CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1249	**Date: MAY 25, 2007**
	Change Request 5578

SUBJECT: Update to Publication 100-4, Chapters 1 & 15 for ZIP5 and ZIP9 Medicare ZIP Code Files.

I. SUMMARY OF CHANGES: This change request revises existing ZIP5 instructions, updates ZIP5 file layout, and adds the new ZIP9 file layout to the IOM to reflect changes made in CR 5208.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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	1/10/10.1.1.1/Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004
R	15/20/20.1.6/Transition Overview

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 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: 1249	Date: May 25, 2007	Change Request: 5578

SUBJECT: Update to Publication 100-4, Chapters 1 & 15 for ZIP5 and ZIP9 Medicare ZIP Code Files.

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: Medicare carriers have been directed to determine payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP code file uses the convention of the United States Postal Service which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount.

In order to correct this, CMS will require the submission of 9-digit ZIP codes to carriers for services paid under the MPFS and anesthesia services only when the services are provided in those ZIP code areas with which there is a problem except for services provided in Place of Service (POS) "Home," and for any other places of service that contractors currently consider to be the same as "Home." (Currently, there is no requirement for the submission of a ZIP code when the POS is "Home.")

Carriers and fiscal intermediaries (FIs) should note that though some states consist of a single pricing locality, zip codes can overlap states thus necessitating the submission of the 9-digit zip code in order to allow the process to identify the correct pricing locality.

Fiscal intermediaries determine locality based upon the ZIP code of the provider's physical address. This address, including the ZIP code, is stored on the provider file as the master address.

Claims for ambulance and laboratory services will continue to be submitted to and priced by the carrier using 5-digit ZIP codes. Claims for ambulance services will continue to be priced by the FI using 5-digit ZIP codes. Laboratory services will continue to be priced by the FI using the locality for non-fee based services. Two ZIP code files will be provided; 5-digit ZIP codes (ZIP5) and 9-digit ZIP codes (ZIP 9). Corresponding file layouts will also be provided. Quarterly updates will continue to be provided to these files. The 9-digit ZIP code file (ZIP9) will only provide 9-digit ZIP codes for the identified problem areas.

Carriers, FIs, and their standard systems will need to make accommodations to accept a revised file layout for the 5-digit ZIP codes and a new file layout for the 9-digit ZIP codes.

Change Request (CR) 5208, Transmittal 1193 released March 9, 2007 with effective date of October 1, 2007, instructed contractors to make the necessary changes to accommodate the new ZIP code files. This CR makes corresponding revisions to the IOM.

B. Policy: This Change Request makes no changes to the policy implemented in CR 5208. The purpose of this CR is to update the chapters in the IOM which were overlooked by CR 5208.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5578.1	Contractors shall note the revisions made to Pub. 100-04, Chapter 1, Section 10.1.1.1.	X		X	X							
5578.2	Contractors shall note the revisions made to Pub. 100-04, Chapter 15, Section 20.1.6.	X		X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None											

IV. SUPPORTING INFORMATION

N/A

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Contact Wendy Knarr at Wendy.Knarr@cms.hhs.gov or dial National Relay @ 711 then have agent dial (410) 786-0843; Leslie Trazzi at Leslie.Trazzi@cms.hhs.gov or (410) 786-7544.

Post-Implementation Contact(s): Your appropriate Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),*** **use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007.

B. ***For Medicare Administrative Contractors (MAC)*****, use the following statement:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004

(Rev. 1249; Issued: 05-25-07; Effective: 10-01-07; Implementation: 10-01-07)

Provided below are separate instructions for processing electronic claims using the ANSI X12N 837 format and paper claims. No changes will be required in either submission or processing for claims for services subject to jurisdictional pricing for services paid under the Medicare physician fee schedule and anesthesia services submitted on the National Standard Format. See §30.2.9 and Chapter 12 for additional information on purchased tests.

A. ANSI X12N 837 P Electronic Claims

Please note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home –12, use the address on the beneficiary file (or wherever else the beneficiary information is currently being stored) to determine pricing locality. (See §10.1.1.)

Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837 P, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service facility location. Pay the service based on the ZIP code of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ANSI X12N 837 P to determine how information concerning where a service was rendered, the service facility location, must be entered on a claim. Per the documentation, though an address may not appear in the loop named “service facility address,” the information may still be available on the claim in a related loop.

EXAMPLE: On version 4010/4010A of the ANSI X12N 837 P electronic claim format, the Billing Provider loop 2010AA is required and therefore must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, price the service based on the Billing Provider ZIP code.

EXCEPTION: For DMERC claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

Make any necessary accommodations in claims processing systems to accept either the header level or line level information as appropriate and process the claims accordingly. No longer use the provider address on file when the POS is office to determine pricing locality and jurisdiction. Appropriate information from the claim must always be used.

In the following situation, per the information in the 4010/4010A1 version of the ANSI X12N 837 P, the place where the service was rendered cannot be identified from the claim. In this situation, price all services on the claim based on the ZIP code in the Billing Provider loop. Continue to take this action until such time as the ASC documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, use the ZIP code of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the ZIP code for each line must be used.

If the POS code is the same for all services, but the services were provided at different addresses, each service must be submitted with line level information. This will provide a ZIP code to price each service on the claim.

B. Paper Claims Submitted on the Form CMS-1500

Note that the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be Home. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this

situation as the address will be drawn from the beneficiary file (or wherever else the carrier is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

The provider must submit separate claims for each POS. The specific location where the services were furnished must be entered on the claim. Use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat assigned claims as unprocessable and follow the instructions in §§80.3.1. Carriers must continue to follow their current procedures for handling unprocessable unassigned claims.

Use the following messages:

> Remittance Advice – Adjustment Reason Code 16 – "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate."
>
> Remark Code –M77 – "Missing/incomplete/invalid place of service."
>
> MSN - 9.2 – "This item or service was denied because information required to make payment was missing."

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another carrier's jurisdiction, handle in accordance with the instructions in §§10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

C. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas

Per the instructions above, Medicare carriers have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Please note that as the services on the Purchased Diagnostic Test Abstract file are payable under the MPFS, the 9-digit ZIP code requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP codes that cross localities as well as provide quarterly updates when necessary. The CMS ZIP code file shall be revised to two files: one for 5-digit ZIP codes (ZIP5) and one for 9-digit ZIP codes (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

It should be noted that though some states consist of a single pricing locality, zip codes can overlap states thus necessitating the submission of the 9-digit zip code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit zip code with a 4 digit extension that does not match a 4-digit extension on file, manually verify the 4 digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies Under the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension.

If this process does not validate the ZIP code, the claim must be treated as unprocessable.

The following Remittance Advice and Remark Code messages shall be returned for the unprocessable claims:

Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remark Code MA114 – Missing/incomplete/ information on where the services were furnished.

Should a service be performed in a zip code area that does not require the submission of the 9-digit zip code, but the 4-digit extension has been included anyway, carriers shall price the claim using the carrier/locality on the ZIP5 file and ignore the 4-digit extension.

D. ZIP9 Code to Locality Record Layout

Below is the ZIP9 code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, Section 20.1.6.

ZIP9 Code to Locality Record Layout

(Effective for dates of service on or after October 1, 2007.)

Field Name	*Beg. Position*	*End Position*	*Length*	*Comments*
State	*1*	*2*	*2*	
ZIP Code	*3*	*7*	*5*	
Carrier	*8*	*12*	*5*	
Pricing Locality	*13*	*14*	*2*	
Rural Indicator	*15*	*15*	*1*	*blank=urban, R=rural, B=super rural*
Filler	*16*	*20*	*5*	
Plus Four Flag	*21*	*21*	*1*	*0 = no +4 extension, 1 = +4 extension*
Plus Four	*22*	*25*	*4*	
Filler	*26*	*75*	*50*	
Year/Quarter	*76*	*80*	*5*	*YYYYQ*

20.1.6 - Transition Overview

(Rev. 1249; Issued: 05-25-07; Effective: 10-01-07; Implementation: 10-01-07)

AB-01-185, AB-01-165, AB-02-117

The ambulance FS is subject to a 5-year transition period as follows:

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

Calculating the Blended Rate During the Transition

Before the FS payment of ambulance services followed one of two methodologies.

- Suppliers (carrier claims) were paid based on a reasonable charge methodology; or
- Providers (intermediary claims) were paid based on the provider's interim rate (which is a percentage based on the provider's historical cost-to-charge ratio multiplied by the submitted charge) and then cost-settled at the end of the provider's fiscal year.

For services furnished during the transition period, payment of ambulance services is a blended rate that consists of both a FS component and a provider or supplier's current payment methodology as follows:

- For suppliers, the blended rate includes both a portion of the reasonable charge and the FS amount. For the purpose of implementing the transition to the FS, the reasonable charge for each supplier is the reasonable charge for 2000 (i.e., the lowest of the customary charge, the prevailing charge, or the inflation indexed charge (IIC) previously determined for 2000) adjusted for each year of the transition period by the ambulance inflation factor as published by CMS.
- For services furnished during the transition period, suppliers using Method 3 or Method 4 may bill HCPCS codes A0382, A0384, A0392 through A0999, J-codes, and codes for EKG testing. These Method 3 and Method 4 HCPCS codes are subject to the phase-in blending percentages. Therefore, carriers apply the appropriate transition year blending percentage to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the FS, there is no FS portion for these codes.) A similar payment may be made during the transition period for HCPCS codes A0420 and A0424 if billed by a Method 1 biller or Method 2 biller. Carriers do not change any Method 1 or Method 2 biller to Method 3 or 4.

- Intermediaries must determine both the reasonable cost for a service furnished by a provider and the FS amount that would be payable for the service. They then apply the appropriate percentage to each such amount to derive a blended-rate payment amount applicable to the service. The cost report is used for the calculation. The reasonable cost part of the rate is provider specific.

A. Special Instructions for Transition (Intermediaries and Carriers)

CMS will provide each contractor with two files: a national ZIP Code file and a national Ambulance FS file.

The national *ZIP5* Code file is a file of 5-digit USPS ZIP Codes that will map each zip code to the appropriate FS locality. Every 2 months, CMS obtains an updated listing of ZIP Codes from the USPS. On the basis of the updated USPS file, CMS updates the Medicare ZIP Code file and makes it available to contractors.

The following is a record layout of the ZIP5 file effective October 1, 2007:

ZIP5 CODE to LOCALITY RECORD LAYOUT

Field Name	***Position***	***Format***	***COBOL Description***
State	*1-2*	*X(02)*	*Alpha State Code*
ZIP Code	*3-7*	*X(05)*	*Postal ZIP Code*
Carrier	*8-12*	*X(05)*	*Medicare Part B Carrier Number*
Pricing Locality	*13-14*	*X(02)*	*Pricing Locality*
Rural Indicator	*15*	*X(01)*	*Blank = urban, R=rural, B=super rural*
Bene. Lab CB Locality	*16-17*	*X(02)*	*Lab competitive bid locality;* *Z1= CBA1* *Z2= CBA2* *Z9= Not a demonstration locality*
Filler	*18-20*	*X(03)*	
Plus Four Flag	*21*	*X(01)*	*0 = no +4 extension*

			1 = +4 extension
Filler	*22-75*	*X(54)*	
Year/Quarter	*76-80*	*X(05)*	*YYYYQ*

NOTE: Effective October 1, 2007, claims for ambulance services will continue to be submitted and priced using 5-digit ZIP codes. Contractors will not need to make use of the ZIP9 file for ambulance claims.

A ZIP code located in a rural area will be identified with either a letter "R" or a letter "B." Some zip codes will be designated as rural due to the Goldsmith Modification even though the zip code may be located, in whole or in part, within an MSA or NECMA.

A"B" designation indicates that the ZIP code 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. Effective for claims with dates of service between July 1, 2004 and December 31, 2009, contractors must apply a bonus amount to be determined by CMS to the base rate portion of the payment under the FS for ground ambulance services with a POP "B" ZIP code. This amount is in addition to the rural bonus amount applied to ground mileage for ground transports originating in a rural POP ZIP code.

Each calendar quarter beginning October 2007, CMS will upload updated ZIP5 and ZIP9 ZIP code files to the Direct Connect (formerly the Network Data Mover). Contractors shall make use of the ZIP5 file for ambulance claims and the ZIP9 file as appropriate per Pub. 100-04, Chapter 1, Section 10.1.1.1 and the additional information found in Transmittal 1193, Change Request 5208. The updated files will be available for downloading November 15th for the January 1 release, February 15th for the April 1 release, May 15th for the July 1 release, and August 15th for the October 1 release.

Contractors are responsible for retrieving the ZIP Code files upon notification and must implement the following procedure for retrieving the files:

1. Upon quarterly Change Requests, the availability of updated ZIP Code files, go to the Direct Connect and search for the files. Confirm that the release number (last 5 digits) corresponds to the upcoming calendar quarter. If the release number (last 5 digits) does not correspond to the upcoming calendar quarter, notify CMS.

2. After confirming that the ZIP code files on the Direct Connect corresponds to the next calendar quarter, download the files and incorporate the files into your testing regime for the upcoming model release.

The names of the files will be in the following format: MU00.AAA2390.ZIP5.LOCALITY.Vyyyyr and MU00.AAA2390.ZIP9.LOCALITY.Vyyyyr where "yyyy" equals the calendar year and "r" equals the release number with January =1, April =2, July =3, and October =4. So, for example, the names of the file updates for October 2007 are MU00.AAA2390.ZIP5.LOCALITY.V20074 and MU00.AAA2390.ZIP9.LOCALITY.V20074. The release number for this file is 20074, release 4 for the year 2007.

When the updated files are loaded to the Direct Connect, they will overlay the previous ZIP code files.

NOTE: *Even the most recently updated ZIP code files will not contain ZIP codes established by the USPS after CMS compiles the files. Therefore, for ZIP codes reported on claims that are not on the most recent ZIP code files, follow the instructions for new ZIP codes in* ***§20.1.5***.

CMS will also provide contractors with a national Ambulance FS file that will contain payment amounts for the applicable HCPCS codes. The file will include FS payment amounts by locality for all FS localities. The FS file will be available via the CMS Mainframe Telecommunications System. Contractors are responsible for retrieving this file when it becomes available. The full FS amount will be included in this file. CMS will notify contractors of updates to the FS and when the updated files will be available for retrieval. CMS will send a full-replacement file for annual updates and for any other updates that may occur.

The addresses for the Fee Schedule Files are as follows:

Calendar Year	File Name
2002	MU00.AAA2390.AMBFS.FINAL.V11
2003	MU00.AAA2390.AMBFS.FINAL.V21
2004	
Jan. 1 – Jun. 30	MU00.AAA2390.AFBFS.FINAL.V32
Jul. 1 – Dec. 31	MU00.AAA2390.AMBFS.FINAL.V33

The following is a record layout of the Ambulance Fee Schedule file:

AMBULANCE FEE SCHEDULE FILE RECORD DESCRIPTION

Field Name	Position	Format	Description
HCPCS	1-5	X(05)	Healthcare Common Procedure Coding System
Carrier Number	6-10	X(05)	
Locality Code	11-12	X(02)	
Base RVU	13-18	s9(4)v99	Relative Value Unit
Non-Facility PE GPCI	19-22	s9v9(3)	Geographic Adjustment Factor
Conversion Factor	23-27	s9(3)v99	Conversion Factor
Urban Mileage/Base	28-34	s9(5)v99	Urban Payment Rate or Mileage

Field Name	Position	Format	Description
Rate			Rate (determined by HCPCS)
Rural Mileage/Base Rate	35-41	s9(5)v99	Rural Payment Rate or Mileage Rate (determined by HCPCS)
Current Year	42-45	9(04)	YYYY
Current Quarter	46	9(01)	Calendar Quarter – value 1-4
Effective Date*	47-54	9(8)	Effective date of the fee schedule file (MMDDYYYY)
Filler	55-80	X(26)	Future use

*Beginning on July 1, 2004, CMS will add an effective date field to the Ambulance Fee Schedule File in the filler area of the file.

B. Special Carrier Instructions for Transition

As discussed in the previous section, CMS will provide contractors with two files: a ZIP code file and a national Ambulance FS file. Each carrier must program a link between the ZIP code file to determine the locality and the FS file to obtain the FS amount.

Carriers pay the lower of the submitted charge or the blended amount determined under the FS transition blending methodology. The specific blending percentages are determined by the date of service on the claim.

For implementing the transition to the FS, the reasonable charge for each supplier is the reasonable charge for 2000 (e.g., the lowest of the customary charge, the prevailing charge, or the IIC previously determined for 2000) adjusted by the ambulance inflation factor, as published by CMS, for each subsequent year ending with the last year of the transition period.

Carriers must send a reasonable charge file to the Railroad Retirement Board, the appropriate State Medicaid Agencies, the United Mine Workers, and the Indian Health Service. A reasonable charge update should not be performed for referral to these entities. Instead, the carriers send the same reasonable charge data that was developed for the base year (CY 2000) and updated by the AIF for the current year.

Claims are processed using the new HCPCS codes created for the ambulance FS. Carriers must crosswalk HCPCS codes to determine the reasonable charge amount attributable to the new HCPCS codes. If a carrier currently uses local codes, the carrier must establish their own supplemental crosswalk with respect to any such local codes. If a supplier bills a new HCPCS code for which there is insufficient actual charge data, carriers follow the instructions for gap

filling in the Medicare Claims Processing Manual, Chapter 23, "Fee Schedule Administration and Coding Requirements."

For each ambulance claim, the carrier accesses the ZIP code file provided by CMS to determine the appropriate locality code for the FS. Only the locality code from the FS should be entered into the claim record in the appropriate field for locality code. The CWF edit for locality code will be bypassed for specialty 59 during the transition period. CWF locality codes are required only for items and services payable by reasonable charge.

To establish a supplier specific reasonable charge for the new HCPCS mileage code A0425, carriers develop an average, e.g., a simple average, not a weighted average, from the supplier specific reasonable charges of the old mileage codes A0380 and A0390. The average amount is used as the reasonable charge for 2001 and updated by the Ambulance Inflation Factor.

If a supplier has established a customary charge for only ALS mileage or only BLS mileage, then that customary charge, subject to the inflation indexed charge (IIC) rules, is used to establish the supplier-specific customary charge amount for the reasonable charge portion of the blended payment for A0425 during the transition period. However, the program's payment allowance for the reasonable charge portion of the blended payment for A0425 is based on the lower of the supplier's customary charge (subject to the IIC rules), the prevailing charge, or the prevailing IIC. Therefore, the payment allowance under the reasonable charge portion of the blended payment for A0425 during the transition period will not exceed the prevailing charge or the prevailing IIC that includes both BLS mileage and ALS mileage charge data for the locality in which the charge data was accumulated. The program's payment allowance for A0425 is then based on the lower of the blended rate and the actual charge on the claim.

Methods 3 and 4 HCPCS codes for items and supplies, J-codes, and codes for EKG testing, are valid until the transition to the FS is completed. Payment for such Method 3 and 4 HCPCS codes (which is available only to a current Method 3 or Method 4 biller at the time the FS was implemented) is based on the reasonable charge for such items and services multiplied by the appropriate transitional blending percentage. The reasonable charge for these HCPCS codes for each year of the transition is determined in the same manner as described above for ambulance services.

C. Carrier/Intermediary Determination of Fee Schedule Amounts

The FS amount is determined by the FS locality, based on the POP of the ZIP code. Use the ZIP code of the POP to electronically crosswalk to the appropriate FS amount. All ZIP codes on the ZIP code file are urban unless identified as rural by the letter "R" or the letter "B." Carriers and intermediaries determine the FS amount as follows:

- If an urban ZIP code is reported with a ground or air HCPCS code, the carriers/intermediaries determine the amount for the service by using the FS amount for the urban base rate. To determine the amount for mileage, multiply the number of reported miles by the urban mileage rate.
- If a rural ZIP code is reported with a ground HCPCS code, the carrier/intermediary determines the amount for the service by using the FS amount for the urban base rate. To determine the amount for mileage, carriers/intermediaries must use the following formula:

- For services furnished before July 1, 2004, for rural miles 1-17, the rate equals 1.5 times the urban ground mileage rate per mile. Therefore, multiply 1.5 times the urban mileage rate amount on the FS to derive the appropriate FS rate per mile;
- For services furnished on or after July 1, 2004, for rural miles 1-17, the rate equals 1.5 times the rural ground mileage rate per mile. Therefore, multiply 1.5 times the rural mileage rate amount on the FS to derive the appropriate FS rate per mile;
- For services furnished before January 1, 2004, for rural miles 18-50 the rate equals 1.25 times the urban ground mileage rate per mile. Therefore, multiply 1.25 times the urban mileage rate amount on the FS to derive the appropriate FS rate per mile. For all ground miles greater than 50 the FS rate equals the urban mileage rate per mile;
- For services furnished during the period January 1, 2004 through June 30, 2004, for all ground miles greater than 17, the FS rate equals the urban mileage rate per mile; and
- For services furnished during the period July 1, 2004 through December 31, 2008, for all ground miles greater than 50 (i.e., miles 51+), the FS rate equals 1.25 times the applicable mileage rate (urban or rural). Therefore, multiply 1.25 times the urban or rural, as appropriate, mileage rate amount on the FS to derive the appropriate FS rate per mile.

- If a rural ZIP code is reported with an air HCPCS code, the carrier/intermediary determines the FS amount for the service by using the FS amount for rural air base rate. To determine the amount allowable for the mileage, multiply the number of loaded miles by the rural air mileage rate.

D. Summary of Claims Adjudication Under the Transition

The following summarizes the claims adjudication process for ambulance claims during the FS transition period. These steps represent a conceptual model only. They are not programming instructions.

- The supplier's 2002 reasonable charge for each HCPCS code for each reasonable charge locality is established by adjusting the reasonable charge for 2000 by the 2001 and 2002 ambulance inflation factors. Refer to the chart in the beginning of this section for additional years;
- The carrier must establish a crosswalk for each new HCPCS code to each applicable old HCPCS code for each billing method the carrier currently supports. If a carrier currently uses local codes, the carrier must establish their own supplemental crosswalk with respect to any such local codes. If practical, carriers may convert all suppliers to one billing method. By the full implementation of the FS, all suppliers will bill using the former method 2 for all services. During the transition period, each supplier must select and bill only one method in a carrier's jurisdiction. Providers billing intermediaries use only Method 2;

- For each ambulance claim, the carrier accesses the ZIP code file provided by CMS to determine both the appropriate locality code for the FS and the rural adjustment indicator, if any;
- For each mileage line item with an urban ZIP code, the carrier uses the mileage HCPCS code and the number of reported miles and multiplies the number of miles by the urban mileage rate specified in the FS file;
- If the HCPCS code is a ground service with a rural ZIP code (as indicated in the ZIP code file), then the carrier multiplies the number of miles reported (not to exceed 17 miles) by the urban mileage rate specified in the FS file, then this is multiplied by 1.5. For services furnished before January 1, 2004, for any mileage between 18 and 50 the carrier multiplies the number of miles reported (not to exceed 50 miles) by the urban mileage rate specified in the FS file, then this is multiplied by 1.25; any miles in excess of 50 are multiplied by the urban rate. For services furnished during the period January 1, 2004 through June 30, 2004, any miles in excess of 17 are multiplied by the urban rate.
    - For services furnished during the period July 1, 2004 through December 31, 2008, the carrier multiplies the number of miles reported that exceed 50 miles (i.e., mile 51 and greater) for both urban and rural ZIP codes by the applicable mileage rate specified in the FS file (urban or rural), then this is multiplied by 1.25.
    - For services furnished during the period January 1, 2004 through June 30, 2004, any miles reported in excess of 17 miles are multiplied by the urban rate; For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).
- If the HCPCS code is an air service with a rural ZIP code, then the carrier uses the rural service amount and the rural mileage amount;
- The carrier must then add the appropriate transitional blending percentage of the FS amount for the service and the appropriate transitional blending percentage of the reasonable charge for the service. The resulting sum is the blended amount for the service. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge;
- The carrier must then add the appropriate transitional blending percentage of the FS amount for the mileage and the appropriate transitional blending percentage of the reasonable charge for the mileage (if any). The resulting sum is the blended amount for the mileage. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge;
- If the supplier submits a charge for an allowed separately billable item or service as described in the beginning of this section, §20.1.6, the carrier determines the reasonable charge for that year for the reported HCPCS code for the item and multiplies that amount by the appropriate transitional blending percentage. The carrier then compares that amount (because there is no blended FS amount for separately billable line items) to the submitted charge for that HCPCS code and carries forward the lower of the two amounts;

- The carrier then sums the line item amounts for the service, for the mileage, and, when applicable, for separately billable line items; subtracts the deductible when appropriate, subtracts the coinsurance, and pays the resulting amount.

NOTE: All transition years are calculated according to the blending percentages described in the beginning of this section, §20.1.6.