

## Repetitive Scheduled Non-Emergent Ambulance Transport Reason Codes & Statements (05/27/15)

Reason Code	Insufficient Documentation
<b>AMB1A</b>	No ambulance run sheet/trip record documentation submitted.
<b>AMB1B</b>	Patient record submitted does not match patient billed on ambulance claim.
<b>AMB1C</b>	Ambulance run sheet/trip record submitted does not match origin/destination modifier.
<b>AMB1D</b>	The service billed was not documented in the patient medical record for this ambulance transport.
<b>AMB1E</b>	Dispatch status to support service billed was not documented in patient medical record for this service.
<b>AMB1F</b>	No physician certification statement submitted for non-emergency, scheduled, repetitive ambulance service.
<b>AMB1G</b>	Missing documentation to support the beneficiary/representative signature on the ambulance consent.
<b>AMB1H</b>	The service is denied as the beneficiary refused to sign for the transport or consent.
<b>AMB1I</b>	Missing/insufficient or incomplete documentation to support ambulance mileage.
<b>AMB1Y</b>	Patient record submitted does not match the patient on the ambulance PA request.
<b>AMB1Z</b>	Insufficient Documentation (explain identified problem)

Reason Code	Does not meet definition of Medicare ambulance benefit – Beneficiary Liable
<b>AMB2A</b>	Facility to facility transport denied as the documentation supports that the discharging institution was not an appropriate facility.
<b>AMB2B</b>	This hospital to hospital transport is denied as the patient was already at a facility able to provide the necessary services.
<b>AMB2C</b>	Facility to facility transport denied as the documentation does not support that the receiving institution was the closest facility.
<b>AMB2D</b>	Transportation is only covered to the closest facility that can provide the necessary care.
<b>AMB2E</b>	Facility to facility transport denied as documentation indicates transport due to physician and/or beneficiary preference.
<b>AMB2F</b>	Facility to facility transport denied as documentation indicates transport due to beneficiary wants to be closer to home or family.
<b>AMB2G</b>	Ambulance service to a physician's office or a physician-directed clinic is not covered.
<b>AMB2H</b>	Ambulance service to a funeral home is not covered.

<b>AMB2I</b>	Alternative transport services should have been utilized whether or not they were available; Beneficiary could have been safely transported by another means of transportation.
<b>AMB2J</b>	This service is denied as the beneficiary refused transport.
<b>AMB2K</b>	Non-covered charge(s).
<b>AMB2L</b>	Statutorily excluded service(s).
<b>AMB2M</b>	The ambulance service may be covered by the Hospice provider. Please submit to the Hospice provider.
<b>AMB2N</b>	Transport Not Medically Necessary with an Advance Beneficiary Notice (ABN).
<b>AMB2Z</b>	Does not meet definition of Medicare ambulance benefit (explain identified problem)

<b>Reason Code</b>	<b>Medical necessity – Provider Liable</b>
<b>AMB3A</b>	Transport Not Medically Necessary without an Advance Beneficiary Notice (ABN).
<b>AMB3B</b>	Beneficiary death was prior to ambulance dispatch.
<b>AMB3C</b>	Beneficiary death was after dispatch, before beneficiary loaded onboard ambulance, therefore mileage denied.
<b>AMB3Z</b>	Medical necessity (explain identified problem)

<b>Reason Code</b>	<b>Does not meet benefit (non-clinical)</b>
<b>AMB4A</b>	Missing/incomplete/invalid patient signature or authorized representative signature on ambulance consent.
<b>AMB4B</b>	Missing/Incomplete/Invalid ambulance supplier signature on ambulance record or invalid or no response to signature attestation.
<b>AMB4C</b>	Missing/Incomplete/invalid date on ambulance record.
<b>AMB4D</b>	Missing provider signature on the physician certification statement (non-emergent, scheduled transport).
<b>AMB4E</b>	Incomplete/Invalid provider signature on the physician certification statement (non-emergent, scheduled transport).
<b>AMB4F</b>	Date of service(s) documented on physician certification statement is outside allowed timeframe.
<b>AMB4G</b>	Date of service(s) documented does not match date of service(s) (DOS) billed on ambulance claim.
<b>AMB4H</b>	Incomplete/Invalid/Illegible physician certification statement (non-emergent, scheduled transport).

<b>AMB4Y</b>	Date of service(s) documented does not match date of service(s) (DOS) on ambulance PA request.
<b>AMB4Z</b>	Does not meet non-clinical benefit (explain identified problem)

<b>Reason Code</b>	<b>Mileage related - Provider Liable</b>
<b>AMB5A</b>	Payment for ambulance services does not include mileage when the beneficiary is not loaded in the ambulance (ambulance billed services when the beneficiary was not in the ambulance/ambulance billed mileage from their origin rather than the beneficiary's origin/from the ambulance garage).

<b>Reason Code</b>	<b>Origin/destination related</b>
<b>AMB6A</b>	Non-payable origin/destination modifiers billed (scheduled service such as physician office to beneficiary's residence).
<b>AMB6Y</b>	Non-payable origin/destination modifiers in PA request (scheduled service such as physician office to beneficiary's residence).
<b>AMB6Z</b>	Origin/destination related (explain identified problem)

<b>Reason Code</b>	<b>Bundling/unbundling</b>
<b>AMB7A</b>	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated (can only bill for transport & mileage).
<b>AMB7Z</b>	Bundling/unbundling (explain identified problem)

<b>Reason Code</b>	<b>Incorrect coding</b>
<b>AMB8A</b>	Ambulance claim(s) submitted without valid modifier(s).
<b>AMB8B</b>	Billing provider does not match the rendering provider documented in the medical records.
<b>AMB8C</b>	Ambulance claim(s) submitted with invalid modifier(s) combination.
<b>AMB8X</b>	Ambulance PA request submitted without valid modifier(s).
<b>AMB8Y</b>	Ambulance PA request submitted with invalid modifier(s) combination.
<b>AMB8Z</b>	Incorrect coding (explain identified problem)

<b>Reason Code</b>	<b>Local Coverage Determination (LCD)</b>
<b>AMB9A</b>	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.gov/mcd">www.cms.gov/mcd</a> , or if you do not have web access, you may contact the contractor to request a copy of the LCD.
<b>AMB9B</b>	Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision.
<b>AMB9Y</b>	Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your PA request. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision.
<b>AMB9Z</b>	Local Coverage Determination (explain identified problem)

<b>Reason Code</b>	<b>Provider Eligibility</b>
<b>AMB0A</b>	The Ambulance provider is not approved by Medicare.
<b>AMB0B</b>	The Ambulance provider is not eligible for Medicare benefits.
<b>AMB0C</b>	The Ambulance provider is not authorized or eligible to bill for BLS services.
<b>AMB0Z</b>	Provider Eligibility (explain identified problem)

<b>Reason Code</b>	<b>Other</b>
<b>AM11A</b>	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
<b>AM11B</b>	This claim was adjusted after records were reviewed and it was determined that the documentation did not support the level of service billed on the claim (i.e., recoding the ambulance service to the level of care that reflects the services rendered, or down coding services when the title of the emergency personnel cannot be validated).
<b>AM11C</b>	This claim is a duplicate to another claim.
<b>AM11D</b>	Service with no paid base rate in history or no base rate submitted.
<b>AM11W</b>	PA request for service not covered by this payer/contractor. You must send the request to the correct payer/contractor.
<b>AM11X</b>	This PA request was adjusted after records were reviewed and it was determined that the documentation did not support the level of service requested (i.e., recoding the ambulance service to the level of care that reflects the services rendered, or down coding services when the title of the emergency personnel cannot be validated).

<b>AM11Y</b>	This PA request is a duplicate to another request.
<b>AM11Z</b>	The documentation (explain identified problem)

<b>Reason Code</b>	<b>Air Ambulance</b>
<b>AM12A</b>	The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.

<b>Reason Code</b>	<b>Rejection/Invalid Ambulance Prior Authorization Request</b>
<b>AM00A</b>	The state where the ambulance company is garaged is not included in the repetitive scheduled non-emergent ambulance transports prior authorization demonstration. States included in the demonstration include New Jersey, Pennsylvania, and South Carolina.
<b>AM00B</b>	The codes of the ambulance trip(s) requested are not specific to the repetitive scheduled non-emergent ambulance transports prior authorization demonstration.
<b>AM00Z</b>	The ambulance prior authorization request (explain identified problem).

<b>Reason Code</b>	<b>Affirmed PA response with modifications</b>
<b>AM99A</b>	PA request was affirmed for fewer trips than requested.
<b>AM99B</b>	PA request was affirmed for fewer days than requested.