

# CMS Manual System

## Pub 100-04 Medicare Claims Processing

Transmittal 799

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 30, 2005

Change Request 4217

**SUBJECT: Reminder Notice of the Implementation of Ambulance Transition Schedule**

**I. SUMMARY OF CHANGES:** This change request (CR) reminds intermediaries and carriers to determine the Medicare allowed amount solely on the basis of the ambulance fee schedule (100%) for ambulance services furnished and mileage incurred on or after January 1, 2006.

### NEW/REVISED MATERIAL

**EFFECTIVE DATE: January 01, 2006**

**IMPLEMENTATION DATE: January 03, 2006**

*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/revise 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
N/A	

### III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

### IV. ATTACHMENTS:

Recurring Update Notification

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

# Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 799	Date: December 30, 2005	Change Request 4217
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**SUBJECT: Reminder Notice of the Implementation of the Ambulance Transition Schedule**

## I. GENERAL INFORMATION

This change request (CR) reminds Intermediaries and Carriers to determine the Medicare allowed amount solely on the basis of the ambulance fee schedule (100%) for ambulance services furnished and mileage incurred on or after January 1, 2006.

**A. Background:** On April 1, 2002, CMS implemented a fee schedule that applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals, and skilled nursing facilities. The fee schedule was effective for claims with dates of services on or after April 1, 2002. Under the fee schedule, ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the Ambulance Fee Schedule amount.

As discussed in previously issued instructions, the fee schedule was phased over a 5-year period. Effective January 1, 2006, the fee schedule will be fully implemented and will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

New payment increases for ground ambulance transports available under Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) became effective on July 1, 2004 with the implementation of Transmittals 88 and 220 (CR 3099). No additional changes are required to implement this MMA provision. All applicable provisions of the MMA remain in effect.

This instruction reminds Intermediaries and Carriers of the transition schedule and the necessity to update the fee schedule percentage to 100%, effective January 1, 2006. The cost/charge percentage will no longer apply.

**B. Policy:** The ambulance fee schedule is subject to a 5-year transition period as follows:

<u>Year</u>	<u>Fee Schedule Percentages</u>	<u>Cost/Charge Percentages</u>
Year 1 (4/1/02-12/31/02)	20%	80%
Year 2 (CY 2003)	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

The foregoing schedule signifies that, during the transition period, the Medicare allowed amount for ambulance services, mileage, and separately billable supplies comprised a blended rate. The blended rate included a portion of the fee schedule and a portion of the provider's reasonable cost or the supplier's reasonable charge. (For providers billing ambulance services to intermediaries, all supplies and ancillary

services rendered are considered part of the base rate and are not separately billable under the ambulance fee schedule. For Part B suppliers billing ambulance services, separately billable supplies could be billed during the transition period, depending on the supplier's billing method.)

Beginning January 1, 2006 (the Year 5) and every year thereafter for services, and mileage incurred, the full fee schedule comprises the entire Medicare allowed amount and no portion of the provider's reasonable cost or the supplier's reasonable charge shall be considered. Separately billed supplies and ancillary services (e.g. waiting time, extra attendant) shall no longer be billable for claims with dates of service on or after January 1, 2006.

Temporary Q codes Q3019 (ALS Vehicle Used, Emergency Transport, No ALS Level Services Furnished) and Q3020 (ALS Vehicle Used, Non-Emergency Transport, No ALS Level Services Furnished), and Healthcare Common Procedure Coding System Code A0800 (Ambulance Night Differential Charges) may no longer be used for claims with dates of service on or after January 1, 2006. These codes were only valid during the transition period. (NOTE: Temporary Q codes Q3019 and 3020 appear as valid on the HCPCS file, but it will be updated to reflect this change in a future release).

Jurisdiction for claims submittal shall remain the same until further notice.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*

*"Should" denotes an optional requirement*

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
4217.1	Contractors shall update the Ambulance Fee Schedule to indicate the following transition percentage of 100% for CY 2006 and thereafter with no portion of the provider's reasonable cost or the supplier's reasonable charge.	X		X						
4217.2	For ambulance services furnished, and mileage incurred on or after January 1, 2006, contractors shall determine the Medicare allowed amount solely on the basis of the fee schedule amount.	X		X						
4217.3	Contractors shall deny claims for separately billed supplies and ancillary services furnished during an ambulance transport on or after January 1, 2006. (Note: Supplies and ancillary services are considered part of the fee schedule base rate, and are not separately billable after December 31, 2005.)	X		X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4217.4	Contractors shall continue to use the appropriate Claims Adjustment Reason Code when denying claims for separately billed supplies and ancillary services. If the contractor does not have a Claims Adjustment Reason Code, they shall use 97 “Payment is included in the allowance for another service/procedure” when denying claims for separately billed supplies and ancillary services furnished during an ambulance transport on or after January 1, 2006.	X		X						

### III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
4217.5	A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/medlearn/matters">www.cms.hhs.gov/medlearn/matters</a> shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program	X		X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	correctly.									

**IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS**

**A. Other Instructions: N/A**

X-Ref Requirement #	Instructions

**B. Design Considerations: N/A**

X-Ref Requirement #	Recommendation for Medicare System Requirements

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

**V. SCHEDULE, CONTACTS, AND FUNDING**

<p><b>Effective Date*:</b> January 1, 2006</p> <p><b>Implementation Date:</b> January 3, 2006</p> <p><b>Pre-Implementation Contact(s):</b> Wendy Knarr, Contact Relay at 711 then have agent dial (410) 786 0843 or email: <a href="mailto:Wendy.Knarr@cms.hhs.gov">Wendy.Knarr@cms.hhs.gov</a> (Part B) or Valeri Ritter <a href="mailto:Valeri.Ritter@cms.hhs.gov">Valeri.Ritter@cms.hhs.gov</a> or (410) 786-8652 (Part A)</p> <p><b>Post-Implementation Contact(s):</b> Contact the appropriate Regional Office</p>	<p><b>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</b></p>
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