CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 437

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JANUARY 21, 2005

Change Request 3664

SUBJECT: Revisions and Corrections to the Medicare Claims Processing Manual, Chapter 6, Section 30 and Various Sections in Chapter 15

I. SUMMARY OF CHANGES: This instruction revises Section 30, Chapter 6 to include ICD-9-CM coding guidance for Skilled Nursing Facilities (SNFs) and removes Home Health Agency (HHA) Types of Bill from various sections of Chapter 15 to conform with existing policy.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 01, 2005

IMPLEMENTATION DATE : February 22, 2005

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	6/30/Billing SNF PPS Services
R	15/10/General Coverage and Payment Policies
R	15/20.5.1/Air Ambulance for Deceased Beneficiary
R	15/30/General Billing Guidelines for Intermediaries and Carriers
R	15/30.2/Intermediary Guidelines

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 437	Date: January 21, 2004	Change Request: 3664

SUBJECT: Revisions and Corrections to the Medicare Claims Processing Manual, Chapter 6, Section 30 and Various Sections in Chapter 15

I. GENERAL INFORMATION

A. Background: This instruction revises Section 30, Chapter 6 to include ICD-9-CM coding guidance for Skilled Nursing Facilities (SNFs) and removes Home Health Agency (HHA) bill types from various sections of Chapter 15 to conform to existing policy.

B. Policy: There are no policy changes with this transmittal.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3664.1	FIs shall educate SNF providers on ICD-9-CM coding language added to the Medicare Claims Processing Manual 100-4, Chapter 6, §30.	X								
3664.2	RHHIs do not need to educate providers on manual changes specified in this transmittal since current policy concerning Ambulance billing is not changing.		X							

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3664.2	CR 2175, Transmittal A-02-062, Applicable Bill Types for Ambulance Services (Revenue Code 540)

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** February 22, 2005 **Pre-Implementation Contact(s):** Jason Kerr (410) 786-2123 or JKerr3@cms.hhs.gov ; Yvonne Young (410) 786 1886 or YYoung@cms.hhs.gov . **Post-Implementation Contact(s):** Appropriate regional office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

30 - Billing SNF PPS Services

(Rev. 437, Issued: 01-21-05, Effective: 01-01-05, Implementation: 02-22-05)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record:

- In addition to the required fields identified in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," SNFs must also report occurrence span code "70" to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.

- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1.)

- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.

- Revenue Code, Health Care Claim: ANSI X12N 837 I version 4010 SV201 must contain revenue code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.

- There must be a line item on the claim for each assessment period represented on the claim with revenue code 0022. This code indicates that this claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS rate code(s) and assessment periods.

- The line item date of service date must contain an assessment reference date (ARD) when FL 42 contains revenue code 0022 unless FL 44 contains HIPPS rate code AAA00. Assessment dates are reported on the ANSI X12N 837 I version 4010 using qualifier 866 in DTP01.

- HCPCS/Rates, Health Care Claim: Institutional ANSI X12N 837 I version 4010 SV202-01 must contain a ZZ qualifier and SV202-02 must contain a 5-digit "HIPPS Code" (AAA00-SSC79). The first three positions of the code contain the RUG III group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Tables 1 and 2 below for valid RUG codes and AI codes.

- Service Units, Health Care Claim: Institutional 837 I version 4010 2400 SV205 must contain the number of covered days for each HIPPS rate code.

NOTE: Fiscal Intermediary Shared System (FISS) requirement:

The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of days reported in an OSC 77. (Note: The covered units field is utilized in FISS and has no mapping to the 837 or paper claim).

- Total Charges, Health Care Claim: Institutional ANSI X12N 837 I version 4010 2400 SV203 should be zero total charges when the revenue code is 0022.

- When a HIPPS rate code of RUAxx, RUBxx and/or RUCxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.

- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.

- *Principal Diagnosis Code - SNFs enter the ICD-9-CM code for the principal diagnosis in FL 67. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable.*

- *Other Diagnosis Codes Required – The SNF enters the full ICD-9-CM codes for up to eight additional conditions in FLs 68-75. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-9-CM guidelines.*

10 - General Coverage and Payment Policies

(Rev. 437, Issued: 01-21-05, Effective: 01-01-05, Implementation: 02-22-05)

These instructions apply to processing claims to carriers and intermediaries under the ambulance fee schedule (FS).

General rules for coverage of ambulance services are in the Medicare Benefit Policy Manual, Chapter 10. General medical review instructions for ambulance services are in Chapter 6 of the Medicare Program Integrity Manual.

In general, effective April 1, 2002, payment is based on the level of service provided, not on the vehicle used. However, two temporary Q codes (Q3019 and Q3020) are available for use during the transition period when an ALS vehicle is used for a Medicare-covered transport, but no ALS service is furnished.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (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 under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. 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 Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus 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. See section 10.3.3 of Chapter 10 of the Medicare Benefit Policy Manual for further details.

Prior to the implementation of the FS, suppliers used one of four billing methods. Providers used only one billing method, method 2. The FS (effective April 1, 2002) has only one billing method, formerly method 2. This current billing method includes payment for all items and services in the ambulance FS base rate except for the cost of mileage, which is payable separate from the base rate.

NOTE: The cost of oxygen and its administration in connection with and as part of the ambulance service is covered. Under the ambulance FS oxygen and other items and services provided as part of the transport are included in the FS base payment rate and are generally NOT separately payable.

The intermediary is responsible for the processing of claims for ambulance services furnished by providers; i.e., hospitals *and* skilled nursing facilities. The carrier is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. Effective December 21, 2000, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH are paid on a reasonable cost basis, but only if the CAH or entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH or entity. Beginning February 24, 1999, ambulance transports to or from a nonhospital-based dialysis facility, origin and destination modifier "J," satisfy the program's origin and destination requirements for coverage.

Ambulance supplier services furnished under arrangements with a provider, e.g., hospital *or* SNF are not billed by the supplier to its carrier, but are billed by the provider to its intermediary. The intermediary is responsible for determining whether the conditions described below are met. In cases where all or part of the ambulance services are billed to the carrier, the carrier has this responsibility, and the intermediary must contact the carrier to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the intermediary should accept the carrier's determination without pursuing its own investigation.

Where a provider furnishes ambulance services under arrangements with a supplier of ambulance services, such services can be covered only if the supplier's vehicles and crew meet the certification requirements applicable for independent ambulance suppliers.

The ambulance FS is effective for 4claims with dates of service on or after April 1, 2002. The FS is phased in over a transition period through the end of 2005. During the transition period payment amounts are a blended amount: part ambulance FS, and part reasonable charge (for independent suppliers) or reasonable cost for providers. The percentages for the blended rate during the transition period are as follows:

Transition Year	**Reasonable Charge/ Cost Percent**	**FS Percent**
Year One (4/1/2002-12/2002)	80	20
Year Two (CY 2003)	60	40
Year Three (CY 2004)	40	60
Year Four (CY 2005)	20	80
Year Five (CY 2006)	0	100

In order to ensure that suppliers receive the amounts reimbursable under each of these payment methods, CMS will issue a yearly fee schedule and post it on the CMS Web site. In addition, carriers will supply the reasonable charge amounts through the disclosure process.

20.5.1 - Air Ambulance for Deceased Beneficiary

(Rev. 437, Issued: 01-21-05, Effective: 01-01-05, Implementation: 02-22-05)

The policy in this section is effective for carriers March 7, 2002, and for intermediaries July 1, 2002.

Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, e.g., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed. For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

Also no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

Providers and suppliers must use the modifier QL (Patient pronounced dead after ambulance called) to indicate the circumstance when an air ambulance takes off to pick up a beneficiary but the beneficiary is pronounced dead before the pickup can be made.

The provider/supplier must submit documentation with the claim sufficient to show that:

a. The air ambulance was dispatched to pick up a Medicare beneficiary;

b. The aircraft actually took off to make the pickup;

c. The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport;

d. The pronouncement of death was made by an individual authorized by State law to make such pronouncements; and

e. The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

Contractors must allow the appropriate air base rate (fixed wing or rotary wing, as applicable) for a claim for an air ambulance service for deceased beneficiaries but not allow mileage or make a rural adjustment. During the fee schedule transition, contractors must allow an amount based on a blended rate.

For intermediaries, this policy applies to the following types of bills: 12X, 13X, 22X, 23X, 83X, and 85X. Refer to §30 below for additional billing guidelines.

30 - General Billing Guidelines - Intermediaries and Carriers

(Rev. 437, Issued: 01-21-05, Effective: 01-01-05, Implementation: 02-22-05)

Ambulance suppliers may bill the carrier on Form CMS-1500, Health Insurance Claim Form; the NSF EDI data set; or the ANSI X12N 837 data set.

Hospitals *and* SNFs that bill the intermediary use Form CMS-1450 (UB-92), the UB-92 electronic data set, or the ANSI X12N 837 data set.

A - Modifiers Specific to Ambulance

Two of the following modifiers are required for each base line item to report the origin and the destination:

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;

E = Residential, domiciliary, custodial facility (other than 1819 facility);

G = Hospital based ESRD facility;

H = Hospital;

I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;

J = Freestanding ESRD facility;

N = Skilled nursing facility;

P = Physician's office;

R = Residence;

S = Scene of accident or acute event;

X = Intermediate stop at physician's office on way to hospital (destination code only)

R = Residence;

S = Scene of accident or acute event;

X = Intermediate stop at physician's office on way to hospital (destination code only)

B - HCPCS Codes

The following codes and definitions are effective for billing ambulance services on or after January 1, 2001.

AMBULANCE HCPCS CODES CROSSWALK AND DEFINITIONS

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)	A0030
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)	A0040
A0429	Ambulance service, basic life support (BLS), emergency transport, water, special transportation services	A0050
A0428	Ambulance service, BLS, non-emergency transport, all inclusive (mileage and supplies)	A0300 (Method 1)
A0429	Ambulance service, BLS, emergency transport, all inclusive (mileage and supplies)	A0302 (Method 1)
Q3020	Ambulance service, advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0304 (Method 1)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0306 (Method 1)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0308 (Method 1)
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0310 (Method 1)
A0433	Ambulance service, advanced life support, level 2 (ALS2), all inclusive (mileage and supplies)	A0310 (Method 1)

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0434	Ambulance service, specialty care transport (SCT), all inclusive (mileage and supplies)	A0310 (Method 1)
A0428	Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed	A0320 (Method 2)
A0429	Ambulance service, BLS, emergency transport, supplies included, mileage separately billed	A0322 (Method 2)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0324 (Method 2)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0326 (Method 2)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0328 (Method 2)
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0330 (Method 2)
A0433	Ambulance service, ALS2, supplies included, mileage separately billed	A0330 (Method 2)
A0434	Ambulance service, SCT, supplies included, mileage separately billed	A0330 (Method 2)
A0428	Ambulance service, BLS, non-emergency transport, mileage included, disposable supplies separately billed	A0340 (Method 3)
A0429	Ambulance service, BLS, emergency transport, mileage included, disposable supplies separately billed	A0342 (Method 3)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed	A0344 (Method 3)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0346 (Method 3)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately	A0348 (Method 3)

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
	billed	
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0433	Ambulance service, ALS2, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0434	Ambulance service, SCT, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0428	Ambulance service, BLS, non-emergency transport, mileage and disposable supplies separately billed	A0360 (Method 4)
A0429	Ambulance service, BLS, emergency transport, mileage and disposable supplies separately billed	A0362 (Method 4)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0364 (Method 4)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0366 (Method 4)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0368 (Method 4)
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0370 (Method 4)
A0433	Ambulance service, ALS2, mileage and disposable supplies separately billed	A0370 (Method 4)
A0434	Ambulance service, SCT, mileage and disposable supplies separately billed	A0370 (Method 4)
A0425	BLS mileage (per mile)	A0380 (averaged with A0390)
None	BLS routine disposable supplies	A0382

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
None	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	A0384
A0425	ALS mileage (per mile)	A0390 (averaged with A0380)
None	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)	A0392
None	ALS specialized service disposable supplies; IV drug therapy	A0394
None	ALS specialized service disposable supplies; esophageal intubation	A0396
None	ALS routine disposable supplies	A0398
None	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	A0420
None	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	A0422
None	Extra ambulance attendant, ALS or BLS (requires medical review)	A0424
A0800 (Effective 1/5/2004)	Ambulance transport provided between the hours of 7 pm and 7 am	Local Carrier Code
None	Unlisted ambulance service	A0999
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers.	Q0186
A0435	Air mileage; FW, (per statute mile)	Local Carrier Code
A0436	Air mileage; RW, (per statute mile)	Local Carrier Code

NOTE: PI, ALS2, SCT, FW, and RW assume an emergency condition and do not require an emergency designator.

Refer to the Medicare Benefit Policy Manual, Chapter 10, §30.1, for the definitions of levels of ambulance services under the fee schedule.

During the transition period, if an ALS vehicle is used for an emergency transport but no ALS level service is furnished, the fee schedule (FS) portion of the blended payment will be based on the emergency BLS level. The amount on the FS for HCPCS code Q3019 is the same fee as BLS-Emergency (BLS-E) FS HCPCS code A0429. The reasonable charge/cost portion of the blended payment will be the ALS emergency rate.

During the transition period, if an ALS vehicle is used for a nonemergency transport but no ALS level service is furnished, the FS portion of the blended payment will be based on the nonemergency BLS level. The amount displayed on the FS for HCPCS code Q3020 is the same fee displayed for BLS nonemergency, FS HCPCS code A0428. The reasonable charge/cost portion of the blended payment will be the ALS nonemergency rate.

Codes Q3019 and Q3020 are relevant for transitional billing purposes only. (There were old codes that existed for these services that can no longer be used for payment purposes).

HCPCS Code A0800 for ambulance night differential charges, effective January 5, 2004, is valid during the transition period only, and may only be billed in those carrier jurisdictions that paid separately for these charges prior to the implementation of the Ambulance Fee Schedule on April 1, 2002. Therefore, carriers that did not allow separate charges for night services must not begin using HCPCS code A0800. Carriers not eligible to use HCPCS code A0800 must deny claims for such services.

30.2 - Intermediary Guidelines

(Rev. 437, Issued: 01-21-05, Effective: 01-01-05, Implementation: 02-22-05)

For SNF Part A, the cost of transportation to receive most services included in the RUG rate is included in the cost for the service. This includes transportation in an ambulance. Payment for the SNF claim is based on the RUGs, and recalibration for future years takes into account the cost of transportation to receive the ancillary services.

If the services are excluded from the SNF PPS rate, the ambulance service may be billed separately as can the excluded service.

The same rationale applies to hospitals as well.

In general, the intermediary processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill intermediaries using only Method 2.

The provider must furnish the following data in accordance with intermediary instructions. The intermediary will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. General

The reasonable cost per trip of ambulance services furnished by a provider of services may not exceed the prior year's reasonable cost per trip updated by the ambulance inflation factor. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997, and September 30, 1998).

Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

The following instructions provide billing procedures implementing the above provisions.

B - Applicable Bill Types

The appropriate type of bill (13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.

C. Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP code of the

geographic location from which the beneficiary was placed on board the ambulance in FLs 39-41 "Value Codes." The value code is defined as "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance." Providers report the number in dollar portion of the form location right justified to the left to the dollar/cents delimiter. Providers utilizing the UB-92 flat file use Record Type 41 fields 16-39. On the X-12 institutional claims transactions, providers show HI*BE:A0:::12345~, 2300 Loop, HI segment.

More than one ambulance trip may be reported on the same claim if the ZIP code of all points of pickup are the same. However, since billing requirements do not allow for value codes (ZIP codes) to be line item specific and only one ZIP code may be reported per claim, providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different ZIP codes.

D. Revenue Code/HCPCS Code Reporting

Providers must report revenue code 054X and, for services **provided before January 1, 2001,** one of the following CMS HCPCS codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period:

A0030 (discontinued 12/31/2000);

A0040 (discontinued 12/31/2000);

A0050 (discontinued 12/31/2000);

A0320 (discontinued 12/31/2000);

A0322 (discontinued 12/31/2000);

A0324 (discontinued 12/31/2000);

A0326 (discontinued 12/31/2000);

A0328, (discontinued 12/31/2000); or

A0330 (discontinued 12/31/2000).

In addition, providers report one of A0380 or A0390 for mileage HCPCS codes. No other HCPCS codes are acceptable for reporting ambulance services and mileage.

Providers report one of the following revenue codes:

0540;

0542;

0543;

0545;

0546; or

0548.

Do not report revenue codes 0541, 0544, or 0547.

For claims with **dates of service on or after January 1, 2001**, providers must report revenue code 540 and one of the following HCPCS codes in FL 44 “HCPCS/Rates” for each ambulance trip provided during the billing period:

A0426;

A0427;

A0428;

A0429;

A0430;

A0431;

A0432;

A0433; or

A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly.

In addition, all providers report one of the following mileage HCPCS codes:

A0380;

A0390;

A0435; or

A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, providers must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a

unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

However, in the case where the beneficiary was pronounced dead after the ambulance is called but before the ambulance arrives at the scene: Payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing base rate, as applicable, if an air ambulance is dispatched. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Providers report the A0428 (BLS) HCPCS code. Providers report modifier QL (Patient pronounced dead after ambulance called) in Form Locator (FL) 44 "HCPCS/Rates" instead of the origin and destination modifier. In addition to the QL modifier, providers report modifier QM or QN.

E. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided in FL 44 "HCPCS/Rates." Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of x, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D - Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes;

E - Residential, Domiciliary, Custodial Facility (other than an 1819 facility);

H - Hospital;

I - Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;

J - Nonhospital based dialysis facility;

N - Skilled Nursing Facility (SNF) (1819 facility);

P - Physician's office (Includes HMO nonhospital facility, clinic, etc.);

R - Residence;

S - Scene of accident or acute event; or

X - (Destination Code Only) intermediate stop at physician's office enroute to the hospital. (Includes HMO nonhospital facility, clinic, etc.)

In addition, providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM - Ambulance service provided under arrangement by a provider of services; or

QN - Ambulance service furnished directly by a provider of services.

F. Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported on the hard copy UB-92 in FL 45 "Service Date" (MMDDYY), and on RT 61, field 13, "Date of Service" (YYYYMMDD) on the UB-92 flat file.

G. Service Units Reporting

For line items reflecting HCPCS code A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001)** or code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**services on and after January 1, 2001**), providers are required to report in FL 46 "Service Units" each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, the number of loaded miles must be reported. (See examples below.)

Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, A0435, or A0436, the number of loaded miles must be reported.

H. Total Charges Reporting

For line items reflecting HCPCS code:

A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 **(services before January 1, 2001);**

OR

HCPCS code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**on or after January 1, 2001);**

Providers are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS code A0380, A0390, A0435, or A0436, report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units as a separate line item. For the related charges, providers report $1.00 in FL48 for noncovered charges. Intermediaries should assign ANSI Group Code OA to the $1.00 noncovered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

Prior to submitting the claim to CWF, the intermediary will remove the entire revenue code line containing the mileage amount reported in FL 48 "Noncovered Charges" to avoid nonacceptance of the claim.

EXAMPLES: The following provides examples of how bills for Part B ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by providers. Ambulance services provided under arrangement between the provider and an ambulance company are reported in the same manner except providers report a QM modifier instead of a QN modifier. The following examples are for claims submitted with dates of service on or after January 1, 2001.

EXAMPLE 1 - Claim containing only one ambulance trip:

For the UB-92 Flat File, providers report as follows:

Record Type	**Revenue Code**	**HCPCS Code**	**Modifier**		**Date of Service**	**Units**	**Total Charges**
			#1	**#2**			
61	0540	A0428	RH	QN	082701	1 (trip)	100.00
61	0540	A0380	RH	QN	082701	4 (mileage)	8.00

For the hard copy UB-92 (Form CMS-1450), providers report as follows:

FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2 - Claim containing multiple ambulance trips:

For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0429	RH	QN	082801	1 (trip)	100.00
61	0540	A0380	RH	QN	082801	2 (mileage)	4.00
61	0540	A0330	RH	QN	082901	1 (trip)	400.00
61	0540	A0390	RH	QN	082901	3 (mileage)	6.00
61	0540	A0426	RH	QN	083001	1 (trip)	500.00
61	0540	A0390	RH	QN	083001	5 (mileage) 10.00	
61	0540	A0390	RH	QN	082901	3 (mileage)	6.00
61	0540	A0426	RH	QN	083001	1 (trip)	500.00

For the hard copy UB-92 (Form CMS-1450), providers report as follows:

FL 42	FL 44	Modifier		FL 45	FL 46	FL 47
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00

EXAMPLE 3 - Claim containing more than one ambulance trip provided on the same day:

For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0429	RH	QN	090201	1 (trip)	100.00
61	0540	A0380	RH	QN	090201	2 (mileage)	4.00
61	0540	A0429	HR	QN	090201	1 (trip)	100.00
61	0540	A0380	HR	QN	090201	2 (mileage)	4.00

For the hard copy UB-92 (CMS-1450), providers report as follows:

FL 42	FL 44	Modifier		FL 45	FL 46	FL 47
		#1	#2			
0540	A0429	RH	QN	090201	1 (trip)	100.00
0540	A0380	RH	QN	090201	2 (mileage)	4.00
0540	A0429	HR	QN	090201	1 (trip)	100.00
0540	A0380	HR	QN	090201	2 (mileage)	4.00

I. Edits

Intermediaries edit to assure proper reporting as follows:

- For claims with dates of service before January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance trip HCPCS codes - A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330; and one of the following mileage HCPCS codes - A0380 or A0390;

- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes – A0435, A0436 or for claims with dates of service before April 1, 2002, A0380, or A0390, or for claims with dates of service on or after April 1, 2002, A0425;

- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;

- The units field is completed for every line item containing revenue code 0540;

- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;

- Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, A0330, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal “1"

- For claims with dates of service on or after July 1, 2001, each 1-way ambulance trip, line-item dates of service for the ambulance service, and corresponding mileage are equal.