CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1821	**Date: September 25, 2009**
	Change Request 6621

Subject: Billing for an Ambulance Transport with More Than One Patient Onboard

I. SUMMARY OF CHANGES: This CR communicates claims processing instructions that are to be added to the Ambulance chapter of the Medicare Claims Processing Internet Only Manual.

New / Revised Material
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

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

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

R/N/D	Chapter / Section / Subsection / Title
R	15 / 30 / 30.1.2 / Coding Instructions for Paper and Electronic Claim Forms
R	15 / 30 / 30.2 / Fiscal Intermediary Shared System (FISS) Guidelines

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1821	Date: September 25, 2009	Change Request: 6621

SUBJECT: Billing for an Ambulance Transport with More than One Patient Onboard

Effective Date: October 26, 2009

Implementation Date: October 26, 2009

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) issued Transmittal B-02-060, Change Request (CR) 1945, "Payment Policy When More Than One Patient is Onboard an Ambulance" on September 27, 2002, and Transmittal A-02-108, CR 2186 "Multiple Patient Ambulance Transport" on October 25, 2002. These CRs included the payment policy as well as claims processing instructions for ambulance service claims submitted for trips with more than one patient onboard. However, the claims processing instructions were never added to the Ambulance chapter of the Medicare Claims Processing Manual (Publication 100-04, Chapter 15).

B. Policy: This transmittal communicates changes to the Ambulance chapter of the Medicare Claims Processing Manual (Publication 100-04, Chapter 15).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6621.1	Contractors shall be in compliance with the instructions found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 15.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6621.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly	X		X	X						

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

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 1945 CR 2186	

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Contact Eric Coulson at (410) 786-3352 or Eric.Coulson@cms.hhs.gov

Post-Implementation Contact(s): For questions pertaining to the processing of claims for institutionally-based ambulance services, contact Valeri Ritter at (410)786-8652 or Valeri.Ritter@cms.hhs.gov. For questions pertaining to the processing of claims for ambulance suppliers, contact Eric Coulson at (410)786-3352 or Eric.Coulson@cms.hhs.gov.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: ***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.

30.1.2 - Coding Instructions for Paper and Electronic Claim Forms

(Rev. 1821; Issued: 09-25-09; Effective/Implementation Date: 10-26-09)

Beginning with dates of service January 1, 2001, the following coding instructions must be used.

In item 32 of the CMS-1500 Form, billers shall code the 5-digit ZIP Code of the point of pickup.

Electronic billers using ANSI X12N 837 and should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup).

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 CMS-1500 Form item 32, or with multiple ZIP Codes in item 32, must be returned as unprocessable. Carriers 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.

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.

If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1" as the mileage for trips less than a mile.

Ambulance suppliers submitting a claim using the CMS-1500 Form, or the electronic equivalent ANSI X12N 837, 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 to B/MACs / Carriers documentation 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. B/MACs / Carriers 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.

30.2 - Fiscal Intermediary Shared System (FISS) Guidelines

(Rev. 1821; Issued: 09-25-09; Effective/Implementation Date: 10-26-09)

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

The provider must furnish the following data in accordance with A/MAC instructions. The A/MAC 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 to 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 and a table to crosswalk the CMS-1450 form locator to the 837 transaction 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 and a table to crosswalk its CMS-1450 form locator to the 837 transaction 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 and a table to crosswalk its CMS-1450 form locator to the 837 transaction 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. Intermediaries should assign ANSI 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 intermediary 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 and a table to crosswalk its CMS-1450 form locator to the 837 transaction 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

A/MACs edit 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.