Medicare Claims Processing Manual
Chapter 15 - Ambulance

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(Rev. 2310, 09-23-11)
(Rev. 2318, 10-13-11)

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10.1 - Authorities
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

10.1.1 – Statutes and Regulations
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Section 1861(s) (7) of the Social Security Act (Act) establishes an ambulance service as a Medicare Part B service. Payment for ambulance services is addressed at §1834(l) of the Act. Coverage rules are addressed at 42 Code of Federal Regulations (CFR) §410.40. Additional rules, including rules regarding vehicular and staffing requirements, are specified at 42 CFR §410.41. Payment rules under the fee schedule established in 2002 are specified at 42 CFR Part 414, Subpart H (§414.601 et seq.). Payment rules for ambulances services furnished by a critical access hospital (CAH) or by an entity owned and operated by a CAH are specified at 42 CFR §413.70(b)(5). Other general Medicare provisions apply to ambulance services. See Title XVIII of the Act and 42 CFR Parts 400 to 429 to determine applicability.

10.1.2 – Other References to Ambulance Related Policies in the CMS Internet Only Manuals (IOM)
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Coverage: Manual instructions regarding coverage of ambulance services, including specifications for vehicular and staffing requirements, are specified in the Internet-Only Manual (IOM), Pub. 100-02, Medicare Benefit Policy Manual, chapter 10.

Medical Review: Manual instructions regarding medical review for ambulance services are specified in the IOM, Pub.100-08, Medicare Program Integrity Manual, chapter 6.

Payment and Claims Processing: This chapter restates previously issued instructions to Medicare fee-for-service claim processing contractors for processing claims under the Part B ambulance fee schedule (FS). For historical reference, refer to www.cms.hhs.gov/center/ambulance on the CMS website to view the previous version of this chapter.

10.2 - Summary of the Benefit
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Ambulance services are covered under Medicare Part B. However, a Part B payment for an ambulance service furnished to a Medicare beneficiary is available only if the following, fundamental conditions are met:

- Actual transportation of the beneficiary occurs.

- The beneficiary is transported to an appropriate destination.

- The transportation by ambulance must be medically necessary, i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated.

- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements.

- The transportation is not part of a Part A service.

Other requirements specified in this chapter or in the above-cited CMS Manuals may also apply to the provider/supplier or to a particular transport or billing.

10.3 - Definitions

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Most of the definitions previously found in this chapter can now be found in IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services. Other definitions pertaining to payment and claims processing follow.

A/MAC

Definition: For the purposes of this chapter only, the term refers to those contractors that process claims for institutionally-based ambulance providers billed on CMS-1450 Form (UB04) and/or a HIPAA compliant ANSI X12N 837I electronic transaction.

B/MAC

Definition: 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 a HIPAA compliant ANSI X12N 837P electronic transaction.

Date of Service

Definition: The date of service (DOS) of an ambulance service is the date that 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.

Point of Pickup (POP)

Definition: Point of pickup is the location of the beneficiary at the time he or she is placed on board the ambulance.
Application: The ZIP Code of the POP must be reported on each claim for ambulance services so that the correct Geographic Adjustment Factor (GAF) and Rural Adjustment Factor (RAF) may be applied, as appropriate.

Provider

Definition: For the purposes of this chapter only, the term "provider" is used to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.

Supplier

Definition: For the purposes of this chapter, 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.

10.4 – Additional Introductory Guidelines

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Since April 1, 2002 (the beginning of the transition to the full implementation of the ambulance fee schedule), payment for a medically necessary ambulance service is based on the level of service provided, not on the vehicle used.

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 IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 – Ambulance Services, section 10.3.3 – Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional

Service for further details. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing, section 10.5 – Hospital Inpatient Bundling for additional information on hospital inpatient bundling of ambulance services. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing for the definitions of an inpatient for the various inpatient facility types. All Prospective Payment Systems (PPS) have a different criteria for determining when ambulance services are payable (i.e., during an interrupted stay, on date of admission and date of discharge).

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 NOT separately payable.

The A/MAC is responsible for the processing of claims for ambulance services furnished by a hospital based ambulance or for ambulance services provided by a supplier if provided under arrangements for an inpatient. The B/MAC is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. See section 10.2 below for further clarification of the definition of Providers and Suppliers of ambulance services.

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 non-hospital-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 typically not billed by the supplier to its B/MAC, but are billed by the provider to its A/MAC. The A/MAC 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 B/MAC, the B/MAC has this responsibility, and the A/MAC shall contact the B/MAC to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the A/MAC should accept the B/MAC'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.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, ambulance claims submitted with a code(s) that is/are not separately billable and is/are already included in the base rate, contractors shall use Remittance Advice Remark Code N390, "This service cannot be billed separately" and N185, "Do not re-submit this claim/service" with Claim Adjustment Reason Code 97, "Payment was adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." This is true whether the primary transportation service is allowed or denied. When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

Payment for ambulance services may be made only on an assignment related basis.

Prospective payment systems, including the Ambulance Fee Schedule, are exempt from Inherent Reasonableness provisions.

20 – Payment Rules

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
B3-4115, 5116, PM AB-02-131

Medicare covered ambulance services are paid based on the Medicare ambulance fee schedule.

The following subsections describe how contractors calculate the payment amount. Section 20.1 and its subsections describe how the payment amount is calculated for the fee schedule. The other subsections in §20 provide information on certain components of the payment amount (e.g., mileage) or specialized payment amounts (e.g., air ambulance).

20.1 - Payment Under the Ambulance Fee Schedule

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

20.1.1 - General

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Payment under the fee schedule for ambulance services:

- Includes a base rate payment plus a separate payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Does not include a separate payment for items and services furnished under the ambulance benefit.

Payment for items and services is included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing (e.g., ancillary services) - but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit.

For additional information on the fee schedule, contractors may refer to the "Ambulance Services Center" on the CMS Web site at http://www.cms.hhs.gov/center/ambulance.asp.

20.1.2 - Jurisdiction

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Claims jurisdiction for suppliers is considered to be where the ambulance vehicle is garaged or hangared. Claims jurisdiction for institutional based providers is based on the primary location of the institution.

20.1.3 - Services Provided

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
AB-03-106

Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the Medicare beneficiary. In this, as in most instances, Medicare pays only for the level of service provided, and then only when the service provided is medically necessary.

20.1.4 - Components of the Ambulance Fee Schedule

(Rev. 2318, Issued: 10-13-11: Effective: 01-18-12, Implementation: 01-18-12)

The mileage rates provided in this section are the base rates that are adjusted by the yearly ambulance inflation factor (AIF). The payment amount under the fee schedule is determined as follows:

- **For ground ambulance services**, the fee schedule amount includes:

  1. A money amount that serves as a nationally uniform base rate, called a "conversion factor" (CF), for all ground ambulance services;

  2. A relative value unit (RVU) assigned to each type of ground ambulance service;

  3. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (geographic practice cost index (GPCI));

  4. A nationally uniform loaded mileage rate;

  5. An additional amount for certain mileage for a rural point-of-pickup; and

6. For specified temporary periods, certain additional payment amounts as described in section 20.1.4A, below.

- **For air ambulance services**, the fee schedule amount includes:

1. A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;

2. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (GPCI);

3. A nationally uniform loaded mileage rate for each type of air service; and

4. A rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup.

A. Ground Ambulance Services

1. Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF is updated annually by the ambulance inflation factor and for other reasons as necessary.

2. Relative Value Units

Relative value units (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. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, e.g., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

The RVUs are as follows:

Service Level	**RVU**
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20

Service Level	RVU
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

3. Geographic Adjustment Factor (GAF)

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

The location where the beneficiary was put into the ambulance (POP) 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 POP 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 the ground mileage rate.

4. Mileage

In the context of all payment instructions, the term "mileage" refers to loaded mileage. The ambulance FS provides a separate payment amount for mileage. The mileage rate per statute mile applies for all types of ground ambulance services, except Paramedic Intercept, and is provided to all Medicare contractors electronically by CMS as part of the ambulance FS. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

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

The payment rate is greater for certain mileage where the 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.

If the POP is a rural ZIP Code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. For loaded miles 1-17, the rural adjustment for ground mileage is 1.5 times the rural mileage allowance.

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).

The following chart summarizes the above information:

Service	Dates of Service	Bonus	Calculation
Loaded miles 1-17, Rural POP	Beginning 4/1/02	50%	FS Rural mileage * 1.5
Loaded miles 18-50, Rural POP	4/1/02 – 12/31/03	25%	FS Rural mileage * 1.25
All loaded miles (Urban or Rural POP) 51+	7/1/04 – 12/31/08	25%	FS Urban or Rural mileage * 1.25

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.

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.)

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;
- It is located outside of an MSA or NECMA; or
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.

See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 – Ambulance Services, section 30.1.1 – Ground Ambulance Services for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable FS amount for mileage. Thus, when rural mileage is involved, the contractor compares the calculated FS rural mileage payment rate to the provider's/supplier's actual charge for mileage and pays the lesser amount.

The CMS furnishes the ambulance FS files to claims processing contractors electronically. A version of the Ambulance Fee Schedule is also posted to the CMS website (http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp) for public consumption. To clarify whether a particular ZIP Code is rural or urban, please refer to the most recent version of the Medicare supplied ZIP Code file.

6. Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground ambulance transports is subject to a minimum amount. This minimum amount depends upon the area of the country in which the service is furnished. The country is divided into 9 census divisions and each of the census divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national rate and the regional rate in accordance with the following schedule:

Year	**National FS Percentage**	**Regional FS Percentage**
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 – CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. Note that this provision affects only the FS portion of the blended transition payment rate. This floor amount is calculated by CMS centrally and is incorporated into the FS amount that appears in the FS file maintained by CMS and

downloaded by CMS contractors. There is no calculation to be done by the Medicare B/MAC or A/MAC in order to implement this provision.

7. Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2010, the base rate portion of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by a percentage amount determined by CMS . *Section 3105 (c) and 10311 (c) of the Affordable Care Act amended section 1834 (1) (13) (A) of the Act to extend this rural bonus for an additional year through December 31, 2010.* This increase applies if 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. CMS will determine this bonus amount and the designated POP rural ZIP Codes in which the bonus applies. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a "B" indicator on the national ZIP Code file. Contractors must apply the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP Codes.

Subsequently, section of 106 (c) of the MMEA again amended section 1843 (l) (13) (A) of the Act to extend the rural bonus an additional year, through December 31, 2011.

8. Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006 as well as July 1, 2008 through December 31, 2010. For ground ambulance transport services furnished where the POP is urban, the rates are increased by 1 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. For ground ambulance transport services furnished where the POP is rural, the rates are increased by 2 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. *Subsequently, section 106 (a) of the Medicare and Medicaid Extenders Act of 2010 (MMEA) again amended section 1834 (1) (12) (A) of the Act to extend the payment increases for an additional year, through December 31, 2011.* These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS

file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that became effective on July 1, 2004 as well as the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 changes that became effective July 1, 2008 and were extended by the Patient Protection and Affordable Care Act of 2010 *and the Medicare and Medicaid Extenders Act of 2010 (MMEA).*

Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA, MIPPA *and MMEA*

Service	**Effective Dates**	**Payment Increase***
All rural miles	7/1/04 - 12/31/06	2%
All rural miles	7/1/08 – 12/31/1*1*	3%
Rural miles 51+	7/1/04 - 12/31/08	25% **
All urban miles	7/1/04 - 12/31/06	1%
All urban miles	7/1/08 – 12/31/1*1*	2%
Urban miles 51+	7/1/04 - 12/31/08	25% **
All rural base rates	7/1/04 - 12/31/06	2%
All rural base rates	7/1/08 – 12/31/1*1*	3%
Rural base rates (lowest quartile)	7/1/04 - 12/31/1*1*	22.6 %**
All urban base rates	7/1/04 - 12/31/06	1%
All urban base rates	7/1/08 – 12/31/1*1*	2%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

NOTES: * All payments are percentage increases and all are cumulative.

****Contractor systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file.

B. Air Ambulance Services

1. Base Rates

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services.

2. Geographic Adjustment Factor (GAF)

The GAF, as described above for ground ambulance services, is also used for air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50 percent of each of the base rates (fixed and rotary wing).

3. Mileage

The FS for air ambulance services provides a separate payment for mileage.

4. 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 FS 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.

20.1.5 - ZIP Code Determines Fee Schedule Amounts

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
PMs AB-00-88, AB-01-165, Training Book-CH 3, AB-02-131

The POP determines the basis for payment under the FS, and the POP is reported by its 5-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. Part B contractors must report the POP ZIP Code, at the line item level, to CWF when they report all other ambulance claim information. CWF must report the POP ZIP Code to the national claims history file, along with the rest of the ambulance claims record.

A. No ZIP Code

In areas without an apparent ZIP Code, it is the provider's/supplier's responsibility to confirm that the POP does not have a ZIP Code that has been assigned by the USPS. If the provider/supplier has made a good-faith effort to confirm that no ZIP Code for the POP exists, it may use the ZIP Code nearest to the POP.

Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the POP does not have an assigned ZIP Code and annotate the claim to indicate that a surrogate ZIP Code has been used (e.g., "Surrogate ZIP Code; POP in No-ZIP"). Providers and suppliers should maintain this documentation and provide it to their contractor upon request.

Contractors must request additional documentation from providers/suppliers when a claim submitted using a surrogate ZIP Code does not contain sufficient information to determine that the ZIP Code does not exist for the POP. They must investigate and report any claims submitted with an inappropriate and/or falsified surrogate ZIP Code.

If the ZIP Code entered on the claim is not in the CMS-supplied ZIP Code File, manually verify the ZIP Code to identify a potential coding error on the claim or a new ZIP Code established by the U.S. Postal Service (USPS). ZIP Code 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. All such ZIP Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural, unless the contractor exercises its discretion to designate the ZIP Code as rural. (See Section §20.1.5.B – New ZIP Codes)

- If this process does not validate the ZIP Code, the claim must be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

B. New ZIP Codes

New ZIP Codes are considered urban until CMS determines that the ZIP Code is located in a rural area. Thus, until a ZIP Code is added to the Medicare ZIP Code file with a rural designation, it will be considered an urban ZIP Code. However, despite the default designation of new ZIP Codes as urban, contractors have discretion to determine that a new ZIP Code is rural until designated otherwise. If the contractor designates a new ZIP Code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment.

Providers and suppliers should annotate claims using a new ZIP Code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP Code and provide it to their contractor upon request.

If the provider or supplier believes that a new ZIP Code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare FS regulation), it may request an adjustment from the A/MAC or appeal the determination with the B/MAC, as applicable, in accordance with standard procedures.

When processing a claim with a POP ZIP Code that is not on the Medicare ZIP Code file, contractors must search the USPS Web site at http://www.usps.com/, other governmental Web sites, and commercial Web sites, to validate the new ZIP Code. (The Census Bureau Web site located at http://www.census.gov/ contains a list of valid ZIP Codes.) If the ZIP Code cannot be validated using the USPS Web site or other authoritative source such as the Census Bureau Web site, reject the claim as unprocessable.

C. Inaccurate ZIP Codes

If providers and suppliers knowingly and willfully report a surrogate ZIP Code because they do not know the proper ZIP Code, they may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP Code on a claim when not appropriate to do so for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

D. Claims Outside of the U.S.

The following policy applies to claims outside of the U.S.:

- 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 U.S. will be paid at the fee associated with the U.S. ZIP Code at the point of entry; and

- Fees associated with the U.S. border port of entry ZIP Codes will be paid for air transport from areas outside the U.S. to the U.S. for covered claims.

As discussed more fully below, CMS will provide contractors with a file of ZIP Codes that will map to the appropriate geographic location and, where appropriate, with a rural designation identified with the letter “R” or “B.” Urban ZIP Codes are identified with a blank in this position.

20.1.5.1 - CMS Supplied National ZIP Code File and National Ambulance Fee Schedule File

(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)

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

A. 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 January 1, 2009

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)	Effective 1/1/07 Blank = urban, R=rural, B=super rural
Beneficiary Lab CB Locality	16-17	X(02)	Lab competitive bid locality; Z1= CBA1 Z2= CBA2 Z9= Not a demonstration locality
Rural Indicator 2	18	X(01)	What was effective 12/1/06 Blank=urban, R=rural, B=super rural
Filler	19-20	X(02)	

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.

Beginning in 2009, contractors shall maintain separate ZIP Code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP Code file based on the date of service submitted on the claim.

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 Rural Urban Commuting Area (RUCA) Score even though the ZIP Code may be located, in whole or in part, within an MSA or Core Based Statistical Area (CBSA).

A"B" designation indicates that the ZIP Code is in a rural county (or RUCA 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, 2010, 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 IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 1 –General Billing Requirements , section 10.1.1.1 - Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services and the additional information found in Transmittal 1193, Change Request 5208, issued March 9, 2007. The updated files will be available for downloading on approximately November 15th for the January 1 release, approximately February 15th for the April 1 release, approximately May 15th for the July 1 release, and approximately 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 communicating 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(B)**.

B. 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 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)	

Field Name	Position	Format	Description
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 Rate	28-34	s9(5)v99	Urban Payment Rate or Mileage 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.

20.1.6 - Contractor Determination of Fee Schedule Amounts

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

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." Contractors determine the FS amount as follows:

- If an urban ZIP Code is reported with a ground or air HCPCS code, the contractors 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 contractor determines the amount for the service by using the FS amount for the rural base rate. To determine the amount for mileage, contractors must use the following formula:

    - 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 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 contractor 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.

20.2 - Payment for Mileage Charges

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
B3-5116.3, PM AB-00-131

Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to his/her arrival at destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes his basic charge for ambulance services and his rate for loaded mileage. Suppliers should be notified that separate charges for unloaded mileage will be denied.

Instructions on billing mileage are found in §30.

20.3 - Air Ambulance

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
PMs AB-01-165, AB-02-036, and AB-02-131; B3-5116.5, B3-5205 partial

Refer to IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 10.4 – Air Ambulance Services, for additional information on the coverage of air ambulance services. Under certain circumstances, transportation by airplane or helicopter may qualify as covered ambulance services. If the conditions of coverage are met, payment may be made for the air ambulance services.

Air ambulance services are paid at different rates according to two air ambulance categories:

- **AIR** ambulance service, conventional air services, transport, one way, **fixed wing** (FW) (HCPCS code A0430)

- **AIR** ambulance service, conventional air services, transport, one way, **rotary wing** (RW) (HCPCS code A0431)

Covered air ambulance mileage services are paid when the appropriate HCPCS code is reported on the claim:

- HCPCS code A0435 identifies FIXED WING AIR MILEAGE

- HCPCS code A0436 identifies ROTARY WING AIR MILEAGE

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

Air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician's office, or a patient's home may not be paid air ambulance. The destination is identified by the use of an appropriate modifier as defined in Section 30(A) of this chapter.

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing. Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. 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; or

- 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.

IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 – Intermediary MR Guidelines for Specific Services contains instructions for Medical Review of Air Ambulance Services.

20.4 - Ambulance Inflation Factor (AIF)

(Rev. 2310, Issued: 09-23-11, Effective: 01-01-12, Implementation: 01-03-12)

Section 1834(l)(3)(B) of the Social Security Act (the Act) provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the Ambulance Inflation Factor *(*AIF*)*. These updated percentages are issued via Recurring Update Notifications.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Following is a chart tracking the history of the AIF:

CY	AIF
2003	1.1
2004	2.1
2005	3.3
2006	2.5
2007	4.3
2008	2.7
2009	5.0
2010	0.0
2011	-0.1
2012	*2.4*

20.5 - Documentation Requirements

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

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 in order for payment to be made.

IOM Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4 - Physician Certifications and Recertification of Services, contains specific information on supplier requirements for ambulance certification.

IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 – Intermediary MR Guidelines for Specific Services contains information on medical review instructions of ambulance services.

30 - General Billing Guidelines
(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Independent ambulance suppliers may bill on CMS-1500 Form or the ANSI X12N 837P data set. These claims are processed using the Multi-Carrier System (MCS).

Institution based ambulance providers may bill on CMS-1450 Form or the ANSI X12N 837I. These claims are processed using the Fiscal Intermediary Shared System (FISS).

A. Modifiers Specific to Ambulance Service Claims

For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in 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 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)

In addition, institutional-based 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.

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.

B. HCPCS Codes

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

AMBULANCE HCPCS CODES AND DEFINITIONS

HCPCS Code	Description of HCPCS Codes
A0425	BLS mileage (per mile)
A0425	ALS mileage (per mile)
A0426	Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
A0427	Ambulance service, ALS, emergency transport, Level 1
A0428	Ambulance service, Basic Life Support (BLS), non-emergency transport
A0429	Ambulance service, basic life support (BLS), emergency transport
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)
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.
A0433	Ambulance service, advanced life support, level 2 (ALS2)
A0434	Ambulance service, specialty care transport (SCT)
A0435	Air mileage; FW, (per statute mile)
A0436	Air mileage; RW, (per statute mile)

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

Refer to IOM Pub. 100-04, Medicare Benefit Policy Manual, chapter 10 – Ambulance Service, section 30.1 – Categories of Ambulance Services, for the definitions of levels of ambulance services under the fee schedule.

30.1 - Multi-Carrier System (MCS) Guidelines

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
B3-5116

Payment under the fee schedule for ambulance services:

- Includes a base rate payment plus a payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Precludes a separate payment for items and services furnished under the ambulance benefit.

Payment for items and services is included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing - but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit.

30.1.1 - MCS Coding Requirements for Suppliers

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)
PM AB-00-88

The ambulance fee schedule contains the following HCPCS coding logic:

- Seven categories of ground ambulance services;
- Two categories of air ambulance services;
- Payment based on the condition of the beneficiary, not on the type of vehicle used;
- Payment is determined by the point of pickup (as reported by the 5-digit ZIP Code);
- Increased payment for rural services; and
- Services and supplies included in base rate.

30.1.2 - Coding Instructions for Paper and Electronic Claim Forms

(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)

Except as otherwise noted, beginning with dates of service on or after January 1, 2001, the following coding instructions must be used.

In item 23 of the CMS-1500 Form, billers shall code the 5-digit ZIP Code of the point of pickup.

Electronic billers using ANSI X12N 837 should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup). Beginning with the early implementation of the version 5010 837P claim format on January 1, 2011, electronic billers will be required to submit, 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). Again, 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 that the point of drop-off will be an additional reporting requirement on the version 5010 837P claim format.

Since the ZIP Code is used for pricing, more than one ambulance service may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP Code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP Codes.

Claims without a ZIP Code in item 23 on the CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable. Carriers use message N53 on the remittance advice in conjunction with reason code 16.

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

Beginning with dates of service on or after January 1, 2011, if mileage is billed it must be reported as fractional units in Item 24G of the Form 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. When reporting fractional mileage, suppliers 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 greater, 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 1 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. It does not apply to providers billing on the Form CMS-1450.

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

Ambulance suppliers submitting a claim using the CMS-1500 Form, or the electronic equivalent ANSI X12N 837, for an ambulance transport with more than one Medicare beneficiary onboard must use the "GM" modifier ("Multiple Patient on One Ambulance Trip") for each service line item. In addition, suppliers are required to submit to B/MACs / Carriers documentation to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim (HIC) numbers for each Medicare beneficiary. B/MACs / Carriers shall calculate payment amounts based on policy instructions found in Pub.100-02, Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.

Ambulance claims submitted on or after January 1, 2011 in the version 5010 837P electronic claim format require the presence of a diagnosis code and the absence of said 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.

30.1.3 - Coding Instructions for Form CMS-1491

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Effective April 2, 2007, Form CMS-1491 will no longer be a valid format for submitting claims. Suppliers who wish to submit a paper claim must use CMS-1500 Form.

30.1.4 – CWF Editing of Ambulance Claims for Inpatients

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay (see IOM Pub. 100-04, Medicare Claims Processing, chapter 3 – Inpatient Hospital Billing, Section 10.4 – Payment of

Nonphysician Services for Inpatients). CWF performs reject edits to incoming claims from suppliers of ambulance services.

Upon receipt of a hospital inpatient claim at the CWF, CWF searches paid claim history and compares the period between the hospital inpatient admission and discharge dates to the line item service date on an ambulance claim billed by a supplier. The CWF will generate an unsolicited response when the line item service date falls within the admission and discharge dates of the hospital inpatient claim.

Upon receipt of an unsolicited response, the carrier will adjust the ambulance claim and recoup the payment.

Ambulance services with a date of service that are the same as an admission or discharge date on an inpatient claim are separately payable and not subject to the bundling rules.

30.2 - Fiscal Intermediary Shared System (FISS) Guidelines

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

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 6 – SNF Inpatient Part A Billing, Section 20.3.1 – Ambulance Services, for additional information on SNF consolidated billing and ambulance transportation.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing, section 10.5 – Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

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

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

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;

- Name and address of physician ordering service if other than certifying physician;

- Point of pickup (identify place and completed address);

- Destination (identify place and complete address);

- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);

- Cost per mile;

- Mileage charge;

- Minimum or base charge; and

- Charge for special items or services. Explain.

A. General

The reasonable cost per trip of ambulance services furnished by a provider of services may not exceed the prior year's reasonable cost per trip updated by the ambulance inflation factor. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997, and September 30, 1998). Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

The following instructions provide billing procedures implementing the above provisions.

B. Applicable Bill Types

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

C. Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance in

the
Value Code field. The value code is defined as "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance." Providers report the number in dollar portion of the form location right justified to the left to the dollar/cents delimiter.

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

For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

NOTE: Information regarding the claim form locator that corresponds to the Value Code field and a table to crosswalk the CMS-1450 form locator to the 837 transaction is found in Pub.100-04, Medicare Claims Processing Manual, chapter 25 – Completing and Processing the Form CMS-1450 Data Set.

D. Revenue Code/HCPCS Code Reporting

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

A0030 (discontinued 12/31/2000); A0040 (discontinued 12/31/2000); A0050 (discontinued 12/31/2000); A0320 (discontinued 12/31/2000); A0322 (discontinued 12/31/2000); A0324 (discontinued 12/31/2000); A0326 (discontinued 12/31/2000); A0328, (discontinued 12/31/2000); or A0330 (discontinued 12/31/2000).

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

0540;
0542;

0543;
0545;

0546; or
0548.

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

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

A0426; A0427;
A0428; A0429; A0430; A0431; A0432; A0433; or
A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly. In addition, all providers report one of the following mileage HCPCS codes: A0380; A0390; A0435; or A0436.

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

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

NOTE: Information regarding the claim form locator that corresponds to the HCPCS code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Pub. 100-04, Medicare Claims Processing Manual, chapter 25 – Completing and Processing the Form CMS-1450 Data Set.

E. Modifier Reporting

See the above Section 30 (A) (Modifiers Specific to Ambulance Service Claims) for instructions regarding the usage of modifiers.

F. Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in the Service Date field.

NOTE: Information regarding the claim form locator that corresponds to the Service Date and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Pub. 100-04, Medicare Claims Processing Manual, chapter 25 – Completing and Processing the Form CMS-1450 Data Set.

G. Service Units Reporting

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

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

H. Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434**;**

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

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

Prior to submitting the claim to CWF, the intermediary will remove the entire revenue code line containing the mileage amount reported in Non-covered Charges to avoid non-acceptance of the claim.

NOTE: Information regarding the claim form locator that corresponds to the Charges fields and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Pub. 100-04, Medicare Claims Processing Manual, chapter 25 – Completing and Processing the Form CMS-1450 Data Set.

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

EXAMPLE 1: Claim containing only one ambulance trip:

For the hard copy CMS-1450 Form, providers report as follows:

Revenue Code	HCPCS/ Modifiers	Date of Service	Units	Total Charges
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2: Claim containing multiple ambulance trips:

For the hard copy Form CMS-1450, providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00
0540	A0330	RH	QN	082901	1 (trip)	400.00
0540	A0390	RH	QN	082901	3 (mileage)	6.00

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

For the hard copy CMS-1450, providers report as follows:

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

I. Edits

A/MACs edit to assure proper reporting as follows:

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

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

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

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

- Service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal “1"

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

30.2.1 - A/MAC Bill Processing Guidelines Effective April 1, 2002, as a Result of Fee Schedule Implementation

(Rev. 2103 Issued; 11-19-10; Effective Date: 01-01-11; Implementation Date: 01-03-11)

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 6 – SNF Inpatient Part A Billing, Section 20.3.1 – Ambulance Services for additional information on SNF consolidated billing and ambulance transportation.

Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing, section 10.5 – Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

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

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

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

A. Revenue Code Reporting

Providers report ambulance services under revenue code 540 in FL 42 “Revenue Code.”

B. HCPCS Codes Reporting

Providers report the HCPCS codes established for the ambulance fee schedule. No other HCPCS codes are acceptable for the reporting of ambulance services and mileage. The HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used.

Providers must report one of the following HCPCS codes in FL 44 “HCPCS/Rates” for each base rate ambulance trip provided during the billing period:

A0426;
A0427;
A0428;
A0429;
A0430;
A0431;
A0432;
A0433; or
A0434.

These are the same codes required effective for services January 1, 2001.

In addition, providers must report **one** of HCPCS mileage codes:

A0425;
A0435; or
A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, providers must report revenue code 540 (ambulance) on two separate and consecutive line items to accommodate both the 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.

For UB-04 hard copy claims submission, providers code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

For electronic claims submissions prior to January 1, 2011, providers code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

Beginning with dates of service on or after January 1, 2011, for electronic claim submissions only, mileage must be reported as fractional units in the ANSI X12N 837I element SV205 for trips totaling up to 100 covered miles. 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 100 covered miles and greater, 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 1 mile, enter a "0" before the decimal (e.g., 0.9).

NOTE: Fractional mileage reporting applies only to ambulance services billed electronically via the ANSI X12N 837I format. It currently does not apply to billing via the UB-04 hardcopy format.

C. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided and either a QM (Ambulance service provided under arrangement by a provider of services) or QN (Ambulance service furnished directly by a provider of services) modifier in FL 44 "HCPCS/Rates".

D. Service Units Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in FL 46 "Service Units" for each ambulance trip provided. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0425, A0435, or A0436, providers must also report the number of loaded miles.

E. Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in 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 codes A0425, A0435, or A0436, providers are to 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. For the related charges, providers report $1.00 in non-covered charges. A/MACs should assign ANSI Group Code OA to the $1.00 non-covered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

F. Edits (A/MAC Claims with Dates of Service On or After 4/1/02)

For claims with dates of service on or after April 1, 2002, A/MACs perform the following edits to assure proper reporting:

- Edit to assure each pair of revenue codes 540 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 - A0425, A0435, or A0436.

- Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540;

- Edit to assure that the unit's field is completed for every line item containing revenue code 540;

- Edit to assure that service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal "1"; and

- Edit to assure on every claim that revenue code 540, a value code of A0 (zero), and a corresponding ZIP Code are reported. If the ZIP Code is not a valid ZIP Code in accordance with the USPS assigned ZIP Codes, intermediaries verify the ZIP Code to determine if the ZIP Code is a coding error on the claim or a new ZIP Code from the USPS not on the CMS supplied ZIP Code File.

G. CWF (A/MACs)

A/MACs report the procedure codes in the financial data section (field 65a-65j). They include revenue code, HCPCS code, units, and covered charges in the record. Where more than one HCPCS code procedure is applicable to a single revenue code, the provider reports each HCPCS code and related charge on a separate line, and the A/MAC reports this to CWF. Report the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h, "Covered Charges."

30.2.2 - SNF Billing

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09)

The following ambulance transportation and related ambulance services for residents in Part A stays are not included in the PPS rate. They may be billed as Part B services by the supplier only in the following situations:

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS code modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.)

- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS code ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date, and the SNF patient status (FL 22) is other than 30.)

- The ambulance trip is to a hospital based or non-hospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility).

- The ambulance trip is from the SNF to another SNF (the first and second character (origin and destination) of any ambulance HCPCS code modifier is "N" (SNF)) and the beneficiary is not in a Part A stay.

Ambulance payment associated with the following outpatient hospital service exclusions is paid under the ambulance fee schedule:

- Cardiac catheterization;

- Computerized axial tomography (CT) scans;

- Magnetic resonance imaging (MRIs);

- Ambulatory surgery involving the use of an operating room, including the insertion, removal, or replacement of a percutaneous esophageal gastrostomy (PEG) tube in the hospital's gastrointestinal (GI) or endoscopy suite;

- Emergency services;

- Angiography;

- Lymphatic and Venous Procedures; and

- Radiation therapy.

The following ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and may <u>not</u> be billed as Part B services by the supplier. In these scenarios, the services provided are subject to SNF CB and the first SNF is responsible for billing the services to the A/MAC:

- A beneficiary's transfer from one SNF to another before midnight of the same day. The first and second characters (origin and destination) of any HCPCS code ambulance modifier are "N" (SNF).

- A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport. When billing for ambulance transports, suppliers should indicate whether the transport was part of a SNF Part A covered stay, using the appropriate origin/destination modifier (e.g., "NH" for a transport from a SNF to a hospital).

- Suppliers should bill with an "NN" origin/destination modifier when a SNF to SNF transport occurs. A transport between two SNFs is not separately payable when a beneficiary is in a Part A covered SNF stay, and will result in a denial of a claim for such a transport.

  - Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.). 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).

30.2.3 - Indian Health Service (IHS)/Tribal Billing

(Rev. 2102, Issued: 11-19-10, Effective: 04-01-11, Implementation: 04-04-11)

Ambulance services furnished by IHS/Tribal hospitals including Critical Access Hospitals (CAHs) will be paid according to the appropriate payment methodology.

For dates of service on or after December 21, 2000 and prior to January 1, 2004, medically necessary ambulance services furnished by an IHS/Tribal CAH or by an entity that is owned and operated by an IHS/Tribal CAH are paid based on 100 percent of the reasonable cost if the 35 mile rule for cost-based payment is met. In order for the 35 mile rule to be met, the IHS/Tribal CAH or the entity that is owned and operated by the IHS/Tribal CAH, must be the only provider or supplier of ambulance services that is located within a 35 mile drive of the IHS/Tribal CAH or the entity. Those CAHs that meet the 35 mile rule for cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.

For dates of service on or after January 1, 2004, ambulance services furnished by an IHS/Tribal CAH or by an entity that is owned and operated by an IHS/Tribal CAH are paid based on 101 percent of the reasonable cost if the 35 mile rule for cost-based payment is met.

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.

Other IHS/Tribal hospital based ambulance services are reimbursed based on the ambulance fee schedule.

30.2.4 – Non-covered Charges on Institutional Ambulance Claims

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare law contains a restriction that miles beyond the closest available facility cannot be billed to Medicare. Non-covered miles beyond the closest facility are billed with HCPCS procedure code A0888 ("non-covered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility"). These non-covered line items can be billed on claims also containing covered charges. Ambulance claims may use the –GY modifier on line items for such non-covered mileage, and liability for the service will be assigned correctly to the beneficiary.

The method of billing all miles for the same trip, with covered and non-covered portions, on the same claim is preferable in this scenario. However, billing the non-covered mileage using condition code 21 claims is also permitted, if desired, as long as all line items on the claims are non-covered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories but excepting some points in Canada and Mexico in some cases, mileage is also statutorily excluded from Medicare coverage. Such billings are more likely to be submitted on entirely non-covered claims using condition code 21. This scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

Another scenario in which billing non-covered mileage to Medicare may occur is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. The –QL modifier should be used on the base rate line in this scenario, in place of origin and destination modifiers, and the line is submitted with covered charges. The –QL modifier should also be used on the accompanying mileage line, if submitted, with non-covered charges. Submitting this non-covered mileage line is optional for providers.

Non-covered charges may also apply is if there is a subsidy of mileage charges that are never charged to Medicare. Because there are no charges for Medicare to share in, the only billing option is to submit non-covered charges, if the provider bills Medicare at all (it is not required in such cases). These non-covered charges are unallowable, and should not be considered in settlement of cost reports. However, there is a difference in billing if such charges are subsidized, but otherwise would normally be charged to Medicare as the primary payer. In this latter case, CMS examination of existing rules relating to grants

policy since October 1983, supported by Federal regulations (42CFR 405.423), generally requires providers to reduce their costs by the amount of grants and gifts restricted to pay for such costs. Thereafter, section 405.423 was deleted from the regulations.

Thus, providers were no longer required to reduce their costs for restricted grants and gifts, and charges tied to such grants/gifts/subsidies should be submitted as covered charges. This is in keeping with Congress's intent to encourage hospital philanthropy, allowing the provider receiving the subsidy to use it, and also requiring Medicare to share in the unreduced cost. Treatment of subsidized charges as non-covered Medicare charges serves to reduce Medicare payment on the Medicare cost report contrary to the 1983 change in policy.

Medicare requires the use of the –TQ modifier so that CMS can track the instances of the subsidy scenario for non-covered charges. The –TQ should be used whether the subsidizing entity is governmental or voluntary. The -TQ modifier is not required in the case of covered charges submitted when a subsidy has been made, but charges are still normally made to Medicare as the primary payer.

If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider covered charges occurring in the subsidy case, since Medicare had previous billing instructions that stated all charges in the case of a subsidy, not just charges when the entity providing the subsidy never charges another entity/primary payer, should be submitted as non-covered charges, they may contact their FI about reopening the reports in question for which the time period in 42 CFR 405.1885 has not expired. FIs have the discretion to determine if the amount in question warrants reopening. The CMS does not expect many such cases to occur.

Billing requirements for all these situations, including the use of modifiers, are presented in the chart below:

Mileage Scenario	HCPCS	Modifiers*	Liab-ility	Billing	Remit. Require-ments	MSN Message
STATUTE: Miles beyond closest facility, OR **Pick up point outside of U.S.	A0888 on line item for the non-covered mileage	-QM or –QN, origin/destination modifier, and –GY unless condition code 21 claim used	Bene-ficiary	Bill mileage line item with A0888 –GY and other modifiers as needed to establish liability, line item will be denied; OR bill service on condition code 21 claim, no –GY required, claim will be denied	Group code PR, reason code 96	16.10 "Medicare does not pay for this item or service"; OR, "Medicare no paga por este artículo o servicio"
Beneficiary dies after ambulance is	Most appropriate	–QL unless condition code –21	Pro-vider	Bill mileage line item with –QL as non-covered, line item will	Group Code CO,	16.58 "The provider billed this charge as

called	ambulance HCPCS mileage code (i.e., ground, air)	claim		be denied	reason code 96	non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."
Subsidy or government owned Ambulance, Medicare NEVER billed***	A0888 on line item for the non-covered mileage	-QM or –QN, origin/ destination modifier, and -TQ must be used for policy purposes	Pro-vider	Bill mileage line item with A0888, and modifiers as non-covered, line item will be denied	Group Code CO, reason code 96	16.58 "The provider billed this charge as non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

* Current ambulance billing requirements state that either the –QM or –QN modifier must be used on services. The –QM is used when the "ambulance service is provided under arrangement by a provider of services," and the –QN when the "ambulance service is provided directly by a provider of services." Line items using either the –QM or –QN modifiers are not subject to the FISS edit associated with FISS reason code 31322 so that these lines items will process to completion. Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination, and are not non-covered by definition.

** This is the one scenario where the base rate is not paid in addition to mileage, and there are certain exceptions in Canada and Mexico where mileage is covered as described in existing ambulance instructions.

***If Medicare would normally have been billed, submit mileage charges as covered charges despite subsidies.

Medicare systems may return claims to the provider if they do not comply with the requirements in the table.

40 - Medical Conditions List and Instructions

(Rev. 1942; Issued: 04-02-10; Effective/Implementation Date: 05-03-10)

The following list is intended as primarily an educational guideline. This list was most recently updated by CMS Transmittal 1185, Change Request 5542 issued February 23, 2007. 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 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, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the HCPCS code or the condition code by themselves. All current Medicare ambulance policies remain in place.

The 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 International Classification of Diseases, 9th Revision, Clinical Modification (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, and these codes generally do not trigger a payment or a denial of a claim. Some carriers and fiscal intermediaries have Local Coverage Determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the Medical Conditions List is available for those who do find it helpful in justifying that services are reasonable and necessary.

The Medical Conditions List is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and can be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be

selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "PLUS." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "PLUS") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "PLUS"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes. Please see the example below:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "PLUS any other code" requirement when using the alternative list for this condition (abnormal vital signs)). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an Advanced Life Support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a Basic Life Support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the

scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

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

Information on appropriate use of transportation indicators:

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

• **Air and Ground**

• **Transportation Indicator "C1":** Transportation indicator "C1" indicates an interfacility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.

• **Transportation Indicator "C2":** Transportation indicator "C2" indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.

• **Transportation Indicator "C3":** Transportation indicator "C3" may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major

incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.

• **Transportation Indicator "C4":** Transportation indicator "C4" indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appear to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

• **Ground Only**

• **Transportation Indicator "C5"**: Transportation indicator "C5" has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

• For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-yearold beneficiary who has undergone cataract surgery at the Eye Surgery Center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes melitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

• **Transportation Indicator "C6"**: Transportation indicator "C6" has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

• **Transportation Indicator C7**- Transportation indicator “C7” is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient’s condition should also be reported on the claim with a code selected from the list.

• **Air Only**

• All “transportation indicators” imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

• D1 Long Distance - patient's condition requires rapid transportation over a long distance.
• D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.

• D3 Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.

• D4 Pick up point not accessible by ground transportation.

Ambulance Fee Schedule - Medical Conditions List

(Rev. 1942; Issued: 04-02-10; Effective/Implementation Date: 05-03-10)

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
Emergency Conditions - Non-Traumatic						
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6, bi- and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED fired	A0427/A0433
ICD 9 Primary Code	**ICD9 Alternative Specific Code**	**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and Examples (not all-**	**HCPCS Crosswalk**

					inclusive)	
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphorhesis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799	Abnormal vital signs (includes abnormal pulse oximetry)	With or without symptoms.	ALS		A0427/A0433
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69, or 995.7	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest – resuscitation in progress		ALS		A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.99	933.0 or 933.1.	Chocking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature < 95F, deep frost bite, other emergency conditions.	A0427/A0433
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions	A0429
780.97	780.02, 780.03, or 780.09.	Altered level of consciousness (nontraumatic)		ALS	Acute condition with Glascow Coma Scale < 15.	A0427/A0433
780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70 ,345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure and requires medical monitoring/observation.	ALS		A0427/A0433
379.90	368.11, 368.12, or 379.91	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8.	Non-traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0472/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5	Heat exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11	Hemorrhage	Severe (quantity) and potentially life-threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post- surgical bleeding.	A0472/A0433
038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7, 989.9, or 990.	Hazmat exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0472/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical device failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery service.	A0427/A0433
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical device failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen system supply malfunction, orthopedic device failure.	A0429
436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-	HCPCS Crosswalk

					inclusive)	
780.96		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7-10 for severe pain) or patient receiving pharmalogic intervention.	A0427/A0433
724.5	724.2 or 785.9	Back pain – non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
724.9	724.2, 724.5, 847.1, or 847.2.	Back pain – non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms.	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection, or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post-operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening	A0429

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
650	Any code from 630 through 679.	Pregnancy complication/childbirth/labor		ALS		A0427/A0433
292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DTs, withdrawal symptoms.	A0427/A0433
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior.	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick person – fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433

Emergency Conditions - Trauma

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition (Specific)" column	A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-	HCPCS Crosswalk

					inclusive)	
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9.	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee and ankle, deformity of bone or joint.	A0429
880.00	880.00 through 887.7 or 890.0 through 897.7	Other trauma	Penetrating extremity injuries	BLS	Isolated bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1	Other trauma	Amputation – digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation – all other	ALS		A0427/A0433
869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major – per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0472/A0433
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor – per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation.	Potentially life or limb-threatening.	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envonmation.	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near drowning	Airway compromised during near drowning event	ALS		A0427/A0433

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference codes 959.8, 958.2, 869.0/869.1	A0427/A0433
995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		
Non-Emergency						
428.9		Cardiac/hemodynamic monitoring required en route.		ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.		ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.		BLS	Per transfer instructions.	A0428
786.09		Airway control/positioning required en route.		BLS	Per transfer instructions.	A0428

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient safety: Danger to self or others – in restraints.		BLS	Refer to definition in 42 CFR Section 482.13(e).	A0428
293.1		Patient safety: Danger to self or others – monitoring.		BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428
298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90	Patient safety: Danger to self or others – seclusion (flight risk).		BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 CFR Section 482.13(f) for definition.	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
041.9		Special handling en route – isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain – orthopedic device.		BLS	Backboard, halotraction, use of pins and traction etc. Pain may be present.	A0428
719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route – positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with > grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of < 1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures – post-op hip as an example.	A0428

Transportation Indicators

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C1	Inter-facility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C2	Inter-facility transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW,RW		A0428, A0429, A0426, A0427, A0433, A0434
C3	Emergency Trauma Dispatch Condition Code	Major incident or mechanism of injury	**Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.**	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS transport of ALS-level patient	ALS-level condition treated and transport by a BLS-level ambulance.	**This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.**	BLS		A0429

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C6	ALS-level response to BLS-level patient	ALS response required based upon appropriate dispatch protocols – BLS-level patient transport	**Indicates to Carrier/Intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare Ambulance Fee Schedule.**	ALS		A0427

Transportation Indicators Air and Ground	Transportation Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a non- emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list	ALS	Does not apply to self-administered IV medications.	A0426

Air Ambulance Transportation Indicators

Air Ambulance Transportation Indicators	Transportation Indicator Description	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
D1	Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2	Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3		FW, RW		A0430, A0431
D4		FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be cross walked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2318CP	10/13/2011	Update to the Internet Only Manual Pub. 100-04, Chapter 15 - Ambulance, to Include the Medicare and Medicaid Extenders Act of 2010 (MMEA) Provisions	01/03/2012	7558
R2313CP	09/30/2011	Update to the Internet Only Manual Pub. 100-04, Chapter 15 - Ambulance, to Include the Medicare and Medicaid Extenders Act of 2010 (MMEA) Provisions – Rescinded and replaced by Transmittal 2318	01/03/2012	7558
R2310CP	09/23/2011	Ambulance Inflation Factor for CY 2012	01/03/2012	7546
R2162CP	02/22/2011	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set	03/21/2011	7018
R2124CP	12/23/2010	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set - Rescinded and replaced by Transmittal 2162	01/25/2011	7018
R2104CP	11/19/2010	Ambulance Inflation Factor for CY 2011 and Productivity Adjustment	01/03/2011	7042
R2103CP	11/19/2010	Fractional Mileage Units Submitted on Ambulance Claims	01/03/2011	7065
R2102CP	11/19/2010	Systems Changes Necessary to Implement “Technical Correction Related to Critical Access Hospital Services”, Section 3128 of the Affordable Care Act, Pub. 118-148	04/04/2011	7219
R2074CP	10/25/2010	Ambulance Inflation Factor (AIF) for CY 2011 and Productivity Adjustment – Rescinded and replaced by Transmittal 2104	01/03/2011	7042
R2069CP	10/15/2010	Ambulance Inflation Factor (AIF) for CY 2011 and Productivity Adjustment – Rescinded and replaced by	01/03/2011	7042

Rev #	Issue Date	Subject	Impl Date	CR#
		Transmittal 2074		
R2065CP	10/15/2010	Fractional Mileage Units Submitted on Ambulance Claims – Rescinded and replaced by Transmittal 2103	01/03/2011	7065
R2029CP	08/13/2010	Fractional Mileage Units Submitted on Ambulance Claims – Rescinded and replaced by Transmittal 2065	01/03/2011	7065
R1942CP	04/02/2010	Update to the Medical Conditions List and Instructions	05/03/2010	6896
R1921CP	02/19/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010	6563
R1894CP	01/15/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1921	04/05/2010	6563
R1861CP	11/27/2009	Ambulance Inflation Factor for CY 2010	01/04/2010	6631
R1840CP	10/29/2009	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1894	04/05/2010	6563
R1821CP	09/25/2009	Billing for and Ambulance Transport with More Than One Patient Onboard	10/26/2009	6621
R1696CP	03/06/2009	Updates to the Medicare Claims Processing Manual, Publication 100-04, Chapter 15	04/06/2009	6347
R1682CP	02/13/2009	Clarification of Date of Service (DOS) of Ambulance Services	03/13/2009	6372
R1607CP	10/03/2008	Ambulance Inflation Factor for CY 2009	01/05/2009	6113
R1591CP	09/09/2008	ZIP Code Files by Date of Service - Replaced by Transmittal 1591	07/07/2008	5881

Rev #	Issue Date	Subject	Impl Date	CR#
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1463CP	02/22/2008	ZIP Code Files by Date of Service - Replaced by Transmittal 1591	07/07/2008	5881
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1375CP	11/09/2007	Ambulance Inflation Factor for CY 2008	01/07/2008	5801
R1333CP	08/17/2007	Ambulance: New Remark Code for Denying Separately Billed Services	10/01/2007	5659
R1318CP	08/17/2007	Ambulance: New Remark Code for Denying Separately Billed Services - Replaced by Transmittal 1333	10/01/2007	5659
R1249CP	05/25/2007	Update to Publication 100-04, Chapters 1 and 15 for ZIP5 and ZIP9 Medicare Zip Code Files.	10/01/2007	5578
R1185CP	02/23/2007	Ambulance Fee Schedule-Medical Conditions List	04/02/2007	5442
R1144CP	12/29/2006	Elimination of CMS-1491 and CMS-1490U Forms	04/02/2007	5390
R1102CP	11/03/2006	Ambulance Inflation Factor (AIF) for CY 2007	01/02/2007	5358
R1100CP	11/03/2006	Jurisdiction for Ambulance Supplier Claims	01/01/2008	5203
R852CP	02/10/2006	Corrected Ambulance Fee Schedule file for CY 2006	02/24/2006	4362
R789CP	12/23/2005	Ambulance Medical Conditions List	03/27/2006	4221
R762CP	11/25/2005	Ambulance Inflation Factor (AIF) for CY 2006	01/03/2006	4061
R668CP	09/02/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
R622CP	07/29/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933

Rev #	Issue Date	Subject	Impl Date	CR#
R459CP	02/04/2005	Change To CWF SNF Edits For Consolidated Billing for Ambulance Transport to or From Therapeutic Sites -- replaces R342CP	04/04/2005	3676
R437CP	01/21/2005	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.	02/22/2005	3664
R425CP	01/10/2005	Payment of Ambulance Services to Indian Health Service (IHS) or Tribal Hospitals Including (CAHs)	04/03/2005	3521
R411CP	12/23/2004	Ambulance Inflation Factor (AIF) for CY 2005	01/03/2005	3599
R395CP	12/15/2004	Ambulance Fee Schedule - Medical Conditions List	01/03/2005	3619
R367CP	11/12/2004	Replaced by Revision 425CP	04/04/2005	3521
R342CP	10/29/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site	04/04/2005	3427
R220CP	06/25/2004	Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003	07/06/2004	3099
R212CP	06/18/2004	Replaced by Revision 220CP	07/06/2004	3099
R185CP	05/28/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Drugs and Electrocardiogram (EKG) Testing Provided During an Ambulance Transport	10/04/2004	3212
R163CP	04/30/2004	Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site Other than a Physician's Office or Hospital	10/04/2004	3196

Rev #	Issue Date	Subject	Impl Date	CR#
R088CP	02/06/2004	Implementation of Changes to Payment for Ambulance Services Required by Section 414 of MMA	07/05/2004	3099
R059CP	01/02/2004	Corrects the "Ambulance HCPCS Codes Crosswalk and Definitions," makes technical corrections to the manual, and adds a new carrier requirement for HCPCS code A0800	01/05/2004	3035
R056CP	12/24/2003	Ambulance Inflation Factor (AIF) for CY 2004 including the 2004 AIF for determining the payment limit for ambulance services required by $1834(1) of the Social Security Act (the Act), the blending percentages applicable to CY 2004, and the address of the ambulance fee schedule file for CY 2004	01/05/2004	3000
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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