



Ambulance

Published March 2012



Part A and B



IMPORTANT



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AMBULANCE SERVICES

Introduction

This manual outlines the coverage for ambulance services. The policy applies to suppliers (CMS-1500 claim/electronic) and institutional-based providers (CMS-1450 (UB-04) claim/electronic).

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COVERAGE REQUIREMENTS

Overview

Medicare coverage for ambulance transportation is limited by CMS national policy in accordance with federal law.

Ambulance services involve the assessment and administration of emergency care by medically trained personnel and transportation of patients within an appropriate, safe and monitored environment.

Ambulance transportation is a covered service under Medicare when the patient's condition is such that the use of any other method of transportation would endanger the patient's health.

A patient whose condition permits transport in any type of vehicle other than an ambulance would not qualify for services under Medicare.

Medicare payment for ambulance transportation depends on the patient's condition at the actual time of the transport regardless of the patient's diagnosis or any other reason for transport.

To be deemed medically necessary for payment, the patient must require both the transportation and the level of service provided.

For the purposes of this policy, the following definitions apply:

- Medically trained personnel refers to individuals who have fulfilled state training and educational requirements and are certified or licensed by their respective state to provide Basic Life Support (BLS) and/or Advanced Life Support (ALS) Emergency Medical Technician (EMT)-level services.
- The vehicle used as an ambulance must be specially designed or equipped to respond to medical emergencies and, in non-emergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment and other lifesaving emergency medical equipment, and be equipped with emergency warning lights, sirens and telecommunications equipment as required by state or local law. This should include, at a minimum, one two-way voice radio or wireless telephone.

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Requirements for Coverage

For ambulance services to be covered by Medicare, the following requirements must be met:

- Actual transportation of the beneficiary occurs.
- Services must be medically necessary and reasonable for the condition of the patient.
- The condition of the patient would not allow transportation by other means.
- A diagnosis must be on the claim or a detailed description of the patient's condition at the time of transfer must be submitted with the claim or provided upon request to determine medical necessity. **Note:** Suppliers/providers utilizing the 5010 version of the 837P are required to submit ICD-9-CM diagnosis codes.
- Ambulance personnel should document their observations of the patient's condition.
- Transportation to a hospital from another hospital when a patient's needs cannot be met at the first hospital and the patient is admitted to the second hospital.
- Transportation is to an extended care facility or to the patient's home.
- Transportation is to the closest appropriate facilities.
- Transportation is provided by an approved supplier/provider of ambulance services.
- The transportation is not part of a Part A (in patient) service.

Medical Necessity

Ambulance transportation is covered when the patient's condition requires the vehicle itself and/or the specialized services of the trained ambulance personnel. A requirement of coverage is that the needed services of the ambulance personnel were provided and clear clinical documentation validates their medical need and their provision in the record of the service (usually the run sheet).

The following conditions may establish that the patient had to be transported by ambulance:

- Patient is transported in an emergency situation; e.g., as a result of an accident or injury.
- Patient needs to be restrained.
- Patient is unconscious or in shock.
- Patient requires oxygen or other emergency treatment on the way to the destination.
- Patient must remain immobile because of a fracture or the possibility of a fracture that has not been set.
- Patient sustains an acute stroke or myocardial infarction.

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- Patient is experiencing severe hemorrhaging.
- Patient has a condition that requires him to be moved only by stretcher.
- Patient has a condition that makes him bed-confined before and after the ambulance trip.

Definition of Bed-Confined

There is now a national definition of the term “bed-confined.” The patient must meet all of the following criteria:

- Unable to get up from bed without assistance.
- Unable to ambulate.
- Unable to sit in a chair or wheelchair.

Note: The term “bed-confined” is not synonymous with “bed rest” or “non-ambulatory.” In addition, “bed-confined” is not meant to be the sole criterion to be used in determining if the patient must be transported by ambulance. It is one factor to be considered when making coverage determinations.

Denied Services

Program payment will not be made when other transportation could be utilized without endangering the patient’s health, whether such means of transportation is actually available.

A claim may be denied on the grounds that the use of an ambulance service was unreasonable in the treatment of the illness or injury involved.

Non-Covered Services

Medicare does not cover the following services:

- Transportation in Ambi-buses, ambulettes (Mobility Assistance Vehicle (MAV)), Medi-cabs, vans, privately owned vehicles, taxicabs or wheelchair vans.
- Parking fees.
- Tolls for bridges, tunnels and highways.

Beneficiary Signature Requirements

Medicare requires the signature of the beneficiary or that of his representative for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- The beneficiary’s legal guardian.
- A relative or other person who receives Social Security or other governmental benefits on behalf of the beneficiary.

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- A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his affairs.
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services or assistance to the beneficiary.
- A representative of the provider or of the non-participating hospital claiming payment for services it has furnished if the provider or non-participating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1–4).
- A representative of the ambulance provider or supplier who is present during an emergency and/or non-emergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least four years from the date of service.

A provider/supplier (or his employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary or that of his representative at the time of transport, the provider/supplier may obtain this signature any time prior to submitting the claim to Medicare for payment.

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, the ambulance provider/supplier may not bill Medicare but may bill the beneficiary (or his estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

Signature Guidelines for Medical Review Purposes

Medicare requires that services provided/ordered be authenticated by the author. The method used must be a handwritten or electronic signature. Stamped signatures are not acceptable. These guidelines impact the ambulance trip/run sheets and the Physician Certification Statements (PCSs).

Run sheets must have legible signatures, including credentials, from the provider(s) who renders the services documented.

The signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials. Furthermore,

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signatures on the PCS must be dated at the time they are completed.

Signature Authentication Process

If the signature is found to be illegible or missing from the medical documentation, a signature log or attestation statement to determine the identity of the author may be requested by the reviewer before the claim is processed.

Signature Log

A signature log includes the typed or printed name and usual signature of the author associated with initials or an illegible signature. The signature log may be submitted when records are requested. The signature log may be included on the actual page where the initials or illegible signatures are used or it may be a separate document.

Attestation Statement

An attestation statement is required when a signature is missing from the documentation; it must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary and date of service. An attestation is specific to the service documented.

Providers should not add late signatures to the medical record, but make use of the signature authentication process. When medical records are requested, you may notice changes within the request letter. To meet the requirements for signatures, additional documentation (attestation statement or signature log) may need to be submitted with your medical records.

To view all signature requirements, a sample attestation statement and a chart with examples of acceptable and unacceptable legible signatures, please refer to Change Request (CR) 6698 at:

<http://www.cms.gov/transmittals/downloads/R327PI.pdf>

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Documentation

The provider must have full documentary evidence to support his Medicare claim for ambulance services. Without documentation that would establish the medical necessity of a service, the service may be non-covered by Medicare, either as a denial prior to payment or a request for refund after an incorrect payment has been made. The run sheet is used as a medical record for ambulance services. **Vital signs should be included on all run sheets (documentation forms should be filled out by the paramedic/ambulance attendant at the origin location of the ambulance transfer).**

The run sheet can assist the physician and other health care professional in evaluating the patient's condition prior to transport and for treatment provided during the transport.

The medical run sheet can assist in communication and continuity of care among physicians and other health care professionals involved in the patient's care.

An appropriately documented run sheet can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What Do Contractors Want and Why?

Because contractors have a contractual obligation to enrollees, Medicare may require reasonable documentation that services provided are consistent with billing and reimbursement. The Comprehensive Error Rate Testing (CERT) program may also request documentation for its auditing process. Refer to the TrailBlazer Web site at <http://www.trailblazerhealth.com/CERT> for CERT information. Medicare may request information to validate:

- The site of service.
 - The origin and destination modifiers that are submitted on the claim.
 - The medical necessity and appropriateness of the service provided.
- And/or,
- That the services and supplies provided have been accurately reported.

Trip Record Documentation

The principles of documentation listed are applicable to ambulance services that are provided in all settings. It is the responsibility of the ambulance supplier/provider to maintain (and furnish to Medicare upon request) complete and accurate documentation of the beneficiary's condition to demonstrate the ambulance service being furnished meets the medical necessity criteria.

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The trip record should contain a detailed description of the patient's condition at the time of transport. Coverage will not be allowed if the trip record contains an insufficient description of the patient's condition at the time of transfer for Medicare to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the patient's condition is limited to conclusory statements and/or opinions, such as the following:

- "Patient is non-ambulatory."
- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is bed-confined."
- "Patient is unable to sit, stand or walk."

The trip record should "**paint a picture**" of the patient's condition and must be consistent with documentation found in other supporting medical record documentation (including the physician's certification).

Addendums

In the very rare instance when an addendum is required, it must be completed within 24–48 hours of the trip completion.

Documentation on the addendum should include:

- The patient's name.
- Patient's Medicare number (Health Insurance Claim Number (HICN)).
- Date of service.
- Origin and destination.
- An explanation why the addendum is needed.
- The signature of the person who completed the addendum.
- The date the addendum was completed.

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Documentation Requirements

The trip record documentation of each patient encounter should include the following:

- Complete and legible information.
- Reason for the transport.
 - A concise explanation of symptoms reported by the patient and/or other observers and details of the patient's **physical assessments** that explain why the patient requires ambulance transportation and cannot be safely transported by an alternate mode.
- An objective description of the patient's physical condition in sufficient detail to demonstrate that the patient's condition or **functional status** at the time of transport meets Medicare limitation of coverage for ambulance services.
- Relevant history (when available).
- Observations and findings (patient's condition at the time of transfer).
- A detailed description of existing safety issues.
- Description of the traumatic event when trauma is the basis for suspected injuries.
- A detailed description of special precautions taken (if any) and explanation of the need for such precautions.
- Assessment and clinical evaluations that should include:
 - Vital signs.
 - Neurological assessment.
 - Cardiac information.
- Documentation of procedures and supplies provided such as:
 - IV therapy.
 - Respiratory therapy.
 - Intubation.
 - Cardiopulmonary Resuscitation (CPR).
 - Oxygen administered.
 - Drug therapy.
 - Restraints.
 - A description of specific monitoring and treatments required, ordered and performed/ administered. That a treatment (such as oxygen) and/or monitoring (such as cardiac rhythm monitoring) was performed absent sufficient description of the patient's condition (to demonstrate that the treatment and/or monitoring was medically necessary) is inadequate on its own merit to justify payment for the ambulance service. For example, when oxygen is supplied as a basis for ambulance transportation, the patient's

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- pretreatment capillary blood oxygen saturation and clinical respiratory description must be recorded. The two must be consistent with oxygen need.
- Statements such as the following, absent supporting information in relevant bullets above, are insufficient to justify Medicare payment for ambulance services:
 - Patient complained of shortness of breath.
 - History of stroke.
 - Past history of knee replacement.
 - Hypertension.
 - Chest pain.
 - Generalized weakness.
 - Is bed-confined.
 - Point of pickup/destination (identify place and complete address).
 - For hospital-to-hospital transports, the trip record must clearly indicate the precise treatment or procedure (or medical specialist) that is available only at the receiving hospital. Non-specific or vague statements such as “needs cardiac care” or “needs higher level of care” are insufficient.
 - Date and legible identity of the observer.
 - Signatures, including credentials, from the provider(s) who renders the services documented:
 - Services provided/ordered must be authenticated by the author. The method used must be a handwritten or electronic signature:
 - If the signature is found to be illegible or missing from the medical documentation, a signature log or attestation statement to determine the identity of the author may be requested:
 - A signature log includes the typed or printed name and usual signature of the author associated with initials or an illegible signature.
 - An attestation statement is required when a signature is missing from the documentation; it must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary, date of service and be specific to the service documented.
 - Providers should not add late signatures to the documentation.
- Note:** Refer to “Signature Guidelines for Medical Review Purposes” in this section.
- Any additional available documentation that supports medical necessity of ambulance transport (e.g., emergency room report, Skilled Nursing Facility (SNF) record, End Stage Renal Disease (ESRD) facility record, hospital record).
 - A separate run sheet for each transport (e.g., two run sheets for round trips).
 - Dispatch record.

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- Documentation supporting the number of loaded miles billed.
 - For services rendered with dates of service on or after January 1, 2011, miles must be reported as fractional units. For instructions on fractional units refer to “Mileage” under the “Services and Procedure Codes” section in this manual.

Note: The HCPCS codes and ICD-9-CM codes reported on the health insurance claim must be supported by the documentation on the run sheet.

Examples of Documentation

The following is additional information that is important to determine medical necessity for ambulance transfers.

Abdominal Pain

Associated symptoms include nausea, vomiting, fainting. Associated signs include tender or pulsatile mass, distention, rigidity, rebound tenderness on exam, guarding.

Bed-Confined, Bed-Bound, Bed-Fast and Bed-Ridden (Patient Can’t Sit, Stand or Walk)

By CMS definition, a bed-confined patient is one who is “unable to get up from the bed without assistance; unable to ambulate; and is unable to sit in a chair or wheelchair.”

Note: The words “patient bed-confined” or a check-off list indicating the patient is “bed-confined” is insufficient documentation. There must be a narrative description that describes the reason the term “bed-confined” is being used.

Cardiac Arrest/Respiratory Arrest

Documentation should support the use of these conditions.

Cerebrovascular Accident (CVA), Recent or Acute

There should be a note in the documentation indicating whether the Cerebrovascular Accident (CVA) is recent (date of CVA). If the patient is post-CVA and it is written as part of the patient’s history, documentation should support the rationale for an ambulance transport (e.g., coma, non-responsive, contractures and any descriptive information that will help determine medical necessity of the transport).

Possible/Suspected Stroke or Possible/Suspected CVA

- The run sheet must include the paramedic’s description/observation of the patient, (e.g., patient has a sudden onset of facial paralysis, is experiencing loss of speech, etc.).
- Providers should describe the patients who are suffering paralysis from a previous CVA, such as “fetal position, contracture of all extremities,” etc.

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Chest Pain

Acute chest pain is generally covered. The documentation should contain a description of the location and patient's symptoms, overall appearance and/or condition (e.g., sweating, shortness of breath, skin pale, blue nail beds, cold and clammy).

Colon Cancer or Any Type of Cancer That Is Terminal

Documentation should show the patient is emaciated with other symptoms that would require ambulance transport. Patients who have metastatic cancer without any other presenting symptoms can be transported by another vehicle unless the position changes required for them to enter and exit from the vehicle places them at danger of a pathologic fracture or worsens neurologic damage.

Contractures

There should be a notation in the documentation that describes whether the patient has upper or lower limb contracture(s). The location and severity/degree of the contracture should also be documented.

Lower extremity contractures must be of sufficient degree as to prohibit sitting in a wheelchair (severe fixed contractures at or proximal to the knee).

Congestive Heart Failure (CHF)

Some Congestive Heart Failure (CHF) patients are oxygen-dependent and utilize portable oxygen machines. There should be an indication in the documentation to support that in spite of the portable oxygen, the patient is still having difficulty breathing and the vital signs are out of the normal range.

The presence of only congestive heart failure in the past medical history does not meet the requirements for medical necessity.

Note: Symptoms must be documented on the run sheet (e.g., shortness of breath, wheezing, irregular pulse, etc.).

Decubitus Ulcers

Documentation should include the location, size and the stage of the ulcer along with other information that would explain why a wheelchair or other means of moving the patient other than an ambulance could not be used (e.g., large deep ulcer on coccyx, hips or along spinal column).

TrailBlazer covers decubitus ulcers on sacrum or buttocks that are grade 3 or higher for transfers requiring more than 60 minutes of sitting.

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This information may be obtained from the patient's medical records from the nursing home or the patient's attending physician.

Fever

When fever is a factor, the patient's temperature should be documented on the run sheet. For TrailBlazer to allow the transport, the documentation should reflect:

- Significantly high fever unresponsive to pharmacologic intervention or fever with associated symptoms.
- Temperature after pharmacologic intervention $>102^{\circ}$ (adult) and $>104^{\circ}$ (child). Associated neurologic or cardiovascular symptoms/signs, other abnormal vital signs.

Fractures

Arm and Shoulder Fractures

Documentation should show the rationale for transport by ambulance. Generally, an upper extremity fracture does not require ambulance transport unless it is unusually severe (e.g., bone exposed, shock with large amount of blood loss).

Hip Fractures (Recent, Suspected)

A description of the patient's medical condition should indicate:

- The patient has a hip fracture that has not been surgically corrected, resulting in the presence of a hip pseudoarthrosis.
 - Pseudoarthrosis is the formation of a false joint caused by the failure of the bones to fuse. This most commonly occurs when the bones do not heal properly after a fracture.
- If the patient has a possible hip fracture, the run sheet should include:
 - The paramedic's description of the patient's condition at the time of the transfer (e.g., "patient reportedly fell out of bed today and onto his right hip").
 - Patient complaining of severe hip pain and could not walk.
 - Bruising and swelling were evident at the site.And/or,
 - The right leg was shortened and turned in.

Note: The presence of a hip fracture that has been treated in the past (medical history alone) may not meet the medical necessity criteria for coverage. If the patient has had recent hip surgery and is ambulatory with a walker, cane or a wheelchair, it is not medically necessary to be transported by ambulance.

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Hemorrhaging (Severe)

Documentation should reflect observations of the patient, such as blood pressure, pulse rate and other symptoms that describe the patient's condition. This includes uncontrolled bleeding with signs of shock and active severe bleeding (quantity identified), ongoing or recent, with potential for immediate rebleeding. This does not include venous bleeds or non-life-threatening bleeding. The hemorrhage should be hemodynamically significant (e.g., affecting blood pressure).

Motor Vehicle Accident (MVA)

Documentation should describe the reason the transport was medically necessary (e.g., injuries noted to be sustained or suspected to be sustained).

Moved By Stretcher, Drawsheet

Providers must describe the condition that resulted in the patient being moved by stretcher (e.g., patient unconscious, possible hip fracture, terminal debilitating cancer, severe hemorrhage, description of patient's limitation to require the transport, etc.).

Myocardial Infarction (Acute)

Run sheets for claims submitted with this diagnosis should describe patients who are experiencing the medical symptoms associated with a Myocardial Infarction (MI), such as sweating, shortness of breath, chest pain, cyanosis, heartburn or nausea/vomiting.

Note: This does not include patients who have a history of a myocardial infarction and are able to be transported by another method.

Obesity

Morbid obesity (as a sole qualifying condition) must meet the regulatory definition of bed-confined to be covered. Medicare does not expect this to occur with persons whose Body Mass Index (BMI) is <80.

Documentation should give the patient's height and weight if obesity is listed as the reason the patient needed transport by ambulance.

Any special handling and/or equipment used or the use of extra manpower should also be documented.

Oxygen Administered

Vital signs should be included on the run sheets. The run sheet should also include the patient's respiratory rate and oxygen saturation. There should be information to describe why the patient requires oxygen (e.g., respiratory distress, respiratory arrest, shock, terminal debilitating lung cancer, etc.).

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Oxygen administration in the absence of signs or symptoms of respiratory distress is, by itself, inadequate reason to justify ambulance transportation in a patient capable of self-administration of oxygen.

Pain

Pain is at a severity of 7–10 on 10-point severity scale despite pharmacologic intervention. Patient needs specialized handling to be moved. Other emergency conditions are present or reasonably suspected. Signs of other life- or limb-threatening conditions are present. Associated cardiopulmonary, neurologic, or peripheral vascular signs and symptoms are present.

Psychiatric/Behavioral

For TrailBlazer to allow the transport, the documentation should reflect:

- Disorientation, suicidal ideations, attempts and gestures, homicidal behavior, hallucinations, violent or disruptive behavior, drug withdrawal signs/symptoms, severe anxiety, acute episode or exacerbation of paranoia.

Refer to definition of restraints in the CFR, Section 482.13(e).

For behavioral or cognitive risk such that patient requires attendant to ensure the patient does not try to exit the ambulance prematurely, see CFR, Section 482.13(f)(2) for definition.

The patient:

- Is expressing active signs and/or symptoms of an uncontrolled psychiatric condition or acute substance withdrawal.
- Is a threat to self or others requiring restraint (chemical or physical).
- Requires monitoring and/or intervention of trained medical personnel during transport for patient and crew safety.

Transport is required by state law/court order.

Note: Refer to the “Transports” section in this manual for more information on outpatient psychiatric facility transports.

Renal Failure

Providers should describe the condition that caused the dialysis patient to be transferred by ambulance (e.g., total body paralysis, fetal position, etc.).

Respiratory Distress or Shortness of Breath (SOB)

Documentation of the patient's vital signs, which include the respiratory rate, should be documented along with other pertinent information on the run sheet.

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Restraints

Documentation should describe why restraints were used (e.g., patients had to be restrained because they were combative and could injure themselves or others).

Note: This does not include routine strapping of patients onto a gurney and it does not include transfers where restraints might be used. The documentation on the run sheet should fully describe the condition of the patient and explain why restraints were necessary.

Transient Ischemic Attack (TIA)

Documentation should reflect observations of facial drooping, slurred speech, weakness of extremities and other clinical signs that describe the patient's condition.

There should be a note in the documentation indicating whether the Transient Ischemic Attack (TIA) is recent (date of TIA). If the patient is post-TIA and it is written as part of the history, documentation should support rationale for the ambulance transport (e.g., coma, non-responsive, contractures and any descriptive information that will help determine medical necessity of the transport).

Weakness (General)

Generalized weakness is not a covered condition for ambulance transfers. Documentation should describe specific signs and symptoms that require an ambulance transfer.

Note

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the contractor. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria for payment to be made.

For additional information on coverage requirements, refer to the "Ambulance Services (Ground Ambulance)" LCD:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

For additional information on documentation, refer to the ambulance Computer-Based Training (CBT):

<http://www.trailblazerhealth.com/Education/CBTs/Default.aspx>

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Emergency/Non-Emergency Services

Medicare covers both emergency ambulance transportation and non-emergency ambulance transportation.

Emergency Services

Medicare will cover emergency ambulance services when the services are medically necessary, meet the destination limits of closest appropriate facilities, and are provided by an ambulance service that is licensed by the state.

The patient's condition is an emergency that renders the patient unable to go safely to the hospital by other means.

Determining an Emergency

It is very important that suppliers/providers pay particular attention to the patient's condition and the origin and destination, if appropriate, to determine the choice of emergency or non-emergency codes. This information must be kept in the patient's record and be available for review upon request.

For Medicare program purposes, an emergency level of ambulance service depends upon how the ambulance was dispatched and how it responded. An emergency is determined based on the information available to the dispatcher at the time of the call, using standard dispatch protocols. This must be documented in the patient's record. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived.

Definition of Emergency

The patient's condition is an emergency that renders the patient unable to go to the hospital by other means. Emergency ambulance services are services provided after the sudden onset of a medical condition. Acute signs and/or symptoms of sufficient severity must manifest the emergency medical condition such that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- Place the patient's health in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.

The above definition has been extended to include responding immediately.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

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Application: The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Covered Emergency Destinations

Covered destinations for emergency ambulance services include:

- Hospitals.
- Physician's office only if during an emergency transportation to a hospital, the ambulance stops at a physician's office en route due to a dire need for professional attention and thereafter continues to the hospital. In such cases, the patient is deemed not to have been transported to the physician's office and payment may be made for the entire trip.

Extra Charge for Emergency

An extra charge for emergency is not covered by Medicare. The cost has been incorporated into the allowance for the ambulance transfer. "Emergency" should not be billed as a separate service.

Non-Emergency

Medical Necessity

Ambulance services are covered in the absence of an emergency condition in either of the two general categories of circumstances that follow:

- The patient being transported has, **at the time of ground transport**, a condition such that all other methods of ground transportation (e.g., taxi, private automobile, wheelchair van or other vehicle) are contraindicated. In this circumstance, "contraindicated" means that the patient cannot be transported by any other means from the origin to the destination without endangering the individual's health. Having or having had a serious illness, injury or surgery does not necessarily justify Medicare payment for ambulance transportation; thus a thorough assessment and documented description of the patient's current state is essential for coverage. All statements about the patient's medical condition must be validated in the documentation using contemporaneous objective observations and findings.
- The patient is bed-confined before, during and after transportation. The definition

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of “bed-confined” means the patient must meet all of the following three criteria:

- Unable to get up from bed without assistance.
- Unable to ambulate.
- Unable to sit in a chair (including a wheelchair).

As stated in the bullet above, statements about the patient’s bed-bound status must be validated in the record with contemporaneous objective observations and findings as to the patient’s functional physical and/or mental limitations that have rendered him bed-bound.

Non-emergency ambulance services may be those that are scheduled in advance (scheduled services being either repetitive or non-repeating).

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary.

Covered Non-Emergency Destinations

Covered destinations for “non-emergency” transports include:

- Hospitals (“appropriate facility”).
- SNFs.
- Dialysis facilities – Ambulance services furnished to a maintenance dialysis patient should show that the patient’s condition requires ambulance services.
- From an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip (for instance, cardiac catheterization, specialized diagnostic imaging procedures such as computerized axial tomography or magnetic resonance imaging, surgery performed in an operating room, specialized wound care, cancer treatments).
- The patient’s residence (only if the transport is to return from an “appropriate facility”).

Example of Non-Emergency

Any ambulance trip that does not meet the emergency definition criteria would be determined to be a non-emergency service. This includes:

- All scheduled runs (regardless of origin and destination).
- Transports to nursing homes or to the patient’s residence.
- Scheduled transports to and from ESRD facilities for maintenance dialysis.

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Non-Covered, Non-Emergency Ambulance Services

Non-emergency ambulance transportation is not covered for patients who are restricted to bed rest by a physician's instruction but who do not meet the bed-confined definition.

If some means of transportation other than an ambulance (such as private vehicle, wheelchair van, etc.) could be utilized without endangering the individual's health, whether or not such other transportation is actually available.

Non-emergency ambulance transportation is not covered if the patient is transported to receive a service that could have been safely and effectively provided in the point of origin (residence, SNF, hospital, etc.). **Such transportation is not covered even if the patient could only have gone for the service by ambulance.**

Ambulance transportation for services excluded from SNF consolidated billing must meet the criteria as reasonable and necessary stated above.

Ambulance transports to or from an Independent Diagnostic Testing Facility (IDTF) are considered paid in the SNF Prospective Payment System (PPS) rate when the beneficiary is in a covered Part A stay and may **not** be paid separately as Part B services. The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (diagnostic or therapeutic site other than P or H), and the other modifier (origin or destination) is "N" (SNF). In this instance, the SNF is responsible for the costs of the transport. The "D" origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers and all other diagnostic or therapeutic sites.

Ambulance

Physician Certification Statement (PCS)

For patients who are under the direct care of a physician, a PCS is required for scheduled and non-scheduled non-emergency ambulance transports.

A PCS is not required for emergency transports or for non-scheduled non-emergency transports of patients residing at home or in facilities where they are not under the direct care of a physician.

Providers of ambulance transportation must obtain a written statement (PCS) from the patient's attending physician certifying that medical necessity requirements for ambulance transportation are met.

The signature of the medical professional completing the PCS must be legible (or accompanied by a typed or printed name) and include credentials. Furthermore, signatures on the PCS must be dated at the time they are completed.

It is important to note that the mere presence of the signed PCS does not, by itself, demonstrate that the transport was medically necessary and does not absolve the ambulance provider from meeting all other coverage and documentation criteria.

A PCS for repetitive transports must be signed by the physician.

A PCS is **not** required for emergency transports or for non-scheduled, non-emergency transports of patients residing at home or in facilities where they are not under the direct care of a physician.

Guidelines for Obtaining the PCS

The ambulance provider is responsible for obtaining the signed written order and certification with the appropriate signatures as expeditiously as possible, and must obtain the signed order before billing for the service.

PCS requirements for non-emergency scheduled, repetitive ambulance transportation include the following:

- The PCS for repetitive transports must be signed and dated by the attending physician before furnishing the services to the patient.
 - Signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials.
 - Signatures on the PCS must be dated at the time they are completed.
- The PCS must be dated no earlier than 60 days in advance of the transport for those patients who require repetitive ambulance services and whose transportation is scheduled in advance.
- For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days.

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A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary.

PCS requirements for non-emergency unscheduled or scheduled on a non-repetitive basis ambulance transportation include the following:

- The PCS must be obtained from the attending physician within 48 hours after the transport.
- If the ambulance provider is unable to obtain the PCS from the attending physician within 48 hours of transport, the provider may submit a claim if a certification has been obtained from one of the following who is knowledgeable about the patient's condition and who is employed by either the attending physician or the facility to which the patient is admitted:
 - Physician Assistant (PA).
 - Nurse Practitioner (NP).
 - Clinical Nurse Specialist (CNS).
 - Registered Nurse (RN).Or,
 - Discharge planner.

Signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials.

Signatures on the PCS must be dated at the time they are completed.

Unable to Obtain the Required PCS for Unscheduled or Scheduled on a Non-Repetitive Basis Non-Emergency Transport

Alternatively, the provider may submit the claim after 21 days if there is documentation of a good-faith effort to obtain the order and certification. The ambulance supplier must document efforts to obtain certification. When the PCS cannot be obtained, the provider/supplier may send a letter via U.S. Postal Service certified mail with return receipt and/or proof of mailing or other similar service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS. Providers/suppliers may also use the U.S. Postal Service Certificate of Mailing, Form 3817, as an acceptable alternative to certified mail.

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the contractor. It is important to note that neither the presence nor absence of the signed PCS necessarily proves (or disproves) whether the transport was medically necessary. The ambulance service must meet all other coverage criteria for payment to be made.

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Note: Ambulance suppliers who have a large volume of claims that indicate they have been unable to obtain the PCS may be subjected to medical review.

PCS Form Requirements

CMS does not require a particular form or format for the certification and it can be simply a written statement that supports the need for ambulance services. Suppliers and physicians may develop their own certification form. Ambulance company employees should not complete the PCS forms.

To facilitate this process, TrailBlazer recommends that the form **contain a section that allows the physician to provide a narrative description of the patient's physical condition at the time of the transport.** The physician's certification should:

- Be a patient-specific form that is signed and dated by authorized personnel.
Note: Refer to "Signature Guidelines for Medical Review Purposes" in this section.
- Contain pertinent medical information in the narrative portion that will assist Medicare in making medical necessity determinations.
- Confirm or support the medical information submitted on the run sheet and the diagnosis information submitted on the claim form.
- For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days.
- Signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials.
- Signatures on the PCS must be dated at the time they are completed.

Note: The physician certification form should not be altered from its original format.

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Minimum Vehicle and Staff Requirements

Vehicle

The vehicle must be a specially designed and equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first-aid supplies and oxygen equipment. The vehicle must also have other safety lifesaving equipment as required by the state Department of Health or local authorities.

Equipment and Supplies

As previously mentioned, the ambulance must have customary patient-care equipment and first-aid supplies. Reusable devices and equipment such as backboards, neck boards and inflatable leg and arm splints are considered part of the general ambulance service and are included in the cost of the trip.

Crew

The ambulance crew must consist of at least two members. Those crew members responsible for the care or handling of patients must include one individual with adequate first-aid training. This training must be “equivalent” to the standard and advanced Red Cross first-aid training courses. The training includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first-aid course furnished by or under the sponsorship of state or local authorities, an educational institution, fire department, hospital, professional organization or other such qualified organization. On-the-job training involving the administration of first-aid personnel for a period of time sufficient to ensure the trainee's proficiency in handling the wide range of patient-care services that may have to be performed by a qualified attendant can also be considered as equivalent training.

Advanced Life Support (ALS)

An ALS ambulance has complex, specialized, life-sustaining equipment and, ordinarily, equipment for radiotelephone contact with a physician or hospital. Typically, this type of ambulance would require mobile coronary care units and other ambulance vehicles that are appropriately equipped and staffed by personnel trained and authorized to administer IVs, provide anti-shock trousers, establish and maintain a patient's airway, defibrillate the heart, relieve pneumothorax conditions, and perform other advanced life support procedures or services such as cardiac (EKG) monitoring. The ambulance must be staffed by at least two people, one of whom must be certified by the state or local authority as an EMT-Intermediate or an EMT-Paramedic.

ALS assessment is an assessment performed by an ALS crew as part of an **emergency response** that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the

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assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Basic Life Support (BLS)

The BLS ambulance is one that provides transportation plus the equipment and staff needed for such basic services as control of bleeding, splinting fractures, treatment for shock, CPR, etc.

BLS is medically necessary transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by at least two people, one of whom must be certified as an individual who is qualified in accordance with state and local laws as an EMT-Basic. These laws may vary from state to state or within a state.

For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral IV line.

Definitions of Ambulance Service

The following definitions apply to both land and water (hereafter collectively referred to as “ground”) ambulance services unless otherwise specified as applying to air ambulance services.

- **EMT-Intermediate** – EMT-Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.
- **EMT-Paramedic** – EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.
- **Basic Life Support (BLS)** – BLS is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an EMT-Basic. These laws may vary from state to state or within a state. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish an IV line.
- **Basic Life Support (BLS) – Emergency** – When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to

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take the steps necessary to respond to the call.

Application: The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

- **Advanced Life Support (ALS) Personnel** – ALS personnel are individuals trained to the level of the EMT-Intermediate or paramedic.
- **ALS1** – ALS, Level 1: Where medically necessary, transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention. EMT-Intermediate scope includes but is not limited to:
 - Administration of IV fluids (except blood or blood products).
 - Peripheral venous puncture.
 - Blood drawing.
 - Monitoring IV solutions during transport that contain potassium.
 - Administration of approved medications, IV, Sub Q, sublingual, nebulizer inhalation, IM (limited to deltoid and thigh sites only).
- **Advanced Life Support, Level 1 (ALS1) – Emergency** – When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used,

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the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

- **ALS Assessment** – ALS Assessment: An assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

- **ALS Intervention** – ALS Intervention: A procedure that is, in accordance with state and local laws, required to be furnished by ALS personnel. The service must be medically necessary to qualify as an intervention for payment of an ALS level of services.

Note: An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

- **ALS2** – ALS, Level 2: Where medically necessary, transportation by ground ambulance vehicle, medically necessary supplies and services, and at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion, excluding crystalloid hypotonic, isotonic and hypertonic solutions (dextrose, normal saline, or Ringer's lactate); by intravenous push/bolus or by continuous infusion excluding crystalloid hypotonic, isotonic and hypertonic solutions (dextrose, normal saline, or Ringer's lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following procedures:
 - Manual defibrillation/cardioversion.
 - Endotracheal intubation.
 - Central venous line.
 - Cardiac pacing.

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- Chest decompression.
- Surgical airway.
- Intraosseous line.

Application: Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3 of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

Example: An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol, calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, in order to receive payment for an ALS2 level of service, based in part on the administration of Epinephrine, three separate administrations of Epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia

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persists, a second 12 mg dose of Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

- **Specialty Care Transport (SCT)** – SCT is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care or a paramedic with additional training.

Application: The EMT-Paramedic level of care is set by each state. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. Care above that level that is medically necessary and that is furnished at a level of service above the EMT-Paramedic level of care is considered SCT. If EMT-Paramedics, without specialty care certification or qualification, are permitted to furnish a given service in a state, then that service does **not** qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher-level medical services required by critically ill or critically injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

- **Fixed-Wing (FW) Air Ambulance** – FW air ambulance is the transportation by a fixed-wing aircraft that is certified by the Federal Aviation Administration (FAA) as a fixed-wing air ambulance and the provision of medically necessary services and supplies.
- **Rotary-Wing (RW) Air Ambulance** – RW air ambulance is the transportation by a helicopter that is certified by the FAA as a rotary-wing ambulance, including the provision of medically necessary supplies and services.
- **Emergency Response** – Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the

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ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.

Application: The phrase “911 call or equivalent” is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol.

An emergency call need not come through 911 even in areas where a 911 call system exists. However, the determination to respond emergently must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, the provider/supplier’s dispatch protocol and the dispatcher’s actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service.

In areas that do not have a local 911 or equivalent service, then both the protocol and the dispatcher’s actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the state, or if there is no similar jurisdiction, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary’s condition (for example, symptoms) at the scene determines the appropriate level of payment.

- **Adjusted Base Rate** – Adjusted base rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.

With respect to ground service levels, the **adjusted base rate** is the payment amount that results from multiplying the **Conversion Factor (CF)** by the applicable Relative Value Unit (RVU) and applying the **Geographic Adjustment Factor (GAF)**. With respect to fixed-wing and rotary-wing services, the **adjusted base rate** is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the Fee Schedule (FS) and is not calculated by means of a CF and RVU adjusted by the provider/supplier’s GAF.

- **Unadjusted Base Rate** – Unadjusted base rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them. The **unadjusted base rate** is the payment amount that results from multiplying the CF by the RVU without applying the GAF.
- **Conversion Factor (CF)** – CF is the nationally uniform dollar value that, when multiplied by **RVUs** for a service, results in the **unadjusted base rate** amount for that service.

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The CF is, in effect, equal to the unadjusted national ground base rate for a BLS transport. The CF is updated annually for inflation by a factor specified in the statute. The inflated CF is applied to the RVUs of the different levels of ground ambulance service resulting in payment amounts under the ambulance fee schedule.

- **Relative Value Unit (RVU)** – RVUs measure the value of ambulance services relative to the value of a base-level ambulance service.
- **Geographic Adjustment Factor (GAF)** – GAF is a value that is applied to a portion of the **unadjusted base rate** amount to reflect the relative costs of furnishing ambulance services from one area of the country to another. The GAF is equal to the Practice Expense (PE) portion of the Geographic Practice Cost Index (GPCI) from the physician fee schedule.

For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the **unadjusted base rate**. For air ambulance services, the PE portion of the GPCI is applied to 50 percent of the **unadjusted base rate**.

- **Goldsmith Modification** – Goldsmith Modification is the methodology for the identification of rural census tracts located within large metropolitan counties of at least 1,225 square miles, but are so isolated from the metropolitan core of that county by distance or physical features as to be more rural than urban in character.
- **Loaded Mileage** – Loaded mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle. Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates for: 1) ground and water; 2) FW; and 3) rotary-wing. For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.
- **Point of Pickup (POP)** – POP is the location of the beneficiary at the time he is placed on board the ambulance. The ZIP code of the **POP** must be reported on each claim for ambulance services, so that the correct GAF and **Rural Adjustment Factor (RAF)** may be applied, as appropriate.
- **Rural Adjustment Factor (RAF)** – RAF is an adjustment applied to the payment amount for ambulance services when the **POP** is in a rural area.
- **Services in a Rural Area** – Services in a rural area are services that are furnished: (1) in an area outside a Metropolitan Statistical Area (MSA); (2) in New England, outside a New England County Metropolitan Area (NECMA); or (3) an area identified as rural using the **Goldsmith modification** even though the area is within an MSA.
- **Under Direct Care of a Physician** – The physician is responsible for supervising the medical care of the patient, including reviewing the patient's program of care, ordering medications, monitoring changes in the patient's medical status, and signing and dating all orders.

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- **Date of Service (DOS)** – The Date of Service (DOS) of an ambulance service is the date 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.
- **Provider** – For the purposes of this manual only, the term “provider” is used to reference a hospital-based ambulance provider that is owned and/or operated by a hospital, critical access hospital, SNF, comprehensive outpatient rehabilitation facility, home health agency, hospice program or, for purposes of Section 1814(g) and Section 1835(e), a fund.
- **Supplier** – For the purposes of this manual, 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.
- **A/MAC** – For the purposes of this manual only, the term refers to those contractors that process claims for institutionally-based ambulance providers billed on the CMS-1450 form (UB-04) and/or a Health Insurance Portability and Accountability Act (HIPAA)-compliant ANSI X12N 837I electronic transaction.
- **B/MAC** – For the purposes of this chapter only, the term refers to those contractors that process claims for ambulance suppliers billed on a CMS-1500 form and/or an HIPAA-compliant ANSI X12N 837P electronic transaction.

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Paramedic Intercept

Paramedic Intercept (PI) services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

This tiered approach to life-saving is cost-effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Medicare payment could be made for these services but only when the claim was submitted by the entity that actually furnished the ambulance transport. Payment could not be made directly to the intercept service provider. In those areas where state laws prohibit volunteer ambulances from billing Medicare and other health insurance, the intercept service entity could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service.

PI services furnished on or after March 1, 1999, may be separately payable from the ambulance transport, subject to the requirements specified below. The intercept service(s) is:

- Furnished in a rural area.
 - It is designated as a rural area by any law or regulation of a state.
 - It is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA).
- Or,
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.
- Furnished under a contract with one or more volunteer ambulance services.
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

In addition, the volunteer ambulance service involved must:

- Meet the program's certification requirements for furnishing ambulance services.
- Furnish services only at the BLS level at the time of the intercept.
- Be prohibited by state law from billing anyone for any service.

Finally, the entity furnishing the ALS paramedic intercept service must:

- Meet the program's certification requirements for furnishing ALS services.

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- Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether those recipients are Medicare beneficiaries.

For purposes of the PI benefit, a rural area is an area that is designated as rural by a state law or regulation or any area outside of an MSA or in New England, outside an NECMA as defined by the Office of Management and Budget.

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SERVICES AND PROCEDURE CODES

National Ambulance Fee Schedule (AFS)

Overview

Beginning January 1, 2006, 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.

Payment will be determined by the point of pickup, which is reported by the five-digit ZIP code.

Coding Requirements

The following are the concepts from the AFS that are required in coding claims:

- Seven categories of ground ambulance services.
- Two categories of air ambulance services.
- Payment is based on the condition of the beneficiary, not on the type of vehicle used.
- Payment is determined by the point of pickup, which is reported by the five-digit ZIP code.
- Mileage may be billed separately.
- Increased payment for rural services.
- Services and supplies included in the base rate.
- Assignment is mandatory for all ambulance claims. This means that suppliers/providers may not bill or collect from the beneficiary any amount other than any unmet deductible and coinsurance amounts.

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Ground Transport Codes

There are seven categories of ground ambulance services. (**Note:** “Ground” refers to both land and water transportation.)

Providers are required to bill based on the services rendered and patient’s condition at the time of transport.

A0428 Ambulance service, basic life support, non-emergency transport (BLS)

Basic Life Support (BLS): Medically necessary transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an Emergency Medical Technician-Basic (EMT-Basic). These laws may vary from state to state. For example, only in some states is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a Peripheral Intravenous (IV) line.

A0429 Ambulance service, basic life support, emergency transport (BLS-emergency)

The patient’s condition is an emergency that renders the patient unable to go to the hospital by other means. Emergency ambulance services are services provided after the sudden onset of a medical condition. For the purposes of this policy, acute signs and/or symptoms of sufficient severity must manifest the emergency medical condition such that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- Place the patient’s health in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.

Emergency response means responding immediately at the BLS or Advanced Life Support Level 1 (ALS1) level of service to a 911 call or the equivalent. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

For Medicare program purposes, an emergency level of ambulance service depends upon how the ambulance was dispatched and how it responded. An emergency is determined based on the information available to the dispatcher at the time of the call, based on standard dispatch protocols. This must be documented on the trip/run sheet. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived.

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A0426 Ambulance service, advanced life support, non-emergency transport, level (ALS1)

Where medically necessary, transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention. EMT Intermediate scope includes but not limited to:

- Administration of IV fluids (except blood or blood products).
- Peripheral venous puncture.
- Blood drawing.
- Monitoring IV solutions during transport that contain potassium.
- Administration of approved medications, IV, Sub Q, sublingual, nebulizer inhalation, IM (limited to deltoid and thigh sites only).

ALS Assessment: An assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

ALS Intervention: A procedure that is, in accordance with state and local laws, "required to be furnished by ALS personnel."

Note: An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

A0427 Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)

The patient's condition is an emergency that renders the patient unable to go to the hospital by other means. Emergency ambulance services are services provided after the sudden onset of a medical condition. For the purposes of this policy, acute signs and/or symptoms of sufficient severity must manifest the emergency medical condition such that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- Place the patient's health in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent. An immediate response is one in which the

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ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

For Medicare program purposes, an emergency level of ambulance services depends upon how the ambulance was dispatched and how it responded. An emergency is determined based on the information available to the dispatcher at the time of the call, based on standard dispatch protocols. This must be documented on the trip/run sheet. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived.

Note: An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

A0433 Advanced life support, level 2 (ALS2)

Where medically necessary, transportation by ground ambulance vehicle, medically necessary supplies and services, and at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion, excluding crystalloid hypotonic, isotonic and hypertonic solutions (dextrose, normal saline, or Ringer's lactate), or transportation, medically necessary supplies and services, and the provision of at least one of the following procedures:

- Manual defibrillation/cardioversion.
- Endotracheal intubation.
- Central venous line.
- Cardiac pacing.
- Chest decompression.
- Surgical airway.
- Intraosseous line.

Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

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In other words, the administration of 1/3 of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

Example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol, calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, in order to receive payment for an ALS2 level of service, based in part on the administration of Epinephrine, three separate administrations of Epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

Example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

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A0434 Specialty Care Transport (SCT)

Specialty Care Transport (SCT): Specialty care transport is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area; for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

The EMT-Paramedic level of care is set by each state. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. Care above that level that is medically necessary and is furnished at a level of service above the EMT-Paramedic level of care is considered SCT. That is to say, if EMT-Paramedics without specialty care certification or qualification are permitted to furnish a given service in a state, that service does **not** qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher-level medical services required by critically ill or critically injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (e.g., a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

CMS considers a "facility" to include only a Skilled Nursing Facility (SNF) or hospital that participates in the Medicare program or a hospital-based facility that meets CMS' requirement for provider-based status.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, Critical Access Hospitals (CAHs), inpatient acute-care hospitals and Sole Community Hospitals (SCHs).

MEDICARE PART A AND B

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Mileage

A0425 Ground mileage, per statute mile

Mileage can be allowed to the nearest appropriate facility when the ambulance transfer is covered. Only the actual number of “**loaded**” miles from the point where the patient is picked up to the point of destination can be reported as mileage charges.

Separate charges for unloaded mileage are not covered by Medicare. Charges for unloaded miles may not be separately billed to the patient, as they are part of the ambulance base rate.

Miles must be reported as fractional units.

Note: For options on collecting fractional miles, refer to the *Federal Register* at: <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>.

When reporting fractional mileage, suppliers/providers 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 longer, 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 one mile, enter a “0” before the decimal (e.g., 0.9).

Fractional mileage reporting applies only to ambulance services billed on a Form CMS-1500 paper claim, ANSI X12N 837P, or 837I electronic claims.

Part B Suppliers

1500 Claim Form/Electronic Claims

Enter the mileage in Item 24g of the CMS-1500 paper claim or the corresponding loop and segment of the ANSI X12N 837P electronic claim for trips totaling up to 100 covered miles.

For mileage HCPCS codes billed on a CMS-1500 Form or ANSI X12N 837P only, contractors shall automatically default to “0.1” units when the total mileage units are missing in Item 24g.

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Institutional Providers

Electronic Claims

Mileage must be reported as fractional units in the ANSI X12N 837I element SV205 for trips totaling up to 100 covered miles.

For trips totaling 100 covered miles and longer, 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 one mile, enter a "0" before the decimal (e.g., 0.9).

UB-04 Paper Claim

Change Request (CR) 7557 implemented the fractional units requirements for the UB-04 paper ambulance claims submissions.

Beginning with dates of service on or after January 1, 2011, for claims submitted on or after August 1, 2011, 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 one mile, enter a "0" before the decimal (e.g., 0.9). This applies on trips of up to 100 miles.

Non-Covered Mileage

A0888 Non-covered mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)

In situations when a beneficiary wishes to be transported to a facility that is not the closest appropriate facility, Medicare does not cover the additional mileage.

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Paramedic Intercept

A0432 Paramedic Intercept (PI) rural area transport furnished by a volunteer ambulance company that is prohibited by state law from billing third-party payers

Paramedic Intercept (PI) services are ALS services provided by an entity that does not provide the ambulance transport.

This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only a BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

Coverage

Presently, only the state of New York meets these requirements. Contractors will deny all other states.

Based on the definition of the paramedic intercept, the Jurisdiction 4 (J4) states and Virginia suppliers/providers are not meeting the definition when billing the paramedic code.

Colorado, New Mexico, Oklahoma, Texas and Virginia do not prohibit a volunteer ambulance company from billing a third-party payer. The only state that meets the requirements is New York.

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, paramedic intercept services, etc.), the BLS supplier may bill Medicare the ALS rate, provided that a written agreement between the BLS and ALS entities exists.

Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their Medicare Administrative Contractor (MAC) upon request. Contractors must refer any issues that cannot be resolved to the regional office.

The proper way to bill these services would be as a joint response. Refer to “Multiple Arrivals/BLS/ALS Joint Responses” under the “Transports” section of this manual for requirements.

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Supplies, Drugs and Special Services

Services rendered January 1, 2006, and after, supplies, drugs and ancillary services (waiting time, extra attendant, oxygen, EKG, night calls) will no longer be reimbursed by Medicare and cannot be billed to the patient.

Aid Calls

The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. This policy applies to situations in which the beneficiary refuses to be transported, even if medical services are provided prior to loading the beneficiary onto the ambulance (e.g., BLS or ALS assessment). However, the entity that furnishes a non-covered service to a Medicare beneficiary may bill the beneficiary for the service.

When an ambulance crew does not transport a patient but only renders aid, this is a non-covered service by Medicare. The beneficiary will be liable for payment.

Medicare only covers ambulance services when a patient is being transported.

A0998 Ambulance response no treatment, no transport

This code may be reported to Medicare for a denial if the patient is not being transported in the ambulance. In order to receive a proper denial, the GY modifier will need to be submitted with the procedure code. Due to the description of the code, the origin and destination modifiers do not apply.

Example:

- Ambulance dispatched to the scene of an accident and crew renders aid until a helicopter can be sent.
- Ambulance dispatched and patient refuses care.
- Ambulance dispatched and aid only is rendered.

Ambulance Transportation HCPCS Codes A0021 Through A0424 and A0888

Effective January 1, 2012, Medicare contractors will begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily excluded ambulance transportation services and transportation-related services. Medicare will then deny claims containing these codes as “non-covered,” which will allow providers/suppliers to submit the denied claim to a beneficiary’s secondary insurance for coordination of benefits purposes.

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Claim Filing Information

Providers/suppliers billing for statutorily excluded ambulance transportation services and transportation-related services to obtain a Medicare denial should attach the GY modifier to the HCPCS code identifying the service, according to long-standing CMS policy.

Denial Messages

When denying these claims for statutorily excluded services, Medicare contractors will use the following remittance advice language:

- Claim adjustment reason code 96 (non-covered charge(s)).
- Remittance Advice Remark Code (RARC) N425 (statutorily excluded service(s)).
- Group code PR (patient responsibility).

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MEDICAL NECESSITY

Limitation of Liability

In the case of ambulance services, the limitation of liability provision is not applicable to ambulance services partially denied because the trip exceeded covered limits, the statutory vehicle and crew requirements were not met or the patient's condition did not contraindicate use of another method of transportation. Such denials are based on Section 1861(s)(7) of the Social Security Act and not Section 1862(a)(1)(A). Therefore, these denials do not require an Advance Beneficiary Notice of Noncoverage (ABN). For services that require an ABN, see the "Ambulance Advance Beneficiary Notice of Noncoverage (ABN) Requirements" section in this manual.

ICD-9-CM Codes That Support Medical Necessity

TrailBlazer has a Local Coverage Determination Policy (LCD) in effect for ambulance services. This involves covered conditions based on two tables: Table 1 covers the trip to the medical site; Table 2 covers the return trip from the medical site. To view these conditions, refer to the "Ambulance Services (Ground Ambulance)" LCD at:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

Medical necessity and coverage of ambulance services are not based solely on the presence of a specific diagnosis. Medicare payment for ambulance transportation may be made only for those patients whose conditions at the time of transport are such that ambulance transportation is necessary.

For example: It is insufficient that a patient merely has a diagnosis such as pneumonia, stroke or fracture to justify ambulance transportation. In each of those instances, the condition of the patient must be such that transportation by any other means is medically contraindicated. In the case of ambulance transportation, the condition necessitating transportation is often that an accident or injury has occurred giving rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

It is the provider's responsibility to supply the contractor with information describing the condition of the patient that necessitated ambulance transportation. Medicare recognizes limitations of usual ambulance personnel for establishing a diagnosis and recognizes, therefore, that diagnosis coding of a patient's condition using ICD-9-CM when reporting ambulance services may be less specific than for services reported by other professional providers. Also, selected ICD-9-CM diagnosis codes from the CMS Condition Code list are included with instructions to use them in a manner that is contrary to usual ICD-9-CM coding conventions.

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Providers who submit ICD-9-CM diagnosis codes should choose the code that best describes the patient's condition at the time of transport. As a reminder to providers of ambulance services, "rule out" or "suspected" diagnoses should not be reported using specific ICD-9-CM codes. In such instances where a diagnosis is not confirmed, it is more correct to use a symptom, finding or injury code.

Reporting ambulance services using a code from the two lists certifies to Medicare that the ambulance provider believes the code description reasonably reflects the condition of the patient at the time of transport and that the patient's condition was consistent with the requirements of the Medicare ambulance transportation benefit.

TrailBlazer recognizes that ambulance suppliers are currently not required to submit ICD-9-CM codes on their claims if filing on a 1500 claim form or utilizing an electronic version other than the 5010 version of the 837P, though their doing so facilitates timely claim adjudication. The CPT/HCPCS codes included in the LCD will be subjected to "procedure to diagnosis" editing. The two lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered.

If a claim contains one or more ICD-9-CM diagnoses but a covered diagnosis code is not on the claim, the edit will automatically deny the service as not medically necessary. Claims without an ICD-9-CM diagnosis code are adjudicated manually utilizing the information contained in the claim's narrative field and/or medical records (the trip report and any other records supplied to Medicare by the provider upon our request). Ambulance suppliers utilizing the 5010 version of the 837P are required to submit ICD-9-CM diagnosis codes.

Refer to the "Claim Form" section in this manual for more information on submitting ICD-9-CM diagnoses.

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AMBULANCE FEE SCHEDULE MEDICAL CONDITION INSTRUCTIONS

The Medical Conditions List is intended primarily as an educational guideline. 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 information 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 and miles traveled, all of which must be available in the event the claim is selected for Medical Review (MR) by the Medicare contractor or other oversight authority.

Medicare contractors will rely on medical record documentation to justify coverage. The HCPCS code or the Medical Conditions List information by themselves are not sufficient to justify coverage. All current Medicare ambulance policies remain in place.

CMS issued the Medical Conditions List as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the ICD-9-CM codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act (HIPAA)) on most ambulance claims.

To view the Medical Conditions List, refer the CMS Internet-Only Manual (IOM) Pub. 100-04, Chapter 15 at:

<http://www.cms.gov/manuals/downloads/clm104c15.pdf>

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

Note: TrailBlazer has an ambulance Local Coverage Determination (LCD) that indicates some codes are not appropriate for payment in some circumstances. This LCD may be viewed at:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

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MODIFIERS

How Modifiers Are Used

The first alpha character of the modifier represents the point of origin followed by the alpha character for the destination. Modifiers should be used with every ambulance procedure code. Ambulance transport codes and mileage should have an origin/destination modifier. The complete full names and addresses of all origins and destinations should be documented on the run/trip record. If the origin is the scene of an accident without an address, please submit the distance for the closest town (i.e., two miles north of Houston).

The origin and destination for each ambulance transfer must be annotated by the use of a two-character modifier created from the following codes:

- D**.....Diagnostic or therapeutic site/freestanding facility (i.e., radiation therapy center) other than P or H
- E**.....Residential/domiciliary/custodial facility (i.e., non-skilled facility)
- G**.....Hospital-based dialysis facility (hospital or hospital-related)
- H**.....Hospital (i.e., inpatient or outpatient)
- I**.....Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- J**.....Non-hospital-based dialysis facility
- N**.....Skilled Nursing Facility (SNF) (swing bed is considered an SNF)
- P**.....Physician's office (includes HMO and non-hospital facility)
- R**.....Residence (patient's home or any residence)
- S**.....Scene of accident or acute event
- X**.....Intermediate stop at physician's office en route to the hospital (destination code only)
- GM**Multiple patients on one ambulance trip (CMS-1500 claim form only)
- QL**Patient pronounced dead after ambulance called (do not use origin and destination modifiers, only QL)
- CR**Catastrophe/Disaster Related (include origin and destination modifiers) (CMS-1500 claim form only)
- GA**Waiver of liability statement issued, as required by payer policy (Advance Beneficiary Notice of Noncoverage (ABN)) statement on file (CMS-1500 claim form only)
- GW**Service not related to the hospice patient's terminal condition (CMS-1500 claim form only)
- GX** Notice of liability issued, voluntary under payer policy (CMS-1450 (UB-04) claim form only)
- GY**.....Item or service is statutorily excluded or does not meet the definition of any Medicare benefit. **Note:** Use modifier GY to report ambulance services for patients whose conditions do not meet the requirements for coverage or for whom ambulance transportation is non-covered.

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In addition, institutional-based providers (CMS-1450 (UB-04) claim form only) must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QMAmbulance service provided under arrangement by a provider of services.

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.

Note: It is considered inappropriate billing if an ambulance provider uses a modifier that does not describe the origin/destination. For example, if a patient is taken from his residence to the physician's office in the professional building at the hospital, this transfer should be billed with R for residence and P for physician's office.

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TRANSPORTS

The patient must be onboard the ambulance in order for a transport to be considered. No payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports.

Definitions

Destination

An ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for taking the service to the patient.

Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:

- Hospital.
- Critical Access Hospital (CAH).
- Skilled Nursing Facility (SNF).
- Beneficiary's home.
- Dialysis facility for End Stage Renal Disease (ESRD) patient who requires dialysis.

Note: A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

For ambulance services to be a covered benefit, the transport must be to the nearest institution with appropriate facilities for the treatment of the illness or injury involved.

Appropriate Facilities

This term means the institution is generally equipped to provide the needed hospital or skilled nursing care necessary to manage the injury or illness involved. Appropriate facilities are determined by the institution, equipment, personnel and the capability to provide necessary services to support the required medical care.

The fact that a more distant institution is better equipped to care for the patient does not warrant a finding that a closer institution does not have appropriate facilities.

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In the case of a hospital, it also means a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities. However, a legal impediment that bars the patient's admission would preclude that institution from having appropriate facilities.

For example, if the nearest appropriate specialty hospital is in another state and that state's law precludes admission of non-residents, that facility is not an appropriate facility.

If no bed is available at the nearest appropriate facility, coverage will be extended to the next nearest institution generally equipped to provide the needed care for the illness or injury; however, this information must be given on the claim.

More Distant Facility

Ambulance service to a facility more distant than the nearest appropriate facility that is covered by Medicare will be reimbursed at the amount that would have been paid for a trip to the nearest appropriate facility. The mileage will only be allowed to the nearest appropriate facility.

Locality

The term "locality," with respect to ambulance service, means the service area surrounding the institution from which individuals normally come or are expected to come for hospital or skilled nursing services.

Example: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

Out-of-Locality

As a general rule, only local transportation by ambulance is covered. However, payment may be made for an ambulance transfer to an out-of-locality institution if it is the nearest one with appropriate facilities. Such claims should be documented to indicate the reason for transfer to the out-of-locality institution.

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Example: There was no available bed at a local SNF or the patient required radiation therapy services that were not available at the local hospital.

Ambulance Jurisdiction

The following guidelines should be used when providing ambulance services.

Jurisdiction of the claim is based on whether only one ambulance vehicle or multiple vehicles were used.

One Ambulance Vehicle Used

If only one vehicle is used to transport the patient from the point of initial pickup to the final destination, jurisdiction is with the carrier serving the point of origin (i.e., home station of the vehicle). This carrier has qualification information on the ambulance supplier, and in most cases, all other pertinent details necessary to adjudicate a claim.

Example A: A patient is picked up at Johns Hopkins Hospital in Baltimore, Maryland, and transported to his home in West Virginia by an ambulance dispatched from the area of the patient's home. The carrier serving the point of origin of the ambulance, Nationwide Mutual Insurance Company, Part B carrier for the state of West Virginia, has jurisdiction of any claim filed. In this case, Nationwide should have all the data necessary to make proper payment (i.e., certification of the ambulance company, price information and data pertaining to the nearest appropriate company). If an ambulance, whose home station was in Baltimore had been used, the carrier servicing Baltimore, Maryland, would have had jurisdiction. The Baltimore carrier would then have had to obtain data concerning the nearest appropriate facility to the patient's home from Nationwide.

More Than One Vehicle Used

If more than one vehicle is used to transport the patient to his destination, jurisdiction of the claim lies with:

- The carrier serving the home base of the ambulance taking the patient on the **first leg of the trip** on a trip **to** a distant institution more remote than the nearest appropriate facility.
Or,
- The carrier serving the home base of the ambulance taking the patient on the **final leg** of the trip home on a trip **from** an institution more remote than the nearest appropriate facility.
- If there is **no** claim for the final leg of the trip, the carrier serving the patient's home area handles any resulting claims or disallowance actions.

Example B: A patient is transported by ambulance from a hospital in Miami Beach, Florida, to Miami International Airport, and from there by air ambulance to LaGuardia Airport in Queens, New York City. The patient is picked up at the airport by an

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ambulance (based in Yonkers, New York) and taken to his home in Yonkers, New York. The carrier that handles the adjudication is the carrier whose area of responsibility includes Yonkers, New York, since partial reimbursement is based upon the nearest appropriate facility to his residence when he is being returned home from a distant institution.

In examples A and B above, the principle followed is the carrier having the information to determine the “nearest appropriate facility” is the one to adjudicate the claim. In any event, before **any** partial reimbursement can be made, the carriers, as designated in examples A and B, must have all the information concerning the patient’s transportation **from initial pickup to final destination.**

Ambulance

Transports From Institution to Institution

Transports from hospital to hospital and SNF to SNF that are not returned to the original facility must indicate the reason an ambulance was necessary and what facilities or physician specialty was available at the second hospital or SNF that was not available at the first. The information provided should be very specific as to the reason the patient must be transferred.

Note: The ambulance transfer will be denied if the information submitted does not indicate what specific services were available at the second facility that were not available at the first facility.

Example:

- Heart surgeon not available at first hospital.
- Radiation therapy services needed and not available at the first hospital.
- Rehabilitation services were needed and were not available at the first hospital.
- CAT SCAN machine was not working or was not available at the first hospital.
- No beds were available at the first hospital.
- Intensive Care Unit (ICU) was full at the first hospital.
- The orthopedic surgeon was not on call.

This is not an all-inclusive list. Generic statements such as “higher level of care needed,” “specialist not available,” or “patient needed surgery” do not provide enough detailed information supporting the need for the transport. Use of these types of statements will result in denial of the ambulance service(s).

Documentation

Be very specific on the initial claim and include all necessary documentation. For example, on a hospital-to-hospital transfer, indicate that the patient needed a CAT SCAN and the original hospital did not have the necessary equipment.

Occasionally, the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered to the extent of the mileage to be the nearest institution with appropriate facilities.

Reasons for Transport

Transports from hospital to hospital and SNF to SNF that are not returned to the original facility must indicate the reason an ambulance was necessary and what facilities or physician specialty was available at the second hospital or SNF that was not available at the first.

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Some reasons for the transport to a more distant facility are:

- CAT SCAN equipment is not working or is not available at the first hospital.
- Special diagnostic equipment is needed.
- No beds are available at the first hospital.
- Trauma unit is full at the first hospital.
- A specialist or surgeon is not on call or is not available.
- A burn unit is required.

CMS-1500 Claim Form Filing Requirements

Paper Claims

CMS-1500 claim form – Submit trip report with the claim.

Electronic Information

Type of Transport

- I.....Initial Trip.
R.....Return Trip.
T.....Transfer Trip (hospital to hospital).
X.....Round Trip.

Transported To/For

- A.....Patient was transported to the nearest facility for care of symptoms, complaints or both. Can be used to indicate that the patient was transferred to residential facility.
B.....Patient was transported for the benefit of a preferred physician.
C.....Patient was transported for the nearness of family members.
D.....Patient was transported for the care of a specialist or for availability of specialized equipment.
E.....Patient transferred to rehabilitation facility.

Round-Trip for Hospital Inpatient

Round-trip ambulance transfers where a patient remains an inpatient and is transported to and then returned from another hospital or freestanding facility for tests or treatments must be **arranged** through the hospital and billed under Medicare Part A.

Ambulance

CMS-1450 (UB-04) Claim Form Filing Requirements

Inpatient Hospital Billing

Hospital inpatient billings (Type of Bill (TOB) 11X) must not show ambulance revenue code 0540 separately. When an inpatient, the cost of transportation by ambulance to and from another hospital or freestanding facility, for specialized diagnostic or therapeutic services not available at the originating facility, must be billed in the appropriate ancillary service cost center (for example, in the cost of the diagnostic or therapeutic service).

Critical Access Hospital (CAH) and Indian Health Service (IHS)/Tribal Billing

Changes to Payment for CAH Ambulance Services

Effective with dates of service on or after October 1, 2011, for a CAH or a CAH-owned and operated entity to be paid 101 percent of reasonable costs for its ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH. Prior to October 1, 2011, the regulations required that there be no other provider or supplier of ambulance services within a 35-mile drive of the CAH or the entity.

- Also, effective with dates of service on or after October 1, 2011, if there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH, but there is a CAH-owned and operated entity located more than a 35-mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable costs for its ambulance services if it is the closest provider or supplier of ambulance services to the CAH.

Change Request (CR) 7219 implements Section 3128 of the Affordable Care Act, which increased payments for outpatient facility services and ambulance services for CAHs.

Following are key points of CR 7219:

- Effective April 1, 2011, Medicare will pay for CAH ambulance services, including IHS CAHs, with a hospital-based ambulance service on TOB 85X with revenue code 054X (ambulance) and condition code B2 (CAH ambulance attestation) based on 101 percent of reasonable cost.
- Effective April 1, 2011, Medicare will pay for CAH outpatient facility services under the optional method based on 101 percent of reasonable cost.
- When the 35-mile rule for cost-based payment is not met, the CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the CAH is paid based on the ambulance fee schedule.
- When the 35-mile rule for cost-based payment is not met, the IHS/tribal CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the IHS/tribal CAH is paid based on the ambulance fee schedule.

Ambulance

Separately Payable Ambulance Transport Under Part B Benefits Versus Patient Transportation That Is Covered Under a Packaged Hospital Service

Transportation of a beneficiary from his home, an accident scene or any other point of origin is covered under the Part B benefits as an ambulance service only to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury and only if medical necessity and other program coverage criteria are met.

Medicare-covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills under the Part B benefit of the program, or as a packaged service, in which case the entity furnishing the ambulance service must seek payment from the provider who is responsible for the beneficiary's care. If either the origin or the destination of the ambulance transport is the beneficiary's home, then ambulance transport is paid separately by the Medicare Part B benefit and the entity that furnishes the ambulance transport may bill its Medicare contractor directly. If both the origin and destination of the ambulance transport are providers, e.g., a hospital, CAH, SNF, then responsibility for payment for the ambulance transport is determined in accordance with the following sequential criteria.

Note: These criteria must be applied in sequence as a flow chart and not independent of one another.

1. **Provider Numbers:** If the Medicare-assigned provider numbers of the two providers are different, the ambulance service is separately billable to the program. If the provider number of both providers is the same, consider criterion 2, "campus."
2. **Campus:** Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, the transport is not separately billable to the program. In this case, the provider is responsible for payment. If the campuses of the two providers are different, consider criterion 3, "patient status." "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office to be part of the provider's campus.
3. **Patient Status, Inpatient vs. Outpatient:** Following criteria 1 and 2, if the patient is an inpatient at both providers (i.e., inpatient status both at the origin and at the destination, providers sharing the same provider number but located on different campuses), the transport is not separately billable. In this case the provider is responsible for payment. All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program.

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In the case where the point of origin is not a provider, Part A coverage is not available because, at the time the beneficiary is being transported, the beneficiary is not an inpatient of any provider paid under Part A of the program and ambulance services are excluded from the three-day preadmission payment window.

The transfer, i.e., the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also payable as a Part B ambulance transport benefit, provided all program coverage criteria are met, because, at the time that the beneficiary is in transit, he is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes an outpatient transfer from a remote, off-campus Emergency Room (ER) department to becoming an inpatient or outpatient at the main campus hospital, even if the ER is owned and operated by the hospital.

Once a beneficiary is admitted to a hospital, CAH or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered “patient transportation” and is covered as an inpatient hospital or CAH service and as an SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. (If the beneficiary is a resident of an SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under the Part B benefit.) Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under the Part B benefit. This includes intracampus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intracampus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.

Same-Day Discharge and Readmission

- Same diagnosis – The hospital will combine both claims into one. The patient’s status will not reflect a discharge.
- Different diagnosis – The hospital will submit two claims. The patient’s status will reflect a discharge and a new admit.

Ambulance

Transfer to Renal Dialysis Facility

Coverage Criteria for Hospital-Based Facilities

Medically necessary transportation to a renal dialysis facility that is hospital-based may be reimbursable when:

- The renal dialysis facility is located on or adjacent to the premises of the hospital.
- The facility furnishes services to patients of the hospital, e.g., on an outpatient basis, even though the dialysis facility is primarily in operation to furnish dialysis services to its own patients.
- There is an ongoing professional relationship between the hospital and the renal dialysis facility.

Payment Criteria

Round-trip ambulance service to hospital outpatient dialysis facilities will be reviewed for medical necessity on a per visit basis.

Coverage Criteria for Non-Hospital-Based Dialysis Facilities

Coverage of round-trip ambulance transportation for an ESRD beneficiary living at home to the nearest treatment facility capable of furnishing the necessary dialysis service regardless of whether the dialysis facility is located at a hospital will be considered for payment.

Freestanding Facilities

Transportation to freestanding facilities (other than non-hospital-based dialysis facilities) from non-participating SNFs is not covered by Medicare.

Transports to a Diagnostic or Therapeutic Site From an SNF

Ambulance transports to or from an Independent Diagnostic Testing Facility (IDTF) are considered paid in the SNF Prospective Payment System (PPS) rate when the beneficiary is in a covered Part A stay and may **not** be paid separately as Part B ambulance benefit. The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (Diagnostic or therapeutic site other than P or H), and the other modifier (origin or destination) is "N" (SNF). In this instance, the SNF is responsible for the costs of the transport. The "D" origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers and all other diagnostic or therapeutic sites.

Ambulance

Transports to and From Medical Services for Beneficiaries Who Are Not Inpatients

Ambulance transports to and from a covered destination (i.e., two 1-way trips) furnished to a beneficiary who is not an inpatient of a provider for the purpose of obtaining covered medical services are covered, if all program requirements for coverage are met.

In addition, coverage of ambulance transports to and from a destination under these circumstances is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient. For frequent transports of this kind subject to the contractor's discretion, additional information may be required supporting the need for ambulance services relative to the option of admission to a treatment facility.

Outpatient Hospital Transfers

Non-emergency ambulance service to the hospital outpatient department must indicate the reason an ambulance was necessary, the type of treatment provided, facilities and equipment used (i.e., X-ray of hip, Computerized Axial Tomography (CT) scan, Gastrointestinal (GI) laboratory, gastrostomy tube changed, etc.).

Transfers solely for dressing changes, catheter changes or routine care, etc., are not considered reasonable and, therefore, are not covered. When transferring a patient for a feeding tube change, be specific. Indicate "gastrostomy tube" if that is the kind of feeding tube used.

Documentation should reflect the reason an ambulance was necessary and the type of treatment rendered or facilities used (e.g., X-ray of hip, CT scan, GI laboratory, gastrostomy tube changed, etc.).

Transports to Partial Hospitalization Programs (PHP)

This is clarification of the ambulance benefit in relation to transports to PHPs.

The reason for this clarification is TrailBlazer has received claims where the patient is being transported to the PHP but the reason for transport is due to conditions that would exclude the patient from being enrolled/participating in the PHP.

Example: If the patient is being transported due to a danger to himself and/or others, he would not meet the PHP requirements and this would not be a covered destination.

For a transport to a PHP to be considered, the patient would have to meet the ambulance benefit and the PHP benefit. Most patients do not meet both; therefore, TrailBlazer would not expect to see claims for these types of transports.

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PHP are considered to be at a hospital location; however, the patient must meet requirements for a PHP to participate in the program Likewise, patients must meet Medicare's requirements for coverage for non-emergency ambulance transportation.

Requirements to participate in a PHP are:

- (1) Require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care.
- (2) Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment.
- (3) Do not require 24-hour care.
- (4) Have an adequate support system while not actively engaged in the program.
- (5) Have a mental health diagnosis.
- (6) Are not judged to be dangerous to self or others.
- (7) Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the partial hospitalization program.

Note: Patients must meet all requirements to participate in the program.

If a patient has conditions that could qualify him for an ambulance transport (diagnosed as either a danger to themselves from active signs or symptoms of active psychiatric condition or acute substance withdrawal, require some degree of restraint to ensure there is no flight risk during transport to these hospitals, they're disoriented, combative, exhibit signs and/or symptoms of acute and severe anxiety and/or paranoia), he may meet the qualifications for an ambulance transport but would not be meeting the requirements for a PHP; therefore, transports based on this instance may be denied as not medically necessary.

If the patient is not enrolled in a PHP (or meet all of the PHP requirements) and only meet the Ambulance benefit (cannot be transported by any other means) and is being transported for group therapy or other psychotherapy services, then this would not qualify as an appropriate destination as "hospital" but more a "clinic" with the ability of the service being provided to the patient at their origin.

When an arrangement between the PHP and ambulance supplier exists, the ambulance provider would expect reimbursement for the transport from the PHP and not from Medicare as the arrangement is an agreement that any money paid by Medicare to the provider arranging the service is responsible for payment of arranged service to contracted entities. Many/most of these facilities have patient transportation included in their program.

Ambulance

Helpful Hints

Prior to submitting the claim, suppliers should answer the following questions:

- (1) How is the facility classified and what is the patient's status with that entity?
- (2) Does the patient meet all of the PHP requirements?
- (3) Do they meet the ambulance benefit (they cannot be transported by any other means)?

Note: If the patient is being transported due to a danger to himself and/or others, he would not meet the PHP requirements and this would not be a covered destination.

- (4) Can the service be brought to the patient cheaper than the patient to the service?

Transfers to a Physician's Office/Clinic

Ambulance service to a physician's office or physician-directed clinic is **not covered**. The ambulance may stop at a physician's office because the patient requires emergency treatment and then continue to the hospital; the patient will be deemed not to have been transported to the physician's office and payment may be made for the entire trip. This will be considered as one transfer.

Transportation Requested by Home Health Agency

Where a home health agency has a beneficiary transported by ambulance to a hospital or SNF to obtain needed medical services not otherwise available to the individual, the trip is covered as a Part B benefit service only if the requirements are met for ambulance transportation from wherever the patient is located (place of origin). Such transportation is not covered as a home health service.

Two or More Ambulances in the Same Transfer

In some unusual cases, one ambulance may not be able to transport the patient (i.e., the ambulance has mechanical problems) and a second ambulance is dispatched. Medicare will reimburse each ambulance for the transport and mileage. The mileage billed must only be the loaded mileage actually involved in the transport by each ambulance. Each ambulance must document the circumstances that required the use of two different ambulances.

Multiple Arrivals/BLS/ALS Joint Responses

When multiple units respond to a call for services, Medicare may only pay the entity that provides the transport for the beneficiary for all services furnished.

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (for example, ALS assessment, Paramedic Intercept (PI) services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists. Providers must provide a copy of the agreement or other such evidence (signed attestation) as determined by their contractor upon request.

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While there must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service, Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment will be reimbursed. In this situation, the ALS entity's services are not covered and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

For example, Basic Life Support (BLS) and Advanced Life Support (ALS) ambulances respond to a call. The BLS furnishes the transport after an ALS assessment is furnished. The BLS supplier may bill at the ALS, Level 1 (ALS1) rate. Medicare will pay the BLS supplier based on the ALS1 rate. The ALS ambulance company must obtain payment from the BLS ambulance company for its services.

Two or More Beneficiaries in the Same Ambulance

Indicate on each claim when more than one patient is transported in the same ambulance at the same time. List the number of patients in the ambulance.

Reimbursement for ambulance service is generally limited to emergency ambulance service. In some situations, it may be necessary to transport more than one patient in the same ambulance at the same time. The full charge for the ambulance service to both patients is not considered reasonable under existing Medicare regulations.

When an ambulance transports more than one patient simultaneously, the payment allowance is based on the number of patients (Medicare and non-Medicare) on board. The mileage payment amount is divided by the number of patients on board.

If two patients were on board, the payment allowance for each Medicare beneficiary is equal to 75 percent of the service payment allowance for the level of care provided to the beneficiary, plus 50 percent of the mileage allowance.

If three or more patients were on board for the same transport, the payment allowance is 60 percent of the level of care furnished the patient. The mileage amount is divided by the number of patients (Medicare and non-Medicare) on board.

Claims Filing Requirements

Providers Using CMS-1450 (UB-04) Claim Form

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.

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Suppliers Using CMS-1500 Claim Form

GM Multiple patients on one ambulance trip

Paper: Documentation must be submitted with this information. Indicate the number of patients on board and the Health Insurance Claim (HIC) number of each Medicare beneficiary or indicate “not a Medicare patient.”

Electronic: Loop 2300 or 2400 Segment NTE01= ADD, and NTE02 = number of patients and HIC number or indicate “not a Medicare patient.”

Pronouncement of Death

The following information clarifies Medicare policy related to the death of a beneficiary and the payment for any ambulance services.

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, there is no Medicare-covered service. In general, if the beneficiary dies before being transported, no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the state to make such pronouncements.

The following three scenarios apply to payment for ambulance services when the beneficiary dies before a ground or air ambulance arrives.

- If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment based on the base rate may be made. However, neither mileage nor a rural adjustment would be paid.
- Payment is made based on the BLS level of service if a ground vehicle is dispatched. (TrailBlazer only allows A0428 and A0429 to be submitted with QL modifier for suppliers submitting on the CMS 1500 claim form).
- If an air ambulance is dispatched, payment is made based on the fixed-wing or rotary-wing base rate, as appropriate.
- The beneficiary is pronounced dead after being loaded into the ambulance, regardless of whether the pronouncement is made during or subsequent to the transport. A determination of “Dead on Arrival” (DOA) is made at the facility to which the beneficiary is transported.
- Payment is made following the usual rules of payment (as if the beneficiary had not died).
- No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called or dispatched.

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Claims Filing Requirement

The QL modifier (patient pronounced dead after ambulance called) must be indicated on the claim. (Do not use origin and destination modifiers, only QL.)

The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

Ground Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	Medicare Payment Determination
Before dispatch	None
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point of pickup)	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim
After pickup, prior to or upon arrival at the receiving facility	Medically necessary level of service furnished

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the Medicare payment determination is based on whether the beneficiary was onboard the air ambulance.

Air Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	Medicare Payment Determination
Prior to takeoff to point of pickup with notice to dispatcher and time to abort the flight	None Note: This scenario includes situations in which the air ambulance has taxied to the runway and/or has been cleared for takeoff, but has not actually taken off.
After takeoff to point of pickup, but before the beneficiary is loaded	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility	As if the beneficiary had not died

Ambulance

AIR AMBULANCE SERVICES

Introduction

Medically appropriate air transportation is a covered Medicare service. Air ambulance transportation is approved if the beneficiary's condition is such that transportation by either basic or advanced life support land ambulance is contraindicated.

Air Ambulance Transportation Services

There are two categories of air ambulance services: fixed-wing (airplane) and rotary-wing (helicopter) aircraft. These may be determined to be covered only if:

- Transportation is provided by an approved supplier of ambulance services.
- The beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by land ambulance because either:
 - The point of pickup is inaccessible by land vehicle.
 - Or,
 - Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities.
- All coverage requirements for ground ambulance transportation are met.

There are very limited emergency cases where land transportation is available, but the time required to transport the patient by land as opposed to air endangers the beneficiary's life or health. Medicare considers that when it would take a land ambulance 30–60 minutes or more to transport an emergency patient, air ambulance may be the appropriate mode of transportation.

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Air Ambulance Mileage

A0435 Fixed-wing air mileage, per statute mile

A0436 Rotary-wing air mileage, per statute mile

Services Rendered Prior to January 1, 2011

Air mileage must be reported in whole numbers of loaded statute miles flown. Contractors must ensure the appropriate air transport code is used with the appropriate mileage code.

Services Rendered with Dates of Service on or After January 1, 2011

Miles must be reported as fractional units.

For instructions on fractional units, refer to "Mileage" under the "Services and Procedure Codes" section in this manual.

Ambulance

Medical Necessity for Air Transports

As a reminder, if medical necessity or appropriateness of the air transport is not supported, the transfer may be allowed as a ground transfer or denied. If ground transfer is the method of payment, only one base rate and appropriate ground mileage will be allowed. An Advance Beneficiary Notice of Noncoverage (ABN) may be required for this. See the “Ambulance Advance Beneficiary Notice of Noncoverage (ABN) Requirements” section in this manual.

Please refer to the following example of an actual combined ground and air transport. In this example, Medicare made payment for the air transport as a ground transport because the patient’s condition did not require an air transfer.

Example: The patient was taken from hospital to airport by ground ambulance, from airport to airport by air ambulance and from airport to hospital by ground ambulance. Payment was made to the first ground provider for a base rate and mileage. The air provider was paid only the ground mileage (from the origin facility to the destination facility) still remaining after the mileage paid to the first ground provider was deducted. The air provider was not paid for a base rate, since the medical determination was that the patient’s condition, while it did require transport by ambulance, did not require transport by air ambulance. The second ground provider would not receive any payment. In making payment to these two providers, Medicare appropriately paid for a base rate and appropriate mileage from the origin facility to the destination facility.

Documentation

It is extremely important to document the necessity/reasonableness of the air ambulance transfer.

Medical reasonableness is only established when the beneficiary’s condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary’s survival or seriously endangers the beneficiary’s health. Following is an advisory list of examples of cases for which air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed:

- Intracranial bleeding requiring neurosurgical intervention.
- Cardiogenic shock.
- Burns requiring treatment in a burn center.
- Conditions requiring treatment in a hyperbaric oxygen unit.
- Multiple severe injuries.
- Life-threatening trauma.

Ambulance

Note: To determine the medical appropriateness of air ambulance services, the contractor may request that documentation be submitted that indicates the air ambulance services are reasonable and necessary to treat the beneficiary's life-threatening condition. The contractor's medical staff may consider reviewing all claims for air ambulance services.

Hospital-to-Hospital Transport

Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria are met, that is, transportation by ground ambulance would endanger the beneficiary's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such specialized medical services that are generally not available at all types of facilities may include, but are not limited to burn care, cardiac care, trauma care and critical care. A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician.

Special Coverage Rule

Air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician's office or a beneficiary's home.

Special Payment Limitations

If a determination is made to order transport by air ambulance but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport.

If the air transport was medically appropriate (that is, ground transportation was contraindicated and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which he was transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

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Air Ambulance Transports Canceled Due to Weather or Other Circumstances Beyond the Pilot's Control

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather or other circumstances beyond the pilot's control.

Air Ambulance Scenarios: Aborted Flights	
Aborted Flight Scenario	Medicare Payment Determination
Anytime before the beneficiary is loaded onboard (i.e., prior to or after take-off to point of pickup)	None
Transport after the beneficiary is loaded onboard	Appropriate air base rate, mileage, and rural adjustment

Ambulance

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Section 415

Medicare's implementation of Section 415 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) amends the Social Security Act (SSA) (Section 1834(l)) to provide appropriate coverage of rural air ambulance services. A summary of these changes is outlined below.

Reasonable Requests

Rural air ambulance transport shall be considered reasonable and necessary when a physician or other qualified medical personnel orders or certifies the air transport service. A physician or other qualified medical personnel must certify or determine that the individual's condition required air transport due to time or geographical factors, requested the transport. Medicare considers the following to be personnel qualified to order air ambulance services:

- Physician.
- Registered nurse practitioner (from the transferring hospital).
- Physician assistant (from the transferring hospital).
- Paramedic or Emergency Medical Technician (EMT) (at the scene).
- Trained first responder (at the scene).

Emergency Medical Services (EMS) Protocols

Please note that the reasonable and necessary requirement for rural air transport can be "deemed" to be met when service is provided pursuant to an established state or regional protocol that has been recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through CMS.

Air ambulance providers anticipating that transports will be made pursuant to such a state or regional protocol must submit the written protocol to their contractor in advance for review and approval. The Medicare contractor will post instructions for submission of the protocol on its Web site.

A Medicare contractor must review the protocol to ensure the contents are consistent with the statutory requirements of 1862(1)(A), directing that all services paid by Medicare must be reasonable and necessary for the diagnosis or treatment of an illness or injury. The contractor will notify providers of its protocol review determinations within 30 days of receipt of the protocol.

Remember to adhere to all requirements in the Act at 1861(s)(7) and regulatory requirements at 42 CFR 424.10, which directs that all services paid by Medicare must be reasonable and necessary, including the requirement that payment can be made only to the closest facility capable of providing the care needed by the beneficiary.

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Prohibited Air Ambulance Relationships

A contractor will not apply the “deemed” reasonable and necessary determination in the following cases:

- If there is a financial or employment relationship between the person requesting the air ambulance service and the entity furnishing the service.
- If an entity is under common ownership with the entity furnishing the service.
- If there is a financial relationship between an immediate family member of the person requesting the service and the entity furnishing the service.

The only exception to this provision occurs when the referring hospital and the entity furnishing the air ambulance service are under common ownership. Then the above limitation does not apply to remuneration by the hospital for provider-based physician services furnished in a hospital reimbursed under Part A, and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

Reasonable and Necessary Services

Medicare contractors may perform medical review of rural air ambulance claims with “deemed” medical necessity status when there are questions as to whether:

- The decision to transport was reasonably made.
 - The transport was made pursuant to an approved protocol.
- Or,
- The transport was inconsistent with an approved protocol.

In addition, the contractor may conduct a medical review in those instances where there is a financial or employment relationship between the person requesting the air ambulance transport and the person providing the transport.

Medicare payment can be made only to the closest facility capable of providing the care needed by the beneficiary irrespective of who orders the transport.

Additional Information

For purposes of these revised sections of the *Medicare Program Integrity Manual*, the term “rural air ambulance service” means fixed-wing and rotary-wing air ambulance services in which the point of pickup of the individual occurs in a rural area (as defined in Section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification published in the *Federal Register* on February 27, 1992 (57 Fed. Reg. 6725)). The official instruction issued to a contractor regarding this change, including the revised portion of Chapter 6 of the *Medicare Program Integrity Manual*, may be found at:

<http://www.cms.gov/manuals/downloads/pim83c06.pdf>

Ambulance

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) AS IT RELATES TO AMBULANCE SERVICES

Background

When the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians and other practitioners. Consolidated Billing (CB) assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to the Medicare Part B benefit by the entity that actually furnished the service.

See MLN Matters® Special Edition (SE) 0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at:

<http://www.cms.gov/MLN MattersArticles/downloads/SE0431.pdf>

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e., based on the reason the ambulance service is needed.

This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement since 1983.

Since the law describes CB in terms of services that are furnished to a "resident" of an SNF, the initial ambulance trip that brings a beneficiary to an SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)–(iv) as ending the beneficiary's SNF "resident" status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or Critical Access Hospital (CAH) (see discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF).

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- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care.
 - A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below).
- Or,
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are themselves excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization.
- Computerized Axial Tomography (CT) imaging scans.
- Magnetic Resonance Imaging (MRI) services.
- Ambulatory surgery involving the use of an operating room, including the insertion, removal or replacement of Percutaneous Esophageal Gastrostomy (PEG) tubes in a Gastrointestinal (GI) or endoscopy suite).
- Emergency room services.
- Radiation therapy.
- Angiography.
- Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under the Part B benefit by the outside supplier. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Ambulance

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he retains the status of an SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)).

Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under Section 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate.

The preamble to the July 30, 1999, final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Ambulance

Non-Coverage of Transportation by Any Means Other Than Ambulance

In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van or litter van. Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary, that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance – for example, via wheelchair van – the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance also would not be covered (because the use of an ambulance in such a situation would not be medically necessary). As with any non-covered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to "... inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."

Ambulance

Additional Information

The CMS Consolidated Billing Web site can be accessed at:

<http://www.cms.gov/SNFConsolidatedBilling/>

The Web site includes the following relevant information:

- General SNF CB information.
- HCPCS codes that can be separately paid by the Medicare contractor (i.e., services not included in CB).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

It also includes the following relevant information:

- Background.
- Historical questions and answers.
- Links to related articles.
- Links to publications (including transmittals and *Federal Register* notices).

See MLN Matters® articles SE0431 and SE0433 for a detailed overview of SNF CB. These articles list services excluded from SNF CB and can be found at:

<http://www.cms.gov/MLNMattersArticles/downloads/SE0431.pdf>

<http://www.cms.gov/MLNMattersArticles/downloads/SE0433.pdf>

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Ambulance

Ambulance Services During the Prospective Payment System (PPS) Period

Type of Trip	Bill Part B Contractor	Bill Facility
1. Initial Admission to SNF	X	
2. Final Discharge from SNF		
a. To home (no return same day)	X	
b. To home (return to same SNF same day)		X
c. To another SNF for elevated level of care		X*
3. Inpatient Hospital Admission		
a. To hospital from SNF for admission	X	
b. To SNF from hospital (i.e., discharge)	X	
4. Trip to Beneficiary's Home for Medicare Home Health Services	X	
5. Transport to/from Dialysis	X	
6. Trip to Hospital for Outpatient Services		
a. Transports for all services other than those listed in 6b below must be billed to the facility, including:		
• Physical, occupational, speech therapy		X
• Diagnostic tests or services routinely provided by the SNFs		X
• Evaluation or treatment services (other than a hospital admission or one of the outpatient services listed in 6b below)		X
*Discharging facility is responsible.		
Reminder: If the services are not specifically listed above as billable to the contractor, it is the facility's responsibility.		

MEDICARE PART A AND B

Ambulance

Type of Trip	Bill Part B Contractor	Bill Facility
b. The following trips to a hospital for outpatient services should be billed to Part B, if for:		
• Emergency	X	
• Cardiac catheterization	X	
• CT scans	X	
• MRI	X	
• Ambulatory surgery involving operating room (this includes PEG tube procedures, even if performed in a hospital GI suite or endoscopy suite)	X	
• Angiography	X	
• Lymphatic and venous procedure	X	
• Radiation therapy	X	
<p>Note: All services in 6b must be performed at the hospital (not a freestanding facility) for the provider to bill the contractor. If not performed at the hospital, the SNF/swing bed facility is responsible.</p>		
7. Transports to any Medicare provider for chemotherapy, chemotherapy administration, radioisotopes, customized prosthetic devices		X
8. Transports to a physician's office (only during a Part A stay)		X
<p>*Discharging facility is responsible.</p> <p>Reminder: If the services are not specifically listed above as billable to the contractor, it is the facility's responsibility.</p>		

Ambulance

HOSPICE

Overview

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare-certified hospice is covered under the hospice benefit provisions.

Services Unrelated to the Terminal Illness

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected and that are furnished during a hospice election period may be billed to Medicare by the provider/supplier.

Claims should be submitted with a diagnosis not related to the terminal illness for Medicare to reimburse.

Claims filing requirements for:

- Providers using CMS-1450 (UB-04) claim form:
 - Providers must report condition code 07.
- Suppliers using CMS-1500 claim form:
 - Modifier GW service not related to the hospice patient's terminal illness

Ambulance

AMBULANCE FEE SCHEDULE (AFS) REIMBURSEMENT

Overview of Ambulance Fee Schedule

As of January 1, 2006, the total allowed amount for ground ambulance providers and suppliers is based on 100 percent of the national Ambulance Fee Schedule (AFS). The total payment amount for air ambulance providers and suppliers will be based on 100 percent of the national AFS. Medicare pays 80 percent of the AFS and the patient is responsible for the 20 percent.

The fee schedule applies to all ambulance suppliers. This includes volunteer, municipal, private, independent and institutional providers, e.g., hospitals, Critical Access Hospitals (CAHs), Skilled Nursing Facilities (SNFs) and home health agencies.

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate. For Calendar Year (CY) 2006, this blend will be 40 percent regional ground base rate and 60 percent national ground base rate.

Coinsurance and Deductible Requirements

The allowed amount is subject to any remaining unmet deductible amount and coinsurance requirements.

Components of the AFS

Ground Ambulance Services

The fee schedule amount comprises:

- A Conversion Factor (CF) is a money amount that serves as a nationally uniform base rate for all ground ambulance services.
- A Relative Value Unit (RVU) assigned to each category of ground ambulance service.
- A Geographic Adjustment Factor (GAF) for each AFS area (Geographic Practice Cost Index (GPCI)).
- A national mileage rate for loaded miles.
- A rural adjustment on loaded mileage for services furnished in a rural area.

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Description of Fee Schedule Components

Ground Ambulance Services

Conversion Factor (CF)

The CF is a money amount used to develop a base rate for each category of ground ambulance service. The CF will be updated as necessary.

Relative Value Units (RVUs)

RVUs set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. An RVU expresses the constant multiplier for a particular type of service. An RVU of 1.00 is assigned to the Basic Life Support (BLS) of ground service. Higher RVU values are assigned to the other types of ground ambulance services, which require more resources than BLS.

Geographic Adjustment Factor (GAF)

The GAF is one of two factors used to address regional differences in the cost of furnishing ambulance services. The GAF for the AFS uses the non-facility practice expense of the GPCI of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the AFS are the same as those used for the physician fee schedule.

The point of pickup, i.e., location where the beneficiary was put into the ambulance, establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the point of pickup establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70 percent of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to mileage.

Mileage

The AFS provides a separate payment amount for mileage. The mileage rate per statute mile applies for all types of ground ambulance services, and is provided to all Medicare contractors electronically by CMS as part of the AFS. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item when submitting claims.

MEDICARE PART A AND B

Ambulance

Adjustment for Certain Ground Mileage for Rural Points of Pickup (POP)

The payment rate is greater for certain mileage where the Point of Pickup (POP) is in a rural area to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period.

The POP, as identified by ZIP code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the ZIP code of the POP establishes whether a rural adjustment applies to such second (or subsequent) transport.

ZIP Code Determines Fee Schedule Amounts

The POP determines the basis for payment under the AFS, and the POP is reported by its five-digit ZIP code. Thus, the ZIP code of the POP determines both the applicable GPCI and whether a rural adjustment applies.

If the ambulance transport required a second or subsequent leg, then the ZIP code of the POP of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the ZIP code of the POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service (USPS) ZIP code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or in New England, a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith Modification." (The Goldsmith Modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

CMS furnishes contractors electronic files that identify a ZIP code as rural or urban.

Locating the AFS

The AFS and the ZIP code files are located on the following CMS Web site:

<http://www.cms.gov/AmbulanceFeeSchedule/>


MEDICARE PART A AND B

Ambulance


Steps to Locating the Fee Schedule Allowed Amount

Step One

Downloads


[National Breakout of the Geographic Area Definitions by Zip Code \[ZIP, 1.4MB\]](#) 

[Zip Code to Carrier Locality File \[ZIP, 4.14MB\] - Updated 6/18/10](#) 

[Zip Codes requiring +4 extension \[ZIP, 2KB\] - Updated 05/13/10](#) 

[2009 End of Year Zip Code File \[ZIP, 4.17MB\]](#) 

View the ZIP code file.

[Regional Office Contacts \[PDF, 39KB\] - Updated 02/12/09](#) 

MEDICARE PART A AND B

Ambulance

Locate the POP ZIP code.

The indicators will specify if the POP is urban, rural or the lowest quartile.

	A	B	C	D	E	F
35179	TN	38579	05440	35	R	20051
35180	TN	38580	05440	35	R	20051
35181	TN	38581	05440	35	R	20051
35182	TN	38582	05440	35	R	20051
35183	TN	38583	05440	35	R	20051
35184	TN	38585	05440	35	B	20051
35185	TN	38587	05440	35	R	20051
35186	TN	38588	05440	35	R	20051
35187	TN	38589	05440	35	R	20051
35188	TX	73301	00900	31		20051
35189	TX	73344	00900	31		20051
35190	TX	75001	00900	11		20051
35191	TX	75002	00900	99		20051
35192	TX	75006	00900	11		20051
35193	TX	75007	00900	99		20051
35194	TX	75008	00900	99		20051
35195	TX	75009	00900	99		20051
35196	TX	75010	00900	99		20051
35197	TX	75011	00900	11		20051
35198	TX	75013	00900	99		20051
35199	TX	75014	00900	11		20051
35200	TX	75015	00900	11		20051
35201	TX	75016	00900	11		20051
35202	TX	75017	00900	11		20051
35203	TX	75019	00900	11		20051
35204	TX	75020	00900	99		20051
35205	TX	75021	00900	99		20051
35206	TX	75022	00900	99		20051
35207	TX	75023	00900	99		20051
35208	TX	75024	00900	99		20051
35209	TX	75025	00900	99		20051
35210	TX	75026	00900	99		20051
35211	TX	75027	00900	99		20051
35212	TX	75028	00900	99		20051

R Indicator = Rural

B Indicator = Lowest Quartile

No Indicator = Urban

MEDICARE PART A AND B


Ambulance


Step Two

View the AFS for appropriate year.

Downloads

[CY 2010 File \[ZIP 245KB\] - Updated 7/1/2010](#) 


[CY 2009 File \[ZIP 94KB\]](#)  - Updated 4/10/09


[CY 2008 File \[ZIP 184KB\]](#)  - Updated 10/01/08

[CY 2007 File \[ZIP 130KB\]](#) 

[CY 2006 File \[ZIP 134KB\]](#) 

[CY 2005 File \[ZIP 179KB\]](#) 

[January - June 2004 AFS PUF \[ZIP 111KB\]](#) 

[July - December 2004 AFS PUF \[ZIP 132KB\]](#) 

[CY 2003 File \[ZIP 391KB\]](#) 

[CY 2002 File \[ZIP 110KB\]](#) 

View the AFS.

	A	C	D	F	H	J	L	N	R	S	T	U	V	W	X
	(1) CARRIER	(2) LOCAL	(3) HCPCS	(4) CONV FAC	(5) RVU	(6) GPCI	(7) BASE RATE & URBAN MILEAGE	(7)(a) RURAL BASE RATE & RURAL MILEAGE	(7)(b) RURAL BASE RATE - LOWEST QUARTIL E*	(8) RURAL BASE/MIL ES 1-17*	(9) URBAN MILES 51+*	(10) RURAL MILES 51+*			
711	00900	09	A0427	195.81	1.90	0.970	\$367.87	\$371.51	\$455.47	n/a	n/a	n/a			
712	00900	09	A0428	195.81	1.00	0.970	\$193.61	\$195.53	\$239.72	n/a	n/a	n/a			
713	00900	09	A0429	195.81	1.60	0.970	\$309.78	\$312.85	\$383.55	n/a	n/a	n/a			
714	00900	09	A0430	195.81	2,467.95	0.970	\$2,430.93	\$3,646.40	n/a	\$3,646.40	n/a	n/a			
715	00900	09	A0431	195.81	2,869.35	0.970	\$2,826.31	\$4,239.46	n/a	\$4,239.46	n/a	n/a			
716	00900	09	A0432	195.81	1.75	0.970	\$338.83	\$342.18	n/a	n/a	n/a	n/a			
717	00900	09	A0433	195.81	2.75	0.970	\$532.44	\$537.71	\$659.23	n/a	n/a	n/a			
718	00900	09	A0434	195.81	1.75	0.970	\$629.25	\$635.48	\$779.10	n/a	n/a	n/a			
719	00900	09	A0435	1.00	1.00	0.970	\$7.00	\$10.50	n/a	\$10.50	n/a	n/a			
720	00900	09	A0436	1.00	1.00	0.970	\$7.00	\$10.50	n/a	\$10.50	n/a	n/a			
721	00900	09	Q3019												
722	00900	09	Q3020												
723	00900	11	A0425												
724	00900	11	A0426												
725	00900	11	A0427	195.81	1.90	1.063	\$392.33	\$396.21	\$485.75	n/a	n/a	n/a			
726	00900	11	A0428	195.81	1.00	1.063	\$206.49	\$208.53	\$255.66	n/a	n/a	n/a			
727	00900	11	A0429	195.81	1.60	1.063	\$330.38	\$333.65	\$409.05	n/a	n/a	n/a			
728	00900	11	A0430	1.00	2,467.95	1.063	\$2,545.69	\$3,818.54	n/a	\$3,818.54	n/a	n/a			
729	00900	11	A0431	1.00	2,869.35	1.063	\$2,959.73	\$4,439.60	n/a	\$4,439.60	n/a	n/a			
730	00900	11	A0432	195.81	1.75	1.063	\$361.36	\$364.93	n/a	n/a	n/a	n/a			
731	00900	11	A0433	195.81	2.75	1.063	\$567.85	\$573.47	\$703.07	n/a	n/a	n/a			
732	00900	11	A0434	195.81	2.25	1.063	\$671.09	\$677.74	\$830.91	n/a	n/a	n/a			

Locate state and HCPCS code.

Step Three

Medicare will then pay 80 percent of the allowed amount with the patient responsible for the remaining 20 percent.

Ambulance

Components of Air Transports

For air ambulance services, the fee schedule amount includes:

- A nationally uniform base rate for fixed-wing and a nationally uniform base rate for rotary wing.
- A GAF for each ambulance fee schedule area (GPCI).
- A nationally uniform loaded mileage rate for each type of air service.
- A rural adjustment to the base rate and mileage for services furnished in a rural area POP.

Air Ambulance Services

Base Rates

Each type of air ambulance service has a base rate. There is no CF applicable to air ambulance services. There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage.

Geographic Adjustment Factor (GAF)

The GAF, as described for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50 percent of each of the base rates for fixed-wing and rotary-wing aircraft.

Mileage

The fee schedule for air ambulance services provides a separate payment for mileage. The air ambulance mileage rate is calculated per actual loaded (patient on board) miles flown and is expressed in statute miles (not nautical miles).

Adjustment for Services Furnished in Rural Areas

The payment rates for air ambulance services where the POP is in a rural area are greater than in an urban area. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted fee schedule amount, e.g., the applicable air service base rate multiplied by the GAF plus the mileage amount or, in other words, 1.5 times both the applicable air service base rate and the total mileage amount.

The basis for a rural adjustment for air ambulance services is determined in the same manner as for ground services. That is, whether the POP is within a rural ZIP code as described above for ground services.

Ambulance

ZIP Code Determines Applicable Fee Schedule Amount

The POP determines the basis for payment under the fee schedule, and the POP is reported by its five-digit ZIP code. Thus, the ZIP code of the POP determines both the applicable GPCI and whether a rural adjustment applies.

If the ambulance transport required a second or subsequent leg, then the ZIP code of the POP of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the ZIP code of the POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a USPS ZIP code that is located, in whole or in part, outside of either a MSA or in NECMA, or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith Modification." (The Goldsmith Modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

CMS furnishes contractors electronic files that identify a ZIP code as rural or urban.

POP ZIP Code for Services Outside of the United States

For coverage and limitations for ambulance services furnished in connection with foreign inpatient hospital services, refer to the MIM Section 3698.4, the MCM Section 2312 and 42 CFR Section 411.9.

For POP services outside of the United States or in U.S. territorial waters, suppliers and providers should report the POP ZIP code according to the following:

The following policy applies to claims outside of the United States:

- Ground transports with pickup and drop off points within Canada or Mexico will be paid at the fee associated with the U.S. ZIP code that is closest to the POP.
- For water transport from the territorial waters of the U.S., the fee associated with the U.S. port of entry ZIP code will be paid.
- Ground transports with pickup within Canada or Mexico to the United States will be paid at the fee associated with the U.S. ZIP code at the point of entry.
- Fees associated with the U.S. border port of entry ZIP codes will be paid for air transport from areas outside the United States to the United States for covered claims.

Ambulance

Additional Air Mileage

The contractor may allow additional air mileage when circumstances beyond the pilot's control occur. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions.
- Hazardous weather.
- Variances in departure patterns and clearance routes required by an air-traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor once the Medicare beneficiary is loaded onto the air ambulance.

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IMPLEMENTATION OF SECTION 414 OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT (MMA) OF 2003

Background

The Implementation of Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 provides several changes to the payment for ground ambulance services under Section 414 of the Act. Specifically, this section establishes a floor amount for the fee schedule portion of the payment, provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low density population areas, and provides a 25 percent bonus on the mileage rate for ground transports of 51 miles or greater. These payment changes apply to ground transports only, and the air ambulance base and mileage rates remain unchanged. **All increases are percentage increases and are cumulative.**

Important Dates

These changes will sunset on different dates but all apply beginning with services furnished on July 1, 2004.

Regional Ambulance Fee Schedule (AFS) Payment Rate Floor for Ground Ambulance Transports

Regional Ambulance Fee Schedule (AFS) payment rate floor for ground transport services. For services furnished during the period of July 1, 2004, through December 31, 2009, the base rate portion of the payment under the AFS for ground transports is subject to a minimum amount. This minimum depends upon the area of the country in which the service is furnished.

Basically, the country is divided into nine census divisions, and each of those divisions has a regional fee schedule that is constructed using the same methodology as the national fee schedule. Where the regional fee schedule is greater than the national fee schedule, the base rates for ground ambulance transports are determined by a blend of the national fee schedule rate and the regional rate in accordance with the following schedule:

Year	National Fee Schedule Percentage	Regional Fee Schedule Percentage
7/1/04–12/31/04	20%	80%
Calendar Year (CY) 2005	40%	60%
CY 2006	60%	40%
CY 2007–CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

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Where the regional rate is not greater than the national rate, there is no blending and only the national fee schedule amount applies.

Adjustment to the Ground Mileage Payment Amount for Miles Greater Than 50

For services furnished during the period July 1, 2004, through December 31, 2008, a 25 percent increase is applied to the appropriate AFS mileage rate for each mile of a transport (both urban and rural Points of Pickup (POP)) that exceeds 50 miles (i.e., 51 miles or greater) when the beneficiary is on board the ambulance.

The 50 percent increase applied to the rural AFS mileage rate for the first 17 miles of a rural POP continues to apply as it always has under the fee schedule.

This provision has sunset as of December 31, 2008. Effective for dates of service on or after January 1, 2009, services paid under the ambulance fee schedule will not include this temporary increase.

Adjustments for Fee Schedule Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004, through December 31, 2009, there is a 22.6 percent increase in the fee schedule portion of the base payment for ground ambulance services in low population density rural areas. This increase applies where the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. These rural areas are identified by a ZIP code with a "B" indicator on the national ZIP code file.

This section of the MMA has been extended. See the Patient Protection and Affordable Care Act (PPACA) and Medicare and Medicaid Extenders Act of 2010 (MMEA) sections for more information.

Ambulance

THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted July 15, 2008. In accordance with Section 146(a) of MIPPA, ambulance fee schedule amounts for ground ambulance services will increase.

The increase will be effective for claims with dates of service on or after July 1, 2008, through December 31, 2009, as follows:

- For covered ground ambulance transports that originate in a rural area, the fee schedule amounts increased by 3 percent.
- For covered ground ambulance transports that originate in a non-rural area, the fee schedule amounts increased by 2 percent.

This section of the MIPPA has been extended. See the PPACA and MMEA sections for more information.

Medicare Payment for Air Ambulance Services Under Section 146(b)(1) of the MIPPA

Section 146(b)(1) of the MIPPA further amends the designation of rural areas for air ambulance services.

The statute specifies that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the Ambulance Fee Schedule (AFS) for air ambulance services, will be treated as a rural area for purposes of making payments under the AFS for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.

Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently redesignated as urban, CMS has re-established the “rural” indicator on the ZIP code file for air ambulance services, effective July 1, 2008.

The Medicare contractor will process air ambulance transport and mileage claims (i.e., A0430, A0431, A0435, A0436) in accordance with these revised designations.

The implementation date of this change is January 5, 2009. In addition to the successful installation of the revised Calendar Year (CY) 2008 ZIP Code File, the Medicare contractor will mass-adjust all air ambulance claims with dates of service on or after July 1, 2008, through December 31, 2008, which were previously paid under an urban ZIP code that was considered rural December 31, 2006. In addition, the revised ZIP Code File will be used to process such claims that were not already processed.

This section of the MIPPA has been extended. See the PPACA and MMEA sections for

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more information.

Background

The AFS was implemented in April 2002 based on a final rule published in the *Federal Register* (67 Fed. Reg. 9100 (February 27, 2002)). The elements of this final rule allowed for payment for various ground ambulance services and rotary and fixed-wing air ambulance services under a fee schedule. The payment for these services is based on the type of service provided and on the geographical Points of Pickup (POP). The final rule also establishes increased payment for services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance.

When the fee schedule was implemented, a rural area was defined as one that was outside any area defined by the Office of Management and Budget as a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA). The definition of “rural” also included the Goldsmith modification. The Goldsmith modification was developed because of the need to identify small towns and rural areas within large metropolitan counties. Some of these communities were isolated from central areas with health services because of distance or other physical features. The urban and rural areas were identified for payment purposes by a nexus of the ZIP code file and the AFS. The ZIP code file is updated quarterly.

Another final rule published in 71 Fed. Reg. 69713 (December 1, 2006) revised the geographic designations for urban and rural areas as set forth in OMB’s Core-Based Statistical Areas (CBSAs) standard. It added the definition of “urban area” as defined by the Executive Office of Management and Budget (OMB). In addition, it removed the definition of Goldsmith modification and amended the definition of rural area to include areas determined to be rural under the most recent version of the Goldsmith modification. Updating the MSA definition to conform with OMB’s CBSA-based geographic area designations, coupled with updating the Goldsmith modification (that is, using the current Rural Urban Commuting Areas (RUCAs) version, as discussed in Section III.B.1.b of the final rule), more accurately reflected the contemporary urban and rural nature of areas across the country for ambulance payment purposes and made AFS payments more accurate. These changes became effective January 1, 2007.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). PPACA Sections 3105 and 10311 impact certain ambulance payment provisions:

- Section 3105 establishes the implementation date as April 1, 2010.
- Section 10311 revises Section 3105 and changes the implementation date retroactive to January 1, 2010.

PPACA Extends Three Ambulance Provisions

The PPACA:

- Extends increases in the ambulance fee schedule amounts for covered ground ambulance transports that originated in rural areas by 3 percent and for covered ground ambulance transports that originated in urban areas by 2 percent retroactive to January 1, 2010, through December 31, 2010.
- Extends the provision for air ambulance services provided in any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for services furnished December 31, 2006. Therefore, CMS will re-establish the “rural” indicator on the ZIP code file for air ambulance, effective for services provided January 1, 2010, through December 31, 2010.
- Extends retroactive to January 1, 2010, through December 31, 2010, Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which established the super rural bonus.

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MEDICARE AND MEDICAID EXTENDERS ACT OF 2010 (MMEA)

On Wednesday, December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA). In Section 106 of the MMEA the law included the extension of ambulance add-on payments.

MMEA Extends Three Ambulance Provisions

The MMEA:

- Extends increases in the ambulance fee schedule amounts for covered ground ambulance transports that originated in rural areas by 3 percent and for covered ground ambulance transports that originated in urban areas by 2 percent for services rendered January 1, 2011, through December 31, 2011.
- Extends the provision related to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services. Therefore, CMS will re-establish the “rural” indicator on the ZIP code file for air ambulance, effective for services provided January 1, 2011, through December 31, 2011.
- Extends the super rural bonus for ground ambulance services rendered January 1, 2011, through December 31, 2011.

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TEMPORARY PAYROLL TAX CUT CONTINUATION ACT (TPTCCA) OF 2011

Extension of Ambulance Add-On Payments

The provisions that were extended by Section 306 of the TPTCCA are: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas; (2) the provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and (3) the provision relating to payment for ground ambulance services where the base rate of the fee schedule is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through February 29, 2012. As previously advised, Medicare Administrative Contractors (MACs) will be holding new, January 2012 ambulance claims for up to 10 business days to effectively implement the new 2012 ambulance fee schedule. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected.

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MIDDLE CLASS TAX RELIEF AND JOB CREATION ACT OF 2012 (MCTRJCA)

Extension of Ambulance Add-On Payments

Sections 3007(a), 3007(b) and 3007(c) of the MCTRJCA extend through December 31, 2012, the following three TPTCCA ambulance payment provisions, respectively:

- 1. The 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban area.*
- 2. The provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services.*
- 3. The provision relating to payment for ground ambulance services where the base rate of the fee schedule is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density (known as the "super rural" bonus).*

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AMBULANCE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) REQUIREMENTS

ABN Requirements for Non-Emergency Transports

The Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131) is a written notice a physician or provider/supplier gives to a Medicare beneficiary before items or services are furnished when the physician or provider/supplier believes that Medicare probably or certainly will not pay for some or all of the items or services on the basis of certain Medicare statutory exclusions.

An ABN is rarely used for ambulance services and may only be issued for non-emergency transports. An ABN may not be used when a beneficiary is under great duress. A beneficiary is considered to be under great duress when his medical condition requires emergency care. Contractors use the following guidelines to determine when it is appropriate for an ambulance provider/supplier to issue an ABN for ambulance services.

An ABN may be needed and may be used for *non-emergency* transports in the following situations:

- A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.
- A level of care downgrade, e.g., from Advanced Life Support, Level 2 (ALS-2) to Advanced Life Support, Level 1 (ALS-1), or from Advanced Life Support (ALS) to Basic Life Support (BLS), when the transport at the lower level of care is a covered transport.

An ABN is not needed and should not be used in the following situations:

- Any denial where the patient could be transported safely by other means (these are denials under Section 1861(s)(7) of the Social Security Act (the Act)).
- Any denial that is based on not meeting an origin or destination requirement (these denials are based on 42 CFR 410.40 and generally also constitute Section 1861(s)(7) denials).
- A denial for mileage that is beyond the nearest appropriate facility (for the same reason as the second bullet above).
- A denial where the Physician Certification Statement (PCS) or accepted alternative (e.g., certified mail) is not obtained (for the same reason as the second bullet above).
- A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for his needs, but wants to be transferred to a second hospital to be closer to family (for the same reason as the second bullet above).

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The following table summarizes situations when an ABN is applicable regarding ambulance services:

Situation	Statutory Provision	ABN Applicable	Limitation on Liability Applicable	Responsible for Payment
Other means of transportation not contraindicated	1861(s)(7) Benefit category	No	No	Beneficiary
Air to ground downcoding	1862(a)(1)(A) Reasonable and necessary	Yes*	Yes	Supplier/provider or beneficiary if ABN is signed
ALS to BLS downcoding	1862(a)(1)(A) Reasonable and necessary	Yes*	Yes	Supplier/provider or beneficiary if ABN is signed
Mileage partial denial	1861(s)(7) Benefit category	No	No	Beneficiary

*Indicates that an ABN is applicable. However, if it is an emergency transport, ABNs cannot be used since beneficiaries are considered under great duress in such situations.

Ambulance

ABN Requirements for International Flights

Absent the rare circumstance of coverage of an ambulance service under Section 1814(f) of the Act, services outside the United States furnished to a Medicare beneficiary are statutorily excluded from Medicare coverage under Section 1862(a)(4) of the Act. Thus, when the Point of Pickup (POP) is outside the United States, including a POP outside of the U.S. territories, the transport from the POP to the nearest U.S. point of entry is statutorily excluded. The use of an ABN is not indicated but the beneficiary should be informed that Medicare will not pay for the international portion of the flight. If the beneficiary (or his representative) desires a formal Medicare determination on a claim for a transport originating outside the United States, then the transporting entity must file a claim to Medicare.

Following the international portion of a flight, if the beneficiary is then transported from the nearest point of entry by ambulance, including the same aircraft used to transport the beneficiary on the international flight, then standard Medicare rules apply. If the beneficiary is transported from the nearest point of entry to the nearest appropriate facility, then, assuming all other Medicare rules are met, the transport would be covered and payable. If the transporting entity has a reasonable basis to believe that the domestic portion of a non-emergency flight would not be covered because it is not reasonable and necessary under Medicare rules, then use of an ABN is indicated for non-emergency ambulance transports.

For comprehensive guidelines on completing the ABN, refer to the *Advance Beneficiary Notice of Noncoverage* manual located on the TrailBlazer Web site at:

<http://www.trailblazerhealth.com/Publications/Training Manual/abn.pdf>

Ambulance

CMS-1450 (UB-04) CLAIM/ELECTRONIC

Instructions for Ambulance Providers

The following fields are required when filing ambulance claims.

Applicable Bill Types

The bill type is a mandatory three-position alphanumeric field providing the following information:

- First position identifies type of facility (hospital, Skilled Nursing Facility (SNF) or special facility).
- Second position identifies bill classification (classifies the type of care provided such as inpatient Part B only or outpatient).
- Third position identifies the frequency of billing (for example, admission, interim claim, discharge, late charge, adjustment or void/cancel).

Data elements in the CMS uniform billing specifications are consistent with the UB-04 claim form. The Type of Bill (TOB) is located in Form Locator (FL) 4 of the UB-04.

Appropriate ambulance bill types include:

- 12X – Hospital inpatient (ancillary).
- 13X – Hospital outpatient.
- 22X – SNF, inpatient Part B only.
- 23X – SNF, outpatient.
- 83X – Specialty facility, Ambulatory Surgery Center (ASC) in a non-Outpatient Prospective Payment System (non-OPPS) setting such as Indian Health Service (IHS), hospitals, Maryland hospitals under PPS waiver, and hospitals located in Saipan, American Samoa and Guam. (Effective for dates of service on or after January 1, 2008, the contractor no longer processes claims on TOB 83X for ASCs. All IHS ASC providers must submit their claims to the designated contractor.)
- 85X – Critical Access Hospitals (CAHs).

CAHs that are exempt from the ambulance fee schedule and bill ambulance services on a 12X TOB will remain exempt from the ambulance fee schedule.

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National Provider Identifier (NPI) in the Attending Physician Field

(CR 7557 implemented the requirement of the attending physician's NPI number on claims with dates of service on or after April 1, 2012:

Only non-emergency trips (i.e., HCPCS codes A0426 and A0428) require a National Provider Identifier (NPI) in the Attending Physician field. Entry of an NPI in the Attending Physician field is not required for emergency trips (i.e., HCPCS codes A0427, A0429, A0430, A0431, A0432, A0433 and A0434).

Revenue Codes

Each loaded one-way ambulance trip must be reported with a unique pair of revenue code lines on a claim. Unloaded trips and mileage are not reported. Code one mile for trips that are less than one mile. Miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number, for UB-04 paper form only.

Mileage reported electronically for services rendered January 1, 2011, and after must be reported as fractional units.

For instructions on fractional units refer to Mileage under the Services and Procedure Codes section in this manual.

Ambulance services should be billed utilizing revenue code 0540 in FL 42 (revenue code). Providers are to report revenue code 0540 on two separate and consecutive line items to accommodate both the base-rate ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period.

Origin and Destination Modifiers

Modifiers are used with HCPCS codes to report an origin and destination for each ambulance trip.

The first position alphabetic value is used to report the origin of service. The second position alphabetic value is used for the destination of service. Modifiers must indicate both the origin and destination for each ambulance trip provided. For example, if the origin is the patient's home and the destination is a hospital, the modifier would be RH. If the origin is a hospital and the destination is a nursing home, the modifier would be HE.

Other Modifiers

QM/QN Modifiers

One of the following modifiers must be reported for each ambulance trip to describe whether the service was provided under arrangement or directly.

- QM – Ambulance service provided under arrangement by a provider of services.
- QN – Ambulance service furnished directly by a provider of services.

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QL Modifier

The QL modifier is valid for claims with dates of service on or after July 1, 2002. It is used when a beneficiary is pronounced dead after an ambulance (ground or air) is called, but before the ambulance arrives. Providers must report the QL modifier (patient pronounced dead after the ambulance was called) instead of the origin and destination modifier. In addition to the QL modifier, the provider must continue to report the QM or QN (which ever is applicable) modifiers.

GY Modifier

A provider uses the GY modifier when the ambulance transport is expected to be denied because the service is statutorily excluded or does not meet the definition of any Medicare benefit. The service is non-covered by Medicare statute (e.g., service is not part of a recognized Medicare benefit). The lines submitted as non-covered will be denied.

GX Modifier

The new GX modifier is valid for dates of service on or after April 1, 2010. Providers may use the GX modifier to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute. The GX modifier must be submitted with non-covered charges only and will be denied as beneficiary liability.

Value Codes

Value Code A0

The value code is defined as “ZIP code of the location from which the beneficiary is initially placed on board the ambulance.” It is required on all ambulance claims. Value code A0 should be reported in FLs 39–41 (value codes). Only one ZIP code may be reported per claim.

Providers should report the five-digit ZIP code in the dollar portion of the FL, right justified to the left of the dollar/cents delimiter.

Value Code 32

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.

Condition Code

Condition code B2 is only required for CAH facilities that are exempt from the ambulance fee schedule.

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Condition code DR is required to report disaster-related services effective August 31, 2009.

Complete the UB-04 claim form. Instructions may be located at:

<http://www.trailblazerhealth.com/Publications/Job Aid/UB-04AmbulanceBillingExamples.pdf>

Ambulance

CMS-1500 CLAIM/ELECTRONIC VERSION

Complete CMS-1500 claim form instructions can be located at:

<http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf>

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ELECTRONIC VERSION 5010 837P

ZIP Code Requirement for Point of Pickup and Point of Drop-Off

Ambulance claims submitted in the Version 5010 837P electronic claim format require *point of drop off* 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). Please refer to the appropriate Implementation Guide to determine how to report the destination information. It is important to remember that only the ZIP code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off, but the point of drop-off will be an additional reporting requirement on the Version 5010 837P claim format.

Diagnosis Codes

Ambulance claims submitted in the Version 5010 837P electronic claim format require the presence of a diagnosis code, and the absence of a diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. It is important to note that the 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 the inclusion of a diagnosis code will be an additional reporting requirement on the Version 5010 837P claim format.

References for 5010 837P

- **MLN Matters® Article:**
<http://www.cms.gov/MLN MattersArticles/downloads/MM7018.pdf>.
- **Web Sites:**
 - **TrailBlazer:**
<http://www.trailblazerhealth.com/Electronic Data Interchange/5010.aspx>.
 - **CMS:**
<http://www.cms.gov/Versions5010andD0/>.

MEDICARE PART A AND B

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APPENDIX

Acceptable Abbreviations

Below is a list of acceptable abbreviations that may be used for documentation and when filing Medicare claims. Please contact our office if additional abbreviations become common in the industry so that we may update the list.

Abbreviation	Definition
abd	Abdomen, Abdominal
ABG	Arterial Blood Gases
ADM	Admission
A-fib	Atrial Fibrillation
ALS	Advanced Life Support
ASA	Aspirin
ASHD	Arteriosclerotic Heart Disease
BBB	Bundle Branch Block
Bilat.	Bilateral
BLS	Basic Life Support
BP, B/P	Blood Pressure
c/c	Chief Complaint
CHF	Congestive Heart Failure
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardiopulmonary Resuscitation
C-Spine	Cervical Spine
CTR	Center
CVA	Cerebrovascular Accident
disch	Discharged (from hospital)
DM	Diabetes Mellitus
DOA	Dead on Arrival
EKG	Electrocardiogram
EOA	Esophageal Obturator Airway
ER	Emergency Room
ETOH	Ethanol Alcohol

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Abbreviation	Definition
FUO	Fever of Unknown Origin
fx	Fracture
GEN	General
HM	Home
Hx	History
IM	Intramuscular
inj, injs	Injuries
IV	Intravenous
LOC	Loss of Consciousness
MAST	Military Anti-Shock Trouser
MVA	Motor Vehicle Accident
NH	Nursing Home
NTG	Nitroglycerin
Abbreviation	Definition
O ₂	Oxygen
OBS	Organic Brain Syndrome
PVS, PVCs	Premature Ventricular Contractions
RBBB	Right Bundle Branch Block
RSCH	Research
resp.	Respiration
SNF	Skilled Nursing Facility
SOB	Shortness of Breath
ST	Street
THPY	Therapy
TIA	Transient Ischemic Attack
TKO	To Keep Open
Tx	Treatment
Vfib, V-fib	Ventricular Fibrillation
VS, V/S	Vital Signs
Vtach/V-tach	Ventricular Tachycardia

Ambulance

Resources

CMS Internet-Only Manuals (IOMs)

- IOM Pub. 100-02, Chapter 10.
<http://www.cms.gov/manuals/Downloads/bp102c10.pdf>
- IOM Pub. 100-04, Chapter 15.
<http://www.cms.gov/manuals/downloads/clm104c15.pdf>

MEDICARE PART A AND B

Ambulance

REVISION HISTORY

Date	Section	Revision
March 2009	Coverage Requirements	Section updated to include Change Requests (CRs) 6372, 6318 and 6347.
	Services and Procedure Codes	Section updated to include CR 6318.
	Modifiers	Section updated to include CR 6347.
	Transports	Section updated to include CR 6318.
	Air Ambulance	Section updated to include CR 6318.
	AFS Reimbursement	Section updated to include CR 6318.
	Skilled Nursing Facility (SNF) Consolidated Billing (CB) as It Relates to Ambulance Services	Section updated to include CR 6347.
May 2009	Services and Procedure Codes	Added additional information for Special Care Transport (SCT).
July 2009	Services and Procedure Codes	Added note for Colorado suppliers for aid calls.
October 2009	Ambulance Services	Added "Introduction" section.
	Services and Procedure Codes	<ul style="list-style-type: none"> • Added additional information for paramedic intercept. • Updated form name.
	Modifiers	Updated form name.
	Transports	<ul style="list-style-type: none"> • Updated form name. • Added electronic information per CR 6621.
	Part A Providers	Added DR condition code per CR 6451.
November 2009	Coverage Requirements.	Removed defibrillator and oxygen information from Respiratory Distress or Shortness of Breath.
December 2009	Modifiers	Section updated to include CR 6563.
	Transports	Section updated to include CR 6707 and added information about same-day discharge and readmission.
	Air Ambulance Services	Section updated to include CR 6682.
	CMS-1450 (UB-04) Claim Form	Section updated to include CR 6563.
April 2010	Coverage Requirements	Section updated to include CR 6698.
	Services and Procedure Codes	Removed note for Colorado suppliers for aid calls.

MEDICARE PART A AND B

Ambulance

Date	Section	Revision
	Modifiers	Updated form name.
	Transports	Added "Ambulance Jurisdiction" section.
	Implementation of Section 414 of the MMA of 2003	Section updated to include the PPACA.
	MIPPA	Section updated to include the PPACA.
August 2010	Coverage Requirements	Section updated to include CR 7058, addendums, updated documentation examples and paramedic intercept.
	Services and Procedures	Added note under aid calls.
	Transports	<ul style="list-style-type: none"> • New title: Transports To and From Medical Services for Beneficiaries Who Are Not Inpatients. • Added Information on PHPs. • Added note under Pronouncement of Death.
	Hospice	New section.
	AFS Reimbursement	Updated CMS screen shots.
December 2010	Coverage Requirements	Section updated to include fractional mileage.
	Service and Procedure Codes	Section updated to include CR 7056.
	Air Ambulance Services	Section updated to include CR 7161 and CR 7056.
	Implementation of Section 414 of the MMA of 2003	Section updated to include the MMEA.
	MIPPA	Section updated to include the MMEA.
	Medicare and Medicaid Extenders (MMEA) Act of 2010	Section updated to include the MMEA.
	CMS 1450 (UB-04) Claim/Electronic	Section updated to include fractional mileage.
	CMS-1500 Claim/Electronic	Section updated to include fractional mileage.
February 2011	Services and Procedure Codes	Added GY modifier information to A0998.
	Modifiers	Section updated to include CR 6563 and CR 7121.
April 2011	Coverage Requirements	Updated to include updates to the Ambulance LCD.
	Medical Necessity	Updated to include updates to the Ambulance LCD.
	CMS-1500	Updated to include updates to the

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Date	Section	Revision
	Claim/Electronic Version	Ambulance LCD.
	Transport	Updated to include CAH and IHS payments in CR 7219.
	Electronic Version 5010 837P	New section added to include CR 7018.
May 2011	Coverage Requirements	Removed number of loaded miles from run report documentation and added it as a stand-alone bullet.
	Services and Procedure Codes	Added information on collecting mileage.
December 2011	Services and Procedure Codes	<ul style="list-style-type: none"> • Added information from CR 7489. • Added information regarding accepting and processing all ambulance transport HCPCS codes. • Added information from CR 7557 on the requirements for the UB-04 claim form for fractional mileage.
	Transports	<ul style="list-style-type: none"> • Added information from CR 7508. • Changes to payment for CAH ambulance Services.
	Temporary Payroll Tax Cut Continuation Act (TPTCCA) of 2011	Added new section regarding extension of ambulance add-on payments.
	CMS-1450 (UB-04) Claim/Electronic	Added information from CR 7557, National Provider Identifier (NPI) in the Attending Physician field.
March 2012	<i>Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA)</i>	<i>Added new section regarding extension of ambulance add-on payments (TDL-12246).</i>
	<i>CMS-1500 Claim/Electronic Version</i>	<i>Removed claim form instructions and linked to the claim form manual.</i>