **Transportation Indicator "C6"**: Transportation indicator "C6" has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

• **Transportation Indicator C7**- Transportation indicator "C7" is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.

• **<u>Air Only</u>**

• All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

• D1 Long Distance - patient's condition requires rapid transportation over a long distance.

• D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.

• D3 Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.

• D4 Pick up point not accessible by ground transportation.

Ambulance Fee Schedule - Medical Conditions List

(Rev.3027, Issued: 08-14-14)

Emergency Conditions - Non-Traumatic

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6, bi- and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED fired	A0427/A0433
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphorhesis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799	Abnormal vital signs (includes abnormal pulse oximetry)	With or without symptoms.	ALS		A0427/A0433
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69, or	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior history of anaphylaxis,	A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
	995.7				wheezing, difficulty swallowing.	
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest – resuscitation in progress		ALS		A0427/A0433
786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.99	933.0 or 933.1.	Chocking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature < 95F, deep frost bite, other emergency conditions.	A0427/A0433
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions	A0429
780.97	780.02, 780.03, or 780.09.	Altered level of consciousness (nontraumatic)		ALS	Acute condition with Glascow Coma Scale < 15.	A0427/A0433
780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70 ,345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure and requires medical monitoring/observation.	ALS		A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
379.90	368.11, 368.12, or 379.91	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8.	Non-traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0472/A0433
536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5	Heat exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11	Hemorrhage	Severe (quantity) and potentially life-threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post- surgical bleeding.	A0472/A0433
038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429
987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7, 989.9, or 990.	Hazmat exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0472/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1,	Medical device failure	Life or limb threatening malfunction, failure, or	ALS	Malfunction of ventilator, internal	A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
	or 996.2.		complication.		pacemaker, internal defibrillator, implanted drug delivery service.	
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical device failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen system supply malfunction, orthopedic device failure.	A0429
436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
780.96		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7-10 for severe pain) or patient receiving pharmalogic intervention.	A0427/A0433
724.5	724.2 or 785.9	Back pain – non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
724.9	724.2, 724.5, 847.1, or 847.2.	Back pain – non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms.	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection, or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological	ALS		A0427/A0433

			intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.			
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post-operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening	A0429
650	Any code from 630 through 679.	Pregnancy complication/childbirth/labor		ALS		A0427/A0433
292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DTs, withdrawal symptoms.	A0427/A0433
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior.	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick person – fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433

Emergency Conditions - Trauma

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92,	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso,	ALS	See “Condition (Specific)” column	A0427/A0433

	851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.		extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.			
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9.	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee and ankle, deformity of bone or joint.	A0429
880.00	880.00 through 887.7 or 890.0 through 897.7	Other trauma	Penetrating extremity injuries	BLS	Isolated bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1	Other trauma	Amputation – digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation – all other	ALS		A0427/A0433
869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive	A0427/A0433

					abdominal signs on exam, internal bleeding criteria, evisceration.	
ICD 9 Primary Code	**ICD9 Alternative Specific Code**	**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and Examples (not all-inclusive)**	**HCPCS Crosswalk**
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major – per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0472/A0433
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor – per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation.	Potentially life or limb-threatening.	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envonmation.	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near drowning	Airway compromised during near drowning event	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference codes 959.8, 958.2, 869.0/869.1	A0427/A0433
995.80	995.53 or V71.5 PLUS any code from 910.0	Sexual assault	With minor or no injuries	BLS		

	through 919.9, 920 through 924.9, or 959.01 through 959.9.					

Non-Emergency

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
428.9		Cardiac/hemodynamic monitoring required en route.		ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.		ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.		BLS	Per transfer instructions.	A0428
786.09		Airway control/positioning required en route.		BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient safety: Danger to self or others – in restraints.		BLS	Refer to definition in 42 CFR Section 482.13(e).	A0428
293.1		Patient safety: Danger to self or others – monitoring.		BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428
298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90	Patient safety: Danger to self or others – seclusion (flight risk).		BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 CFR Section 482.13(f) for definition.	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS	A0428

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
					criteria.	
041.9		Special handling en route – isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain – orthopedic device.		BLS	Backboard, halotraction, use of pins and traction etc. Pain may be present.	A0428
719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route – positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with > grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of < 1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures – post-op hip as an example.	A0428

Transportation Indicators

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C1	Inter-facility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434
C2	Inter-facility transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW,RW		A0428, A0429, A0426, A0427, A0433, A0434
C3	Emergency Trauma Dispatch Condition Code	Major incident or mechanism of injury	**Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.**	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim	A0427/A0433

					entrapped in vehicle.	
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS response	Indicates to *A/B MAC (A or B)* that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS transport of ALS-level patient	ALS-level condition treated and transport by a BLS-level ambulance.	**This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.**	BLS		A0429

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C6	ALS-level response to BLS-level patient	ALS response required based upon appropriate dispatch protocols – BLS-level patient transport	**Indicates to *A/B MAC (A or B)* that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare Ambulance Fee Schedule.**	ALS		A0427

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C7		IV meds required en	This transportation indicator is used for patients that require an ALS level transport in a non- emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not	ALS	Does not apply to self-administered IV medications.	A0426

		route.	apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list			

Air Ambulance Transportation Indicators

Air Ambulance Transportation Indicators	Transportation Indicator Description	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
D1	Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2	Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3		FW, RW		A0430, A0431
D4		FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be cross walked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.