

# PART B



**J14 A/B MAC**

# Ambulance Billing Guide April 2013

**NHIC, Corp.**

# Ambulance Billing Guide

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### INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Ambulance billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website ([www.medicarenhic.com](http://www.medicarenhic.com)), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-2, Chapter 10 and Publication 100-4, Chapter 6 and 15 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.gov/manuals/>

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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### THE MEDICARE PART B AMBULANCE BENEFIT

To be covered, ambulance services must be medically necessary and reasonable.

Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

*So when submitting a claim to NHIC for payment, provide information on the claim that will substantiate the patient's need to be transported by ambulance versus other forms of transportation.*

In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service.

The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service.

The ambulance benefit is defined in title XVIII of the Social Security Act (the Act) in §1861(s)(7): "ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations."

### COVERAGE CRITERIA

*In addition to the information referenced above, the following coverage criteria must be met before claim can be considered for processing.*

#### Vehicle and Crew Requirements

Ambulance Vehicle: Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in non-emergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by State or local law. This should include, at a minimum, one 2-way voice radio or wireless telephone.

The ambulance must have customary patient care equipment and first aid supplies, including reusable devices and equipment such as backboards, neck boards, and inflatable leg and arm

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splints. These are all considered part of the general ambulance service and payment for them is included in the payment rate for the transport.

**Basic Life Support (BLS) Ambulance** – BLS vehicles must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

**Advanced Life Support (ALS) Ambulance** – ALS vehicles must be staffed by at least two people, at least one of whom must be certified by the State or local authority as an EMT-Intermediate or an EMT-Paramedic.

### Destination

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

- Hospital;
- Critical Access Hospital (CAH);
- Skilled Nursing Facility (SNF);
- Beneficiary's home; or
- Dialysis facility for ESRD patient who requires dialysis; or
- A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

As a general rule, only local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered. Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, only in exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, may full payment for mileage be considered. And then, only if the evidence clearly establishes that the destination institution was the nearest one with appropriate facilities under the particular circumstances. The institution to which a patient is transported need not be a participating institution but must meet at least the requirements of §1861(e) (1) or §1861(j) (1) of the Social Security Act.

### Appropriate Facilities

The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or

does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. In addition, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest tuberculosis hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is also not considered an appropriate facility if there is no bed available. The contractor, however, will presume that there are beds available at the local institutions unless the claimant furnished evidence that none of these institutions had a bed available at the time the ambulance service was provided.

### EXAMPLE

Mr. A becomes ill at home and requires ambulance service to the hospital. The hospitals servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis, and the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with the equipment is covered since it is the nearest one with appropriate facilities.

### Locality

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

### EXAMPLE

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

### Reasonableness of the Ambulance Trip

Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not

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simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the Fee Schedule is made only for the level of service furnished, and then only when the service is medically necessary.

### Bed-Confinement

Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Carriers may presume this requirement is met under certain circumstances, including when the beneficiary was bed-confined before and after the ambulance trip.

A beneficiary is bed-confined if he/she is:

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

The term "bed confined" is not synonymous with "bed rest" or "non-ambulatory". Bed confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the carrier's determination of whether means of transport other than an ambulance were contraindicated.

### Jurisdiction

Jurisdiction of the claim is based on whether only one ambulance vehicle or multiple vehicles were used. (See the "Air Ambulance" section of this guide for regulations on jurisdiction for air transports.)

#### A. One Ambulance Vehicle Used

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

#### EXAMPLE

A patient is picked up at the Johns Hopkins Hospital in Baltimore, Maryland and transported to his home in West Virginia by an ambulance dispatched from the area of the patient's home. The carrier serving the point of origin of the ambulance, the Part B carrier for the State of West Virginia, has jurisdiction of any claim filed. The Carrier for West Virginia should have all the data necessary to make proper payment, i.e., certification of the ambulance company, price information and data pertaining to the nearest appropriate company, price information and data pertaining to the nearest appropriate facility. Had an ambulance whose home station was in Baltimore been used, the carrier servicing Baltimore, Maryland would have had jurisdiction. The

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Baltimore carrier would then have had to obtain data concerning the nearest appropriate facility to the patient's home from the West Virginia Carrier.

### **B. More Than One Vehicle Used**

If more than one vehicle is used in transporting the patient to their destination, jurisdiction of the claim lies with:

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

### **C. Jurisdiction State to State**

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

#### **EXAMPLE**

A patient is picked up at John Hopkins Hospital in Baltimore, Maryland and transported to his/her home in Portland, Maine by an ambulance dispatched from the area of the patient's home. The carrier serving the point of origin of the ambulance, NHIC, Part B carrier of the state of Maine, has jurisdiction of any claim filed. In this case NHIC should have all the data necessary to make proper payment, i.e. certification of the ambulance company, price information and data pertaining to the nearest appropriate facility. Had an ambulance whose home station was in Baltimore been used, the carrier servicing Baltimore, Maryland would have jurisdiction.

## **COVERED SERVICES – GROUND**

### **Instructions to Accept and Process All Ambulance Transportation Healthcare Common Procedure Coding System (HCPCS) Codes**

Effective January 1, 2012, you will be able to submit "no-pay bills" to Medicare for statutorily excluded ambulance transportation services and transportation-related services, to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

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Change Request (CR) 7489, from which this is taken, announces that, effective January 1, 2012, Medicare FIs, carriers, and A/B MACs will revise their claims processing systems to begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily-excluded ambulance transportation services and transportation-related services. Medicare will then deny claims containing these codes as “non-covered,” which will allow you to submit the denied claim to a beneficiary’s secondary insurance for coordination of benefits purposes.

You should ensure that your billing staffs are aware of this change and the need to include the “GY” modifier with the HCPCS code identifying the excluded ambulance transportation service and transportation-related services. In addition, if you are a facility-based ambulance provider billing a CMS-1450 claim form or the electronic equivalent (837I), you should be aware that you need to bill using the following non-covered revenue codes: 541, 542, 544, 547, 549, as applicable to the excluded ambulance transportation and transportation related-services that you are billing.

Certain HCPCS codes identify various transportation services that are statutorily excluded from Medicare coverage and, therefore, not payable when billed to Medicare. In the Medicare Physician Fee Schedule Database (MPFSDB), a status indicator of “I” or “X” is associated with these codes. The “I” indicates that the HCPCS code is “Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services.” The “X” indicates a “statutory exclusion” of the code. (See the “Medicare Claims Processing Manual,” Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 30.2.2 (MPFSDB Status Indicators), available at

<http://www.cms.gov/manuals/downloads/clm104c23.pdf>

on the Centers for Medicare & Medicaid Services (CMS) website.)

Because HCPCS codes are valid codes under the Health Insurance Portability and Accountability Act (HIPAA), claims for ambulance transportation and transportation-related services (HCPCS codes A0021 through A0424 and A0998) that are statutorily excluded or otherwise not payable by Medicare should be allowed into the Medicare claims processing system for adjudication and, since these services are statutorily excluded from, or otherwise not payable by, Medicare, then denied as such. Doing so affords providers and suppliers submitting the claims on behalf of Medicare beneficiaries the opportunity to submit “no-pay bills” to Medicare for statutorily excluded or otherwise not payable by Medicare services with the HCPCS code that accurately identifies the service that was furnished to the Medicare beneficiary. This, in turn, will allow providers/suppliers to obtain a Medicare denial to submit to a beneficiary’s secondary insurance for coordination of benefits purposes.

If you wish to bill for statutorily-excluded ambulance transportation services and transportation-related services to obtain a “Medicare denial,” you should bill for such

services by attaching the “GY” modifier to the HCPCS code identifying the service, according to long-standing CMS policy. Additionally, if you are a facility-based ambulance provider submitting claims on the CMS Form-1450 or its electronic equivalent 837I, you should bill using the following non-covered revenue codes, depending on the statutorily-excluded ambulance transportation and/or transportation-related services that you are billing: 541, 542, 544, 547, 549.

When denying these claims for statutorily excluded services, your carrier, FI, or A/B MAC will use the following remittance advice language:

Claim Adjustment Reason Code - 96 - “Non-covered charge(s);”  
Remittance Advice Remark Code - N425 - “Statutorily excluded service(s);” and  
Group Code - PR - “Patient Responsibility.”

There are seven categories of ground ambulance services. The term “ground” refers to both land and water transportation. Medical necessity must be met for Medicare payment.

### **HCPCS A0428 – Ambulance service, BLS, non-emergency transport, all inclusive**

**Basic Life Support (BLS) – Non-emergency** – Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State or within a State. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

### **HCPCS A0429 – Ambulance service, BLS, emergency transport, all inclusive**

**Basic Life Support (BLS) Emergency** – When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, it responds immediately. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

**Application:** The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider’s/supplier’s dispatch protocol must meet, at a

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

### **HCCPS A0426 – Ambulance service, ALS1, non-emergency transport, specialized ALS services, all inclusive**

**Advanced Life Support, Level 1 (ALS1) Non-emergency** - ALS1 is transportation by ground ambulance vehicle, and the provision of, medically necessary supplies and services including an ALS assessment by ALS personnel or at least one ALS intervention.

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

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

**Advance Life Support Personnel** - Advance Life Support personnel is an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

- The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic **and** who is also certified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications
- The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and in accordance with State and local laws, possesses enhanced skills including the ability to administer additional interventions and medications.

**Advance Life Support Intervention** – Advanced life support (ALS) intervention is a procedure that is, in accordance with State and local laws, required to be performed by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic. An ALS intervention must be medically necessary to qualify for payment as an ALS level of service. An ALS intervention applies only to ground transports.

### **HCPCS A0427 – Ambulance service, ALS1, emergency transport, specialized ALS services, all inclusive**

**Advanced Life Support, Level 1 (ALS1) – Emergency** – When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, it responds immediately. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

### **HCPCS A0433 – Advanced Life Support, Level 2**

**Advanced Life Support, Level 2 (ALS 2)** – ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transportation and the provision of at least one of the ALS2 procedures listed below:

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

**Note:** The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS 2 procedure.

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

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between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

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

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

A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment. Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

### **HCPCS A0434 – Specialty Care Transport**

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

care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Effective for Dates of Service 1-1-07 and after the definition of Specialty care transport (SCT) has been changed to read “SCT is the *interfacility* transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.” For purposes of SCT payment, CMS considers a “facility” to include only a SNF or a hospital that participates in the Medicare program, or a hospital-based facility that meets CMS’ requirements for provider-based status. Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children’s hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute-care hospitals, and sole community hospitals (SCHs).

The EMT-Paramedic level of care is set by each State. Care above that level that is medically necessary and that is furnished at a level of service above the EMT-Paramedic level of care is considered SCT. That is to say, if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a State, then that service does **not** qualify for SCT. The phrase “EMT-Paramedic with additional training” recognizes that a State may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the State in furnishing higher level medical services required by critically ill or critically injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide.

“Additional training” means the specific additional training that a State requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

### **HCPCS A0432 – Paramedic Intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers**

**Paramedic Intercept (PI)** – Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. New York is currently the only state where these services are covered.

### **HCPCS A0425 – Ground mileage, per loaded mile**

### **HCPCS A0888 – Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond the closest appropriate facility)**

### Components of the Ambulance Fee Schedule

#### Ground Ambulance Services

1. Conversion Factor (CF) – A money amount used to develop a base rate for each level of ground ambulance service. The CF will be updated annually by the Ambulance Inflation Factor. The CF does not apply to mileage payment amounts.
2. Relative Value Unit (RVUs) – RVUs set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate. The RVUs are as follows:

<u>Service Level</u>	<u>RVU</u>
BLS	1.00
BLS – Emergency	1.60
ALS1	1.20
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. 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 (Point of Pickup (POP)) establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated or the applicable GPCI. 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 service is the CF multiplied by the applicable RVU. The GPCI is not applied to the ground mileage rate.

4. Mileage – The ambulance fee schedule provides a separate payment amount for mileage. For payment purposes the term mileage refers to loaded mileage or the number of miles for which the beneficiary is transported in the ambulance. Payment is adjusted upward for ambulance services that are furnished in rural areas to account for the higher cost per

## Ambulance Billing Guide

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ambulance trip. A rural area is defined as a U.S. Postal Service Zip code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA), or in 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.)

5. During the transition period, payment for separately billable supplies and ancillary services were calculated on the basis of the reasonable charge component of the blended rate only. Payment for these supplies is included in the base rates; therefore no separate payment is made under the fee schedule component. In 2005, the Medicare allowed amount was 20% of the reasonable charge. Beginning in 2006, supplies and ancillary services will no longer be separately billable.

### Rural Adjustment Factor (RAF)

The Rural Adjustment Factor (RAF) is an adjustment applied to the payment amount for ambulance services when the *POP* is in a rural area.

1. For ground ambulance services *furnished before July 1, 2004*, a 50 percent increase is applied to the urban ambulance *fee schedule* mileage rate for each of the first 17 miles of a rural POP.
2. For services furnished *on or after July 1, 2004*, a 50 percent increase is applied to the rural ambulance *fee schedule* mileage rate for each of the first 17 miles of a rural POP.
3. For services furnished *before January 1, 2004*, a 25 percent increase is applied to the urban ambulance *fee schedule* mileage rate for mileage between 18 and 50 miles of a rural POP; and the urban ambulance *fee schedule* mileage rate applies to every mile of a rural POP over 50 miles.
4. For services furnished *during the period January 1, 2004 through June 30, 2004*, the urban ambulance *fee schedule* mileage rate applies to every mile of a rural POP over 17 miles.
5. For services furnished *on or after July 1, 2004*, the rural ambulance *fee schedule* mileage rate applies to every mile of a rural POP over 17 miles (and this amount is used when applying the bonus amount for long rural trips, as described below).
6. For services furnished *during the period July 1, 2004 through December 31, 2009*, the base rate portion of the payment under the *fee schedule* for ground ambulance transports furnished in certain rural areas is increased by an amount to be determined by CMS. This increase applies where the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density.

## Ambulance Billing Guide

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7. For services furnished *during the period July 1, 2004 through December 31, 2008*, a 25 percent increase is applied to the appropriate ambulance fee schedule mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).

### **Regional Ambulance Fee Schedule (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:

<b>Year</b>	<b>National FS Percentage</b>	<b>Regional FS Percentage</b>
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.

### **Ambulance Inflation Factor (AIF)**

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.

## Ambulance Billing Guide

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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
<b>2012</b>	<b>2.4</b>

## Calculations

### HOW TO CALCULATE AMBULANCE MILEAGE ALLOWANCES

Ground Mileage Procedure Code A0425			
Zip Code Designation	Pricing Period	Quantity	AFSDB Component Calculation
Urban	7/1/04 and After	Miles 1-50	Urban AFSDB
Rural or Super Rural	7/1/04 to 12-31-06	Miles 51+	125% X Urban AFSDB
		Miles 1-17	150% X Rural AFSDB
"R" or "B" Status zip codes*	1-1-07 and After	Miles 18-50	Rural AFSDB
		Miles 51+	125% X Rural AFSDB
		Miles 1-17	150% X AFSDB
		Miles 18 - 50	AFSDB
		Miles 51+	125% X Urban AFSDB

\*A "B" designation (super rural) indicates that the ZIP code is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density.

## Ambulance Billing Guide



2005 Dates of Service	2006 Dates of Service	2007 Dates of Services to December 31, 2008
<p><b>Example: miles</b>                      Fee schedule (FS) = 80 %                      Reasonable charge (RC) = 20% (lower of 75<sup>th</sup>, 50<sup>th</sup> or IIC)                      FS is \$5.90 Urban RC is \$6.80 Rural RC is \$5.96</p>	<p><b>Example: miles</b>                      Fee schedule (FS) = 100 %                      Urban FS is \$5.90 Rural FS is \$5.96</p>	<p><b>Example miles</b>                      Fee schedule (FS) = 100 %                      AFSDB FS is \$5.90</p>
<p><b>How to calculate 10 urban miles:</b>                      FS: <math>\\$5.90 \times 10 = \\$59.00 \times 80\% = \\$47.20</math>                      RC: <math>\\$6.80 \times 10 = \\$68.00 \times 20\% = \\$13.60</math>                      Total allowance is <math>\\$47.20 + \\$13.60 = \\$60.80</math></p>	<p><b>How to calculate 10 urban miles:</b>                      FS: <math>\\$5.90 \times 10 = \\$59.00</math>                      Total allowance is \$59.00</p>	<p><b>How to calculate 10 urban miles:</b>                      AFSDB: <math>\\$5.90 \times 10 = \\$59.00</math>                      Total allowance is \$59.00</p>
<p><b>How to calculate 60 urban miles:</b>                      FS: <math>\\$5.90 \times 50 = \\$295.00</math>  <math>\\$5.90 \times 125\% = \\$7.38 \times 10 = \\$73.80</math>                      Total <math>\\$295.00 + \\$73.80 = \\$368.80 \times 80\% = \\$295.04</math>                      RC: <math>\\$6.80 \times 60 = \\$408.00 \times 20\% = \\$81.60</math>                      Total allowance is <math>\\$295.04 + \\$81.60 = \\$376.64</math></p>	<p><b>How to calculate 60 urban miles:</b>                      FS: <math>\\$5.90 \times 50 = \\$295.00</math>  <math>\\$5.90 \times 125\% = \\$7.38 \times 10 = \\$73.80</math>                      Total <math>\\$295.00 + \\$73.80 = \\$368.80</math>                      Total allowance is \$368.80</p>	<p><b>How to calculate 60 urban miles:</b>                      AFSDB: <math>\\$5.90 \times 50 = \\$295.00</math>  <math>\\$5.90 \times 125\% = \\$7.38 \times 10 = \\$73.80</math>                      Total <math>\\$295.00 + \\$73.80 = \\$368.80</math>                      Total allowance is \$368.80</p>
<p><b>How to calculate 10 rural or super rural miles:</b>                      FS: <math>\\$5.96 \times 150\% = \\$8.94 \times 10 = \\$89.40 \times 80\% = \\$71.52</math>                      RC: <math>\\$6.80 \times 10 = \\$68.00 \times 20\% = \\$13.60</math>                      Total allowance is <math>\\$71.52 + \\$13.60 = \\$85.12</math></p>	<p><b>How to calculate 10 rural or super rural miles:</b>                      FS: <math>\\$5.96 \times 150\% = \\$8.94 \times 10 = \\$89.40</math>                      Total allowance is \$89.40</p>	<p><b>How to calculate 10 rural ("R" status) or super rural ("B" status) miles:</b>                      AFSDB: <math>\\$5.90 \times 150\% = \\$8.85 \times 10 = \\$88.50</math>                      Total allowance is \$88.50</p>
<p><b>How to calculate 60 rural or super rural miles:</b>                      FS: <math>\\$5.96 \times 150\% = \\$8.94 \times 17 = \\$151.98</math>  <math>\\$5.96 \times 33 = \\$196.68</math>  <math>\\$5.96 \times 125\% = \\$7.45 \times 10 = \\$74.50</math>  <math>\\$151.98 + \\$196.68 + \\$74.50 = \\$423.16 \times 80\% = \\$338.53</math>                      RC: <math>\\$6.80 \times 60 = \\$408.00 \times 20\% = \\$81.60</math>                      Total allowance is <math>\\$338.53 + \\$81.60 = \\$420.13</math></p>	<p><b>How to calculate 60 rural or super rural miles:</b>                      FS: <math>\\$5.96 \times 150\% = \\$8.94 \times 17 = \\$151.98</math>  <math>\\$5.96 \times 33 = \\$196.68</math>  <math>\\$5.96 \times 125\% = \\$7.45 \times 10 = \\$74.50</math>  <math>\\$151.98 + \\$196.68 + \\$74.50 = \\$423.16</math>                      Total allowance is \$423.16</p>	<p><b>How to calculate 60 rural ("R" status) or super rural ("B" status) miles:</b>                      AFSDB: <math>\\$5.90 \times 150\% = \\$8.85 \times 17 = \\$150.45</math>                      AFSDB: <math>\\$5.90 \times 33 = \\$194.70</math>                      AFSDB: <math>\\$5.90 \times 125\% = \\$7.38 \times 10 = \\$73.80</math>                      Total <math>\\$150.45 + \\$194.70 + \\$73.80 = \\$418.95</math>                      Total allowance is \$418.95</p>

## Ambulance Billing Guide

### HOW TO CALCULATE GROUND TRANSPORT ALLOWANCES

<b>Ground Transport Codes A0426-A0429, A0433-A0434, (Q3019-Q3020 thru 12-31-05)</b>			
<b>Zip Code Designation</b>	<b>Pricing Period</b>	<b>Quantity</b>	<b>AFSDB Component Calculation</b>
Urban	7/1/04 and After	All	Urban AFSDB
Rural	7/1/04 and 12-31-06	All	Rural AFSDB
Super Rural	1-1-07 to 12-31-09	All	AFSDB
"B" (Super rural) status zip codes POP	7/1/04 and 12-31-06	All	122.6% X Rural AFSDB
	1-1-07 to 12-31-09	All	122.6% X AFSDB

<b>2005 Dates of Service</b>	<b>2006 Dates of Service</b>	<b>2007 Dates of Service to December 31, 2009</b>
<p><b><u>Example: Ground Transportation</u></b>                      Fee schedule (FS) = 80%                      Reasonable charge (RC) = 20% (lower of 75<sup>th</sup>, 50<sup>th</sup>, or IIC)                      FS is \$403.43    Urban RC is \$220.91                      Rural RC is \$407.43</p>	<p><b><u>Example: Ground Transportation</u></b>                      Fee schedule (FS) = 100%                      FS is \$403.43    Urban RC is \$220.91                      Rural RC is \$403.43</p>	<p><b><u>Example: Ground Transportation</u></b>                      Fee schedule (FS) = 100%                      AFSDB is \$403.43</p>
<p><b><u>How to calculate urban ground transportation:</u></b>                      FS: \$403.43 x 80% = \$322.74                      RC: \$220.91 x 20% = \$ 44.18                      Total allowance is \$322.74 + \$44.18 = \$366.92</p>	<p><b><u>How to calculate urban ground transportation:</u></b>                      FS: \$403.43 x 100% = \$403.43                      Total allowance is \$403.43</p>	<p><b><u>How to calculate urban ground transportation:</u></b>                      AFSDB: \$403.43 x 100% = \$403.43                      Total allowance is \$403.43</p>
<p><b><u>How to calculate rural ground transportation:</u></b>                      FS: \$407.43 x 80% = \$325.94                      RC: \$220.91 x 20% = \$44.18                      Total allowance is \$325.94 + \$44.18 = \$370.12</p>	<p><b><u>How to calculate rural ground transportation:</u></b>                      FS: \$407.43 x 100% = \$407.43                      Total allowance is \$407.43</p>	<p><b><u>How to calculate rural ground transportation:</u></b>                      AFSDB: \$407.43 x 100% = \$407.43                      Total allowance is \$407.43</p>
<p><b><u>How to calculate super rural ground transportation:</u></b>                      FS: \$407.43 x 122.6% = \$499.51 x 80% = \$399.61                      RC: \$220.91 x 20% = \$44.18                      Total allowance is \$399.61 + \$44.18 = \$443.79</p>	<p><b><u>How to calculate super rural ground transportation:</u></b>                      FS: \$407.43 x 122.6% = \$499.51                      Total allowance is \$499.51</p>	<p><b><u>How to calculate "B" status zip code ground transportation</u></b>                      AFSDB: \$407.43 x 122.6% = \$499.51                      Total allowance is \$499.51</p>

## **THE BILLING PROCESS**

### **Electronic Billing**

Electronic billing file format can be found in “The Implementation Guide for Health Claim: Professional 837; Guide and V4010A1 Addenda” at <http://www.wpc-edi.com> . The “J14 Part B Medicare FFS 5010A1 Companion Guide” and “Matrix-5010A1 837/276 requirements” can be found at [http://www.medicarenhic.com/ne\\_prov/edi\\_guides.shtml](http://www.medicarenhic.com/ne_prov/edi_guides.shtml).

Programmers should utilize these documents in developing software for Medicare Part B electronic claim submission. In development of electronic claims submission programs for ambulance providers, programmers should give special consideration to the following fields:

### **005010X222A1 Health Care Claim: Professional**

<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Notes/Comments</b>	<b>Category</b>
2300	CR102	Patient Weight	The maximum number of characters to be submitted in the patient weight field is four characters to the left of the decimal and two characters to the right. Patient weight in excess of 9,999.99 pounds will be rejected.	2
2300	CR106	Transport Distance	The maximum number of characters to be submitted in the transport distance is four characters. Transport distance in excess of 9,999 miles will be rejected.	2
2400	QTY02	Ambulance Patient Count	Must be between 1 and 99. Submission of a value less than 1 or greater than 99 will cause your claim to reject.	2
2000B	PAT08	Patient Weight	The maximum number of characters to be submitted in	2

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			the patient weight field is four characters to the left of the decimal and two	
2400	CR3 - Segment Rule	Transport Distance	The maximum number of characters to be submitted in the transport distance is four characters. Transport distance in excess of 9,999 miles will be rejected.	2
2300/ 2400	CR1 Segment	Condition Codes	01 Patient admitted to hospital 04 Patient moved by stretcher 05 Patient unconscious/shock 06 Patient trans. in emerg. sit. 07 Patient physically restrained 08 Patient visibly hemorrhaging 09 Amb. svc. medically necess. 12 Patient confined to bed/chair (use code 12 to indicate patient was bedridden during transport)	

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources of use during the 5010 transition year.

ASC X12 TR3 Implementation Guides	<a href="http://store.x12.org">http://store.x12.org</a>
Washington Publishing Company Health Care Code Sets	<a href="http://www.wpc-edi.com/content/view/711/401/">http://www.wpc-edi.com/content/view/711/401/</a>
Central Version 005010 and D.0 Webpage on CMS website	<a href="http://www.cms.gov/Versions5010andD0/">http://www.cms.gov/Versions5010andD0/</a>
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	<a href="http://www.cms.gov/MFFS5010D0/">http://www.cms.gov/MFFS5010D0/</a>
Frequently Asked Questions	<a href="http://questions.cms.hhs.gov/app/answers/list/kw/5010">http://questions.cms.hhs.gov/app/answers/list/kw/5010</a>
To request changes to HIPAA adopted standards	<a href="http://www.hipaa-dsmo.org/">http://www.hipaa-dsmo.org/</a>

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Effective for claims submitted in the version 5010 837P electronic claim format on and after January 1, 2011, ambulance suppliers will have three options for complying with the new diagnosis reporting requirement.

**Option 1:** Suppliers may choose a code or codes from the Medical Conditions List provided by CMS that corresponds to the condition of the beneficiary at the time of pickup and report the code(s) in the diagnosis field on the claim. The Medical Conditions List and instructions for using this list can be found in the Medicare Claims Processing Manual, Chapter 15, Section 40, "Medical Conditions List and Instructions," available at

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

on the CMS website. The codes in the medical conditions list are taken from the International Classification of Diseases, 9<sup>th</sup> revision, Clinical Modification (ICD-9CM) diagnosis code set. Suppliers must continue to accurately maintain transport records to support any data reported on the claim.

**Option 2:** Suppliers may report an ICD-9 (or ICD-10 when appropriate) diagnosis code that is provided to them by the treating physician or other practitioner.

**Option 3:** Suppliers may report ICD-9 diagnosis code 799.9 (unspecified illness).

Note: Effective October 1, 2013, the new ICD-10 diagnosis code set will be implemented, thus making the ICD-9 code set obsolete.

Suppliers choosing Options 1 or 3 will be given further guidance upon implementation of the new code set.

Suppliers choosing Option 2 should ensure that they are provided with the appropriate ICD-10 diagnosis code for dates of service on and after October 1, 2013.

### Paper Billing

CMS 1500 - Instruction on the proper completion of the CMS 1500 claim form can be found in the "Introduction to Medicare" and/or "1500 Claim Form Instructions" at [http://www.medicarenhic.com/ne\\_prov/publications.shtml](http://www.medicarenhic.com/ne_prov/publications.shtml) for New England providers. Providers should follow the instructions outlined in either of these two publications. Special consideration should be made to the following fields for claim submission by ambulance providers:

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ITEM #	DATA TO INCLUDE
<b>Item 19</b>	Although not mandated by CMS some ambulance providers utilize this item to give us information regarding the patient's condition at the time of transports and/or justification for ALS1, ALS2 or SCT transports or facility to facility transports.
<b>Item 23</b>	CMS mandates the entry of the "zip code" for the point of pick up in this field. Since the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Supplies must prepare a separate claim for each trip if the points of pickup are located in different ZIP codes. Claims without a ZIP code in item 23, or with multiple ZIP codes in item 23, will be returned as unprocessable.
<b>Item 24G</b>	# of loaded miles
<b>Item 32</b>	Although not mandated by CMS some ambulance providers utilize this item to give us the names, city, state and zip codes for the points of pick up and destination.

The CMS 1500 claim form may be ordered from an office supply store or one of the following organizations:

US Government Printing Office  
 Superintendent of Documents  
 Washington, DC 20402  
 202-512-1800

American Medical Association  
 Attention: Order Department  
 PO Box 10946  
 Chicago, IL 60610  
 800-621-8335

### **CMS 1491**

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

*For claims with Dates of Receipt prior to April 2, 2007:*

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Instructions for the proper completion of the CMS 1491 claim form can be found in section 30.1.3 of IOM 100-4, chapter 15 In addition to the outlined instructions, special consideration should be given to the following fields:

- The service HCPCS code is entered into item 22 as well as any information necessary to describe the illness or injury.
- The mileage HCPCS code is entered into item 14 as well as the number of loaded miles. If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code “1” as the mileage for trips less than a mile
- The ZIP code of the point of pickup must be entered in item 12. If there is no ZIP code in item 12 or if there are multiple ZIP codes in item 12, carriers return the claim as unprocessable.

### Beneficiary Signature Requirement

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, a representative payee, relative, friend, representative of the institution providing care, or a government agency providing assistance may sign on his/her behalf. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment. (Note: there is a 15 to 27 month period for filing a Medicare claim, depending upon the date of service.)

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

### Mandatory Assignment

The Balance Budget Act of 1997 added section §1834(1) of the Social Security Act which requires mandatory assignment for all ambulance services. Mandatory assignment means ambulance suppliers must accept the Medicare allowed amount as payment in full and may not bill or collect

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from the beneficiary any amount other than unmet deductible and/or coinsurance amounts and non-covered services.

### Mileage Codes

Ambulance suppliers should not break down their mileage codes (except when billing for covered and non-covered mileage) on a claim. When rural miles are reported, suppliers should bill mileage codes on one line for mileage per trip. When billing for a round trip on the same claim, ambulance suppliers should two (2) lines for mileage – one line per trip (only if both zip originate in the same zip code area).

### Origin and Destination Modifiers

Two single digit modifiers **must** be used with ambulance service codes A0425 through A0436 to identify both the point of origin and the destination. The first single digit modifier indicates the point of origin. The second single digit modifier indicates the destination.

**\*\*To avoid delays in processing, procedure codes A0425 thru A0436 are the only codes that require the origin/destination modifiers.**

This especially helps when round trips or two trips in one day occur. Each trip must be coded on a separate claim; therefore, the modifiers help us to identify the differences in the two services. The only time that CMS allows two trips to be reported on the same claim is if the zip code for the point of pick up for both trips is the same.

Example:

24. A.		B.	C.	D.		E.
DATE(S) OF SERVICE FROM TO		PLACE of	TYPE of	PROCEDURES, SERVICES, SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS
MM DD YY	MM DD YY	SERVICE	SERVICE	CPT/HCPCS	MODIFIER	CODE
02022005	02022005	41		A0428	RH	2
02022005	02022005	41		A0425	RH	2
02022005	02022005	41		A0428	HR	2
02022005	02022005	41		A0425	HR	2

**\*\*\*NOT ALL MODIFIER COMBINATIONS ARE COVERED BY MEDICARE.\*\*\***

These single digit modifiers are defined as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than "P" or "H" (includes free-standing facilities).
E	Residential, domiciliary, custodial facility (includes non-participating facilities).

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G	Hospital-based dialysis facility (hospital or hospital-related).
H	Hospital (includes OPD or ER)
I	Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transfer
J	Non hospital-based dialysis facility (free standing).
N	Skilled Nursing Facility (Medicare participating only).
P	Physician's office.
R	Residence
S	Scene of accident or acute event.
X	Intermediate stop at physician's office on the way to the hospital (destination only)

**Note:** Modifier E applies to Assisted Living and nursing facilities.

### Place of Service Codes

The following place of service codes apply to ambulance transports:

- Ambulance – Land 41
- Ambulance – Air or water 42

### Zip Codes

Payment for ambulance services is based on the zip code at the point of pickup. The five-digit zip code determines both the applicable GPCI and whether a rural adjustment applies. When billing for round trip transports, you may submit both legs of the trip on one (1) CMS-1500 claim form if the point of pickup zip code is the same for both legs of the trip. If the zip code is different, you must submit the trips on separate claim forms.

For points of pickup outside of the United States or in United States territorial waters, suppliers should report the point of pickup zip code according to the following:

- For ground or air transport outside of the United States to a drop off outside of the United States (in Canada or Mexico), use the closest United State zip code to the point of pickup.
- For water transport from the territorial waters of the United States to the United States, use the zip code of the port of entry.
- For ground transport from Canada or Mexico to the United States, use the zip code at the United States border at the point of entry into the United States.
- For air transport from areas outside the United States to the United States, use the zip code at the United States border at the point of crossing into the US.

### Point of Pickup (POP)

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

### Area without a Zip Code

For areas without a zip code, it is the supplier's responsibility to confirm that the point-of-pickup does not have a zip code that has been assigned by the U.S. Postal Service (USPS). If the supplier has made a good-faith effort to confirm that no zip code for the point-of-pickup exists, use the zip code nearest to the point of pickup.

Suppliers should document their confirmation with the USPS, or other authoritative source, that the point of pickup 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"). Suppliers should maintain this documentation and provide it to the carrier upon request.

### New Zip Codes

New zip codes are considered urban until CMS determines that the zip code is located in a rural area. However, despite the default designation of new zip codes as urban, the carriers have discretion to determine that a new zip code is rural until designated otherwise. If the carrier designates a new zip code as rural, and CMS later changes the designation to urban, then the carrier as well as any supplier paid for mileage or for air services with a rural adjustment will be held harmless for this adjustment.

### Reporting Inaccurate Zip Code Information

Suppliers who knowingly and willfully report a surrogate zip code because they do not know the proper zip code may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a 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.

For suppliers submitting claims using the CMS 1500 claim form, the five-digit zip code would be entered in item 23. When reporting claims using the CMS 1491, report the five-digit zip code in item 12. Zip code information may be found at the United States Postal Service website at [www.usps.com](http://www.usps.com).

## DOCUMENTATION

When submitting a claim to NHIC for payment, or appeals, it is essential that providers supply claims information that will substantiate (1) *the patient's need to be transported by ambulance, versus other forms of transportation*, and (2) the level of service utilized. The provider can make use of the following field(s) to communicate this information:

- ICD-9-CM codes, or a written description of the patient's condition at the time of transport (See Medical Condition List in Appendix A)
- CMS 1491 – item 22
- CMS 1500 – item 21
  - Electronically

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- Written description in narrative fields
- ICD-9 CM codes fields (H101-2, H102-2, H103-2, H104-2)
- Narrative fields (NTE02, CR109 and/or CR110)
- Transportation Indicators (enter in narrative field NTE02) (voluntary)
- Condition Indicators (CRC03 – CRC07) (voluntary)
- Type of Transport Indicator (CR103)
- Reason for Transport Indicator (CR104)
- Attachments to a paper claim (for appeals)

In order to determine the medical appropriateness of air ambulance services the carrier may request that documentation be submitted that indicates the air ambulance services are reasonable and necessary to treat the beneficiary's life-threatening condition.

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

### Transportation Indicators

When a claim is submitted for payment, one of the transportation indicators below may be included (however they are not required) 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 should place the transportation indicator in the "narrative" field (NTE02) on the claim.

#### Air and Ground

- **Transportation Indicator "C1":** Transportation indicator "C1" indicates an inter-facility 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 Medical Condition List, as well as the exact service needed by the patient that was unavailable at the originating facility.
- **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 Medical Condition List. In addition, the information about what service the patient requires that was not available at the originating facility 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

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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 indicator 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 appears 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 should include this information in the narrative field (NTE02) on the claim.

Example:

**C2 - D/C from 1<sup>st</sup> fac ADM to 2<sup>nd</sup> fac  
For heart cath not available at 1<sup>st</sup> fac**

### 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-year-old 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 mellitus. 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. This does not apply to self-administered medications. This 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 Medical Conditions 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.

- **Transportation Indicator D1-** Transportation indicator "D1" is used to convey that the decision to use air ambulance was due to "Long Distance." The patient's condition requires rapid transportation over a long distance.
- **Transportation Indicator D2-** Transportation indicator "D2" is used to convey that the decision to use air ambulance was due to "rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required."
- **Transportation Indicator D3-** Transportation indicator "D3" is used to convey that the decision to use air ambulance was due to "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. "
- **Transportation Indicator D4-** Transportation indicator "D4" is used to convey that the decision to use air ambulance was due to "Pick up point not accessible by ground transportation."

## Medical Condition List

The Medical Conditions List is intended primarily as an educational guideline. It will help providers to communicate the patient's condition as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers

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must retain adequate documentation of dispatch instructions, patient's condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on claim and/or medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical conditions list information by themselves is not sufficient to justify coverage.

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.

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 should be used by an ambulance provider to provide information that 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 (CMS 1491) does provide space for the use of multiple ICD-9-CM codes. Please see the example below:

EX: 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.

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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 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. 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 the claim is reviewed, the Medicare Carrier will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

The complete "Medical Condition List" can be found at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf>.

### Physician Certification Statement (PCS) Requirements

A Physician Certification Statement (PCS) is a written order that certifies the need for ambulance transportation. The certification itself is not the sole factor used in determining whether payment for ambulance services will be allowed. Ambulance services must meet all other coverage criteria in order for payment to be made.

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Non-emergency ambulance services are categorized as scheduled or non-scheduled. A physician certification statement (PCS) is required for all:

- Non-emergency **repetitive** scheduled transports (must be signed by the patients MD)
- Non-emergency, non-repetitive scheduled transports; and
- Certain non-emergency non-scheduled ambulance services.

### Repetitive Ambulance Services

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary. However, the requirement for submitting the PCS form for non-emergency repetitive, scheduled, ambulance services is based on the quantitative standard (three or more times during a ten-day period or at least once per week for at least three weeks). Similarly, regularly scheduled ambulance services for follow-up visits, whether routine or unexpected, are not “repetitive” for purposes of the requirement unless one of the quantitative standards is met.

**Scheduled** is defined as transports arranged more than 24 hours prior to patient transports.

**Non-Scheduled** is defined as those transports scheduled less than 24 hours in advance.

**Note:** Patients residing in a facility not under the active care of a physician or those beneficiaries residing at home would not require physician certification statements for non-emergency non-scheduled ambulance services.

The physician certification statement for any transportation other than a non-emergency repetitive, scheduled transport may be completed and signed by the following medical professionals:

- The patient’s attending physician (MD or DO);
- Physician Assistant (PA);
- Nurse Practitioner (NP);
- Clinical Nurse Specialist (CNS);
- Register Nurse (RN); or
- A discharge planner employed by the hospital or facility where the beneficiary is treated, with knowledge of the beneficiary’s condition at the time the transport was ordered or the service was rendered.

CMS does not require a particular form or format for the certification. Suppliers and physicians may develop a certification form. Suppliers may use computer-generated PCS forms and computerized physician signatures to meet the PCS requirements. The written order (regardless of the format used) must be completed by the attending physician or specific professionals listed above. Ambulance company employees must not complete forms on behalf of these individuals.

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The physician certification statement may include the expected length of time ambulance transport would be required. The following chart describes when certification is required.

Nature of Transport	Physician Certification Statement Required	Time Frame
Non-Emergency Repetitive Scheduled	Yes	No earlier than 60 days
Non Emergency Non-Repetitive – Scheduled	Yes	Within 48 hours
Non Emergency Services – Non Scheduled - Under direct Care of a Physician	Yes	Within 48 hours
Non Emergency Services – Non Scheduled - Not under direct care of a Physician	No	Not Required

Suppliers are not required to submit the physician certification statements with the claims. In all cases, the certification and appropriate documentation must be kept on file and, upon request, presented to the carrier. The presence or absence of the physician certification statement does not necessarily prove or disprove whether the ambulance was medically necessary.

Physician certification would not be required when an ambulance service is downgraded by the carrier from an emergency to non-emergency services. For non-emergency ambulance services that are either non scheduled or that are scheduled on a non-repetitive basis, providers/suppliers must obtain a written order from the attending physician within 48 hours of the transport. If unable to obtain a written order from the attending physician within 48 hours, providers/suppliers may submit a claim for the service if a PCS or certificate from an acceptable alternative person has been obtained or after 21 days if acceptable documentation of attempts to obtain the certification has been obtained.

Documentation of the attempt must include a signed return receipt from a US Postal Service or other similar delivery service. The receipt will serve as proof that the supplier attempted to obtain the required signature from the attending physician.

### Abbreviations

NHIC recognizes the fact that providers may use abbreviations in the documentation of the patient's condition. NHIC has provided the following table of abbreviations as a tool for documentation. NHIC claims examiners use the chart below to help them decipher comments included on ambulance claims. The use of these abbreviations by providers is not a requirement of claim submission.

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Abbreviation	Description
5150	Involuntary psychiatric hold issued only by law enforcement in the field, ER physician in the hospital setting or a Psychiatrist in any setting. A legally binding action that requires the restraint and protection of the patient who is deemed a danger to himself or others.
<u>ac</u>	Before Meals
ad lib	At Liberty
ADM	Admitted
AKA	Above Knee Amputation
ALOC	Alter Level Of Conscious
ASHD	Arteriosclerotic Heart Disease
Bid	2 X A Day
BKA	Below Knee Amputation
CA	Cancer
CBC	Complete Blood Count
CHD	Coronary Heart Disease
CHF	Congestive Heart Failure
cl. liq	Clear Liquid Diet
COF	Physician Certificate Statement on file at provider office

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<u>COPD</u>	Chronic Obstructive Pulmonary Disease
CVA	Cerebrovascular Accident
d	Day
D/C	Discharged
dx	Diagnosis
FBS	Fasting Blood Sugar
fuo	Fever Of Unknown Origin
GCS	Glasgow Coma Scale
h	Hour
Hct	Hematocrit
Hgb	Hemoglobin
hs	Bed Time
hx	History
im	Intramuscular
iv	Intravenous
I&O	Intake And Outtake
m with a circle around it	Murmur

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MI	Myocardial Infarction
MRSA	Methicillin Resistant Staphalococci Aureus
npo	Nothing By Mouth
o	Other
ORSA	Oxacillin Resistant Staph Aureus
pc	After Meals
PCS	Physician Certification Statement
po	By Mouth
prn	As Needed
q	Every
qid	4 X A Day
RBC	Red Blood Cell
r	Rectal
r/o	Rule Out
rx	Prescription
sl	Sub Lingual
SOB	Short Of Breath

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sq	Subcutaneous
TIA	Transient Ischemic Attack
tid	3 X A Day
tko	To Keep Open
TPR	Temp., Pulse, Resp.
VRE	Vancomycin Resistant enterobacter
VRSA	Vancamycin Resistant Staph Aureus
WBC	White Blood Cell

## AIR AMBULANCE

Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, carriers approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate.

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.

There are two categories of air ambulance services; fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

### Coverage Requirements

Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if:

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- The vehicle and crew requirements are met;
- The beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either
  - The point of pick-up is inaccessible by ground vehicle, or
  - Great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.

As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary's illness/injury, carriers should consider air transportation to be appropriate.

### Medical Appropriateness

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

- Intracranial bleeding – requiring neurosurgical intervention;
- Cardiogenic shock;
- Burns requiring treatment in a burn center;
- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries, or
- Life-threatening trauma.

### Procedure Codes for Air Services

#### **HCPSC A0430 – Ambulance service, conventional air services, transport, one way, fixed wing**

**Fixed Wing (FW) Air Ambulance** – Fixed wing air ambulance is the transportation by an aircraft that is certified by the Federal Aviation Administration (FAA) as a fixed wing air ambulance including the provision of medically necessary services and supplies.

#### **HCPSC A0431 – Ambulance service, conventional air services, transport, one way, rotary wing**

**Rotary Wing (RW) Air Ambulance** – Rotary wing air ambulance is the transportation by a helicopter that is certified by the FAA as a rotary wing ambulance, including the provision of medically necessary supplies and services.

### **HCCPS A0435 – Fixed Wing air mileage – per statute mileage**

### **HCCPS A0436 – Rotary Wing air mileage- per statute mileage**

### **Billing for Air Mileage**

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, rollout upon landing and taxiing after landing. Additional air mileage may be allowed 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.

### **Air Ambulance Claims Jurisdiction**

For Dates of Service prior to January 1, 2008, Air ambulance suppliers must be submitted to the carrier that has jurisdiction for the locality in which its air ambulance is based (i.e. garaged or hangared). Payment of a claim during the transition period (4-1-02 through 12-31-05) is determined in part by the reasonable charge amount established in the carrier jurisdiction where the ambulance is based and in part by the fee schedule amount in the jurisdiction of the point-of-pickup, as represented by its zip code.

For suppliers that provide services in multiple states, no additional enrollment is necessary for claims submission until the end of the transition period unless the supplier has established a base in another state. If the supplier has established a base/hangar in another state, it must enroll with the carrier for the state. The carrier with jurisdiction for the claim has the supplier's reasonable charge amount and also the fee schedule amounts for the states in which the ambulance supplier provides services to determine the blended payment.

Effective, January 1, 2008 CR 5203 changes ambulance jurisdiction as of 1-1-08. A claim for an ambulance service furnished by a supplier within the United States must be filed with the carrier having jurisdiction for the point of pickup (POP).

Effective April 1, 2007, carriers will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction. For claims with dates of service January 1, 2008 and later, carriers will return claims as unprocessable any claim for a ground or air ambulance service where the POP is not within its jurisdiction.

Where the POP is outside of the United States, the claim for an ambulance service furnished by a supplier must be filed in accordance with the instructions in Publication 100-4 Chapter 1 § 10.1.4.1. Carrier jurisdiction is defined in Publication 100-4 Chapter 1 § 10.1.4.2.

### Payment for Air Ambulance

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services. Also, air ambulance services have no RVUs. The Geographic Adjustment Factor (GAF) is applied in the same manner to air ambulance as ground services. However, for air ambulance services, the applicable GPCI is applied to 50% of each of the base rates (fixed and rotary wing).

### Air Ambulance Rural Adjustments

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 the rural adjustment is an increase of 50 percent to the unadjusted fee schedule amount, e.g., 1.5 times both the applicable air service base rate and the total mileage amount.

### Time Needed for Ground Transport When Considering Air Transports

Differing Statewide Emergency Medical Services (EMS) systems determine the amount and level of basic and advanced life support ground transportation available. However, there are very limited emergency cases where ground transportation is available but the time required to transport the patient by ground as opposed to air endangers the beneficiary's life or health. As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary's illness/injury, contractors should consider air transportation to be appropriate.

### Hospital to Hospital Air Transport

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

### Special Coverage Rule

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

### Medical Review of Rural Air Ambulance Service

Payment for rural air ambulance services is appropriate only when the request for transport was made by a physician or other qualified medical personnel who reasonably determined or

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certified that the individual's condition required air transport due to time or geographical factors. The following should be considered to be personnel qualified to order air ambulance services:

- Physician,
- Registered nurse practitioner (from the transferring hospital),
- Physician's assistant (from transferring hospital),
- Paramedic or EMT (at the scene), and
- Trained first responder (at the scene).

### **Air Ambulance Transports Canceled Due to Weather or Other Circumstances beyond the Pilot's Control.**

If the flight is cancelled prior to loading the beneficiary on board, either prior to or after take off to the point of pickup, no coverage is available. If the flight is aborted after the beneficiary is loaded, payment is made for the appropriate air base rate, mileage and rural adjustment.

### **Billing for Ground to Air Ambulance Transports**

For situations in which a beneficiary is transported by ground ambulance to or from an air ambulance, the ground and air ambulance suppliers providing the transports must bill Medicare independently. Under these circumstances, Medicare pays each supplier individually for its respective services and mileage.

### **Special Payment Limitations**

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

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

## **SPECIAL COVERAGE CONSIDERATIONS**

### **BLS/ALS Joint Responses**

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the definition of an ALS intervention, the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their intermediary or carrier upon request. Medicare does not regulate the compensation between the BLS and ALS entities. The written agreement must be

## Ambulance Billing Guide

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in place prior to submitting the Medicare claim. If no agreement between the BLS and the ALS entity exist, then only the BLS level of payment may be made. The ALS entity’s services are not covered and the beneficiary is liable for such expenses.

### Dialysis Transports

A beneficiary receiving maintenance dialysis on an outpatient basis does not ordinarily require ambulance transportation for dialysis treatment, whether the facility is an independent enterprise or part of a hospital. Ambulance services furnished to a maintenance dialysis patient are not payable unless documentation submitted with the claim shows that the patient’s condition required ambulance services and the facility meets the destination requirements. Claims for non-routine round trip ambulance services to outpatient dialysis facilities must document medical necessity.

### Dry Runs, or Billing for Denial

The Medicare Ambulance Benefit is a transportation benefit. If no transportation occurs there is no benefit. It is not a covered service under Medicare. This is typically referred to as a “dry run.” You may bill the patient directly for services and/or supplies associated with a “dry run.” Medicare does not need to receive a bill for a “dry run.” If requested by the patient, or if a formal Medicare denial of such services is necessary for secondary billing you may submit a claim to Medicare for denial. Please bill all service lines with a **“GY” modifier only and entered “Dry Run – billing for denial only” in the comments field (NTE02).**

Example:

DATE OF SERVICE			PART of Service	TYPE of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIERS	DIAGNOSIS CODE	\$ CHARGES	OR Family UNITS/Plan
From MM DD YY	To MM DD YY							
02022006	02022006	41		A0428	GY	1		1
02022006	02022006	41		A0425	GY	1		25

### Facility to Facility Transports

Billing for Facility to Facility transports requires additional claims documentation. The provider will need to submit the following with the claim:

- As always submit information that answers the question “why an ambulance was needed to transport the patient versus any other form of transportation”
- Patient status information
  - Indicate if the patient has been “discharged” from the first facility and “admitted” to the second facility
  - If the patient retains “inpatient” status from the sending facility the facility should be billed not Part B.

- Name and type of facilities
- Exact reason for transfer (service, equipment)

Example of claim's comments:

**Chest pain D/C from 1<sup>st</sup> fac ADM to 2<sup>nd</sup>  
For heart cath not available @ 1<sup>st</sup> fac**

### **Hospital to Hospital Transfer with Admission**

Medically necessary transfers of a patient from one hospital to another for admission would be submitted to Medicare Part B, if a specialized service, level of care or bed is not available at the originating hospital. The receiving (admitting) hospital must be the closest hospital with the appropriate level of services.

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay. Carriers exclude payment for ambulance services furnished to hospital inpatients within the admission and discharge dates unless billed directly by the hospital or furnished under arrangements. With the exception of the admission and discharge dates, all transportation provided to hospital inpatients must be bundled to the hospital. Ambulance services that are billed to the Carrier with a date of service that falls within the admission or discharge date on a hospital inpatient bill shall be rejected.

The supplier must report that the patient was discharged from the first facility and admitted to the second facility and the reason for the transfer to the second hospital in Item 19 of the CMS-1500, or Item 9, or 22 of the CMS 1491 claim form or the electronic equivalent.

### **Hospital to Hospital Transfer with Return**

When a patient remains in inpatient status at one hospital and is transported to another hospital or facility for tests or specialized services and returns to the originating hospital, the services are covered by Medicare Part A.

### **Ground to Air Transports**

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance supplier may bill Medicare for the level of service provided and mileage from the point of pickup to the point of transfer to the air ambulance. The air ambulance supplier also bills for its respective services and mileage from the point of pick-up to the destination.

### Gurney or Wheelchair Vans Transports

Gurney and wheelchair vans do not meet the staff, vehicle and equipment requirements to meet the Medicare coverage guidelines, therefore transportation provided in a gurney or wheelchair van is not covered by Medicare.

**Note:** If the beneficiary requires a denial, a claim can be submitted using **HCPCS A0999** (unlisted ambulance service) and a **“GY” modifier**. Include in the narrative field that this service is for a gurney or wheelchair van and submitted for denial.

### Hospice Patient Transports

Ambulance transports **unrelated** to the beneficiary’s terminal illness or on the same day as either the start or end date of hospice care is allowed. Submit the claim with the origin and destination modifiers and the GW modifier which indicates the services are unrelated. All other criteria for ambulance transports must be met. Ambulance transports **related** to the beneficiary’s terminal illness should be billed to Medicare Part A.

Example:

A		B		C		D		E		F		G		H	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-HCPCS MODIFIERS		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT	Family Plan	
From MM DD YY	To MM DD YY														
02	02	2006	02	02	2006	41		A0428	RHGW		1		1		
02	02	2006	02	02	2006	41		A0425	RHGW		1		25		

### Hospital Discharge Transports

Patients discharged from inpatient hospital care must meet medical necessity for non-emergency transportation to the patient’s residence, skilled nursing facility, or rehabilitation hospital. Non-emergency ambulance services require a physician certification statement.

### Multiple Arrivals

The general Medicare program rule is that the ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ambulance suppliers respond, payment may be made only to the ambulance supplier that actually furnishes the transport. Ambulance suppliers that arrive on the scene but do not furnish a transport are not due payment from Medicare.

### Multiple Patients Transported Simultaneously

When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport. The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

## Ambulance Billing Guide

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If two patients are transported at the same time in one ambulance to the same destination, the adjusted payment allowance for each Medicare beneficiary would equal 75% of the single-patient allowed amount applicable to the level of service furnished a beneficiary, plus 50% of the total mileage payment allowance for the entire trip.

If three or more patients are transported at the same time in one ambulance to the same destination, the adjusted payment for each Medicare beneficiary would equal 60% of the single-patient allowed amount, plus a proportional mileage allowed amount, i.e., the total mileage allowed amount divided by the number of all the patients onboard.

The fact that the level of medically necessary service among the patients may be different is not relevant to this payment policy. The percentage is applied to the allowed amount applicable to the level of service that is medically necessary for each beneficiary.

If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency versus non-emergency transport.

### For example:

- For an emergency ground transport, which includes BLS-E, ALS1-E, ALS2 and SCT, the mileage payment shall be based on the number of miles to the nearest appropriate facility for each patient, divided by the number of patients on board when the vehicle arrives at the facility. This formula applies cumulatively for beneficiaries who are the 2<sup>nd</sup> and 3<sup>rd</sup> patients to be delivered.
- For a non-emergency ground transport, which includes BLS and ALS1, the mileage payment shall be based on the number of miles from the point of pick up to the nearest appropriate facility for each beneficiary, divided by the number of beneficiaries on board at the point of pick up. This formula applies cumulatively for beneficiaries for multiple points of pick up. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pick up to the nearest appropriate facility is not covered. Thus, for non-emergency transports, the extra mileage that may be incurred by having multi-destinations shall not be taken into account.
- If a Medicare beneficiary is furnished medically necessary supplies and the supplier bills supplies separately, then the allowed amount of the supplies is not subject to an apportionment for multiple patients. The allowed amount for supplies should be determined in the same manner as if the beneficiary was the only patient onboard the vehicle.
- For air transports the policy is the same as for emergency ground transports.

### Billing Guidelines

- Use the “GM” modifier to identify a multiple transport.

## Ambulance Billing Guide

- Submit documentation to specify the particulars of a multiple transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers for each Medicare beneficiary.
- Submit the charges applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip.
- Submit all associated Medicare claims for the multiple transports within a reasonable number of days of submitting the first claim.
- If there is only one Medicare beneficiary in the multiple patient transports, the supplier must document this.

### Non Covered Mileage

Medicare only pays for medically necessary transportation to the closest facility. If a patient requests that they be transported to a more distant facility, the excess mileage will be the responsibility of the patient. A claim should be submitted to Medicare with one line for the "base rate," one line for the "covered mileage" and one line for the "excess mileage". The "excess mileage" should be billed with HCPCS code A0888 and a "GY" modifier only.

*Example: In this example the closest facility is 25 miles from the "place of pick-up." The patient requests that they be transported to a facility 55 miles away from the "place of pick-up." Line 2 represents the "covered" miles (25). Line 3 represents the "non-covered" miles (30) which would be the patient's responsibility.*

DATE(S) OF SERVICE		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS EPSDI OR Family Plan
From MM DD YY	To MM DD YY						
02022006	02022006	41		A0428 RH	1		1
02022006	02022006	41		A0425 RH	1		25
02022006	02022006	41		A0888 GY	1		30

### Patient, Physician or Family Convenience Transports

Coverage is not available if transport is requested solely because the patient and/or family prefer a specific hospital or physician, or so the patient can be closer to home. A request from or on behalf of a Medicare beneficiary for transport by ambulance for the beneficiary's personal convenience or that of the doctor or beneficiary's family is not a Medicare benefit under section 1861(s)(7) of the Social Security Act. If you furnish a service pursuant to such a request, then you may charge the individual your full fee and collect the fee at a time of your choosing. You should advise the beneficiary, in advance of furnishing the service, that such "convenience transportation" is not covered under Medicare. However, the use of an Advance Beneficiary Notice (ABN) is not indicated. You may use a "Notice of Exclusions from Medicare Benefits (NEMB)" to document the agreement for private payment of such services.

### Patient Assistance

If the sole reason for ambulance transport was that the patient needed assistance into the home (e.g., patient resides on second floor), the services would not be considered for payment.

### Patient Refuses Transport

In a situation where the patient refuses transport, Medicare does not cover the services. This also applies to any medical services provided. The beneficiary would be liable for the expenses. The Medicare ambulance benefit is a transportation benefit only.

### Physician Office Transport

Coverage of transports to or from a physician's office is allowed only in the following instance:

- The ambulance transport enroute to a Medicare covered destination, and
- When, during transport, the patient requires immediate professional attention and the ambulance stops at the physician's office for stabilization and then, transports the patient to the hospital.

#### NOTE:

The SX PH modifiers for the origin and destination must be submitted to identify that the above circumstances existed.

### Specialty Care Transports

SCT is a highly skilled level of care of a critically injured or ill patient during transfer from one hospital to another (Effective 1-1-07, coverage is provided for inter-facility transports\*). Typically, this occurs when the patient, who is already receiving a high level of care in the transferring acute care hospital, requires a level of care that the transferring hospital is not able to provide. This includes the situation where a beneficiary is taken by ground ambulance to an air ambulance and then from the air ambulance to the final destination hospital. For services prior to 1-1-07, transfer to or from any other type of facility (e.g., skilled nursing facility, nursing home) is not SCT. When billing SCT transports, be sure to include the following information in the Comments field (NTE02) or on the paper claim:

- Information that the patient was discharged from the 1<sup>st</sup> facility and admitted to the 2<sup>nd</sup> facility.
- Information to show that is providing care beyond the scope of a paramedic.
- Information to indicate what ongoing care is being provided by a health care professional beyond the scope of a paramedic.

Example:

**RN on board IV heparin D/C 1<sup>st</sup>  
ADM 2<sup>nd</sup> heart cath not available @1st**

\*For purposes of SCT payment, CMS considers a “facility” to include only a SNF or a hospital that participates in the Medicare program, or a hospital-based facility that meets CMS’ requirements for provider-based status. Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children’s hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute-care hospitals, and sole community hospitals (SCHs). The following origin/destination modifier combinations will be considered for coverage; HH, HN, NH, NN. In addition, the following origin/destination modifier combinations will be considered for coverage when the final destination is hospital or SNF; NI, IN, HI or IH.

### Skilled Nursing Facility Transports

The following ambulance services are included in consolidated billing. Claims should be submitted by the SNF to Medicare Part A.

- For beneficiaries in a Part A covered stay, a medically necessary ambulance transport from one SNF to another SNF.
- Ambulance transports for beneficiaries in a Part A covered stay, to or from a diagnostic or therapeutic site other than a physicians office or hospital (i.e. IDTF, cancer treatment center, radiation treatment center, wound care center) are to be part of SNF Consolidated billing.
- If the patient is traveling from the SNF to a doctor’s office the trip would be the responsibility of the SNF, as would the return trip.
- Medically necessary ambulance transports that are furnished during the course of a covered Part A stay are **included** in consolidated billing with the exception of specific **excluded** services.

Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services when resident status has ended. These ambulance trips are **excluded** from consolidated billing, and claims should be submitted by the ambulance supplier to the carrier (Part B).

- The ambulance trip is to the SNF for admission
- A medically necessary round trip to a Medicare participating hospital or Critical Access Hospital for the specific purpose of receiving emergency or other excluded services.

## Ambulance Billing Guide

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- Medically necessary ambulance trips after a formal discharge or other departure from the SNF, unless the beneficiary is readmitted or returns to that or another SNF before midnight of the same day.
- An ambulance trip for the purpose of receiving dialysis and dialysis-related services that are excluded from consolidated billing.
- A trip for an inpatient admission to a Medicare participation hospital or Critical Access hospital.
- After discharge from the SNF, a medically necessary trip to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care.

Certain services are excluded from consolidated billing only when furnished on an outpatient basis by a hospital or a critical access hospital. Ambulance transportation for the following services is excluded and should be billed to Part B:

- Cardiac catheterization services;
- Computerized axial tomography scans;
- Magnetic resonance imaging;
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
- Emergency services;
- Angiography; and
- Lymphatic and venous procedures
- Radiology therapy
- Removal, replacement or insertion of a PEG tube

Services for those patients requiring an ambulance that have exhausted the Medicare Part A skilled nursing benefit, who are residents of a SNF, but no longer in a Part A stay, would be reported to the carrier for Part B reimbursement. All the standard coverage and billing requirements apply to these transports (medically necessary, closest facility etc).

### Time of Death Pronouncement

#### Ground or Water

Medicare ambulance benefits are a transport benefit, if no transport of a Medicare beneficiary occurs, and then there is no Medicare covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefits may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements. The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

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Time of Death Pronouncement	Medicare Payment Determination
Before dispatch	No payment
After dispatch, before beneficiary is loaded onboard the ambulance (before or after arrival at the point of pickup).	The ambulance BLS base rate is paid. No mileage or rural adjustment. Use the <b>QL</b> modifier when submitting the claim.
After pickup, prior to or upon arrival at the receiving facility.	Medically necessary level of service furnished is allowed.

### Air Ambulance

Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. The allowed amount is the appropriate air base rate, i.e.; fixed or rotary wing. No amount is allowed for mileage or rural adjustment.

No payment is allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. The supplier must submit documentation with the claim sufficient to show that:

- The air ambulance was dispatched to pick up a Medicare beneficiary;
- The aircraft actually took off to make the pickup;
- The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport;
- The pronouncement of death was made by an individual authorized by State law to make such pronouncements; and
- The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

## Ambulance Billing Guide

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

### Transports Rendered by a Foreign Ambulance Company

Where inpatient services in a foreign hospital are covered, payment may also be made for ambulance services, when necessary, for the trip to the hospital in conjunction with the beneficiary's admission as an inpatient. Return trips from a foreign hospital are not covered. Medicare does not pay for a Canadian ambulance, who works as a back-up to an American ambulance to transport patients within the States.

### Unusual Circumstances (Covered for Date of Service prior to 1-1-06)

As with any reasonable charge determination, amounts above the reasonable charge may be allowed when unusual circumstances are documented. Carriers are expected to make such determinations, with medical staff assistance as needed and on a case by case basis, in deciding whether the services actually furnished exceed the range of services ordinarily provided. Such situations include but are not limited to: night services\*, use of extra attendants to handle disturbed patients, and where the facts indicate that a situation existed above and beyond normal ambulance transportation which justified additional charges. These services may only be paid through the transition period (using the reasonable charge percentages with no ambulance fee schedule percentage).

### Waiting Time (Covered for Date of Service prior to 1-1-06)

Waiting time charges are those charges billed by an ambulance service for time spent while waiting for the patient. In arriving at their charge rate, ambulance companies should consider the total time involved in the picking up a patient and transporting them to the destination. This waiting time is not a separate charge and therefore, not reimbursable unless the waiting time is extraordinarily long and constitutes unusual circumstances. These services may only be paid through the transition period (using the reasonable charge percentages with no ambulance fee

schedule percentage). When the fee schedule is fully implemented, payment will be based solely on the calculated fee schedule amount.

### **COMPLIANCE PROGRAM GUIDANCE FOR AMBULANCE SUPPLIERS**

Compliance Program Guidance for Ambulance Suppliers had been developed by the Office of Inspector General (OIG). The OIG has previously developed and published voluntary compliance program guidance focused on several different areas of the health care industry. This voluntary compliance program guidance should assist ambulance suppliers and other health care providers in developing their own strategies for complying with federal health care program requirements.

The creation of compliance program guidance (CPGs) is a major initiative of the OIG in its effort to engage the private health care community in preventing the submission of erroneous claims and in combating fraudulent and abusive conduct. In the past several years, the OIG has developed and issued CPGs directed at a variety of segments in the health care industry. The development of these CPGs is based on our belief that a health care provider can use internal controls to more efficiently monitor adherence to applicable statutes, regulations, and program requirements.

The CPG for Ambulance Suppliers can be found at:

<http://oig.gov/fraud/docs/complianceguidance/032403ambulancecpgr.pdf>

### **ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS FOR AMBULANCE SUPPLIERS**

#### **ABN Requirements for Non-Emergency Transports**

The ABN is a written notice a physician or supplier gives to a Medicare beneficiary before items or services are furnished when the physician or supplier believes that Medicare probably or certainly will not pay for some or all of the items or services on the basis of certain Medicare statutory exclusions.

An ABN is rarely used for ambulance services, and may only be issued for non-emergency transports. An ABN may not be used when a beneficiary is under great duress. A beneficiary is considered to be under great duress when his or her medical condition requires emergency care.

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

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- a) A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.
- b) A level of care downgrade, e.g., from ALS-2 to ALS-1, or from ALS to Basic Life Support (BLS), when the transport at the lower level of care is a covered transport.
- c) A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary's home, and
- d) A transport of a skilled nursing facility patient to a hospital or to another SNF for a service that can be performed more economically in the first SNF.

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

- a) Any denial where the patient could be transported safely by other means.
- b) Any denial that is based on not meeting an origin or destination requirement.
- c) A denial for mileage that is beyond the nearest appropriate facility.
- d) A denial where the PCS or accepted alternative (i.e. certified mail) is not obtained.
- e) A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family.

The Notice of Exclusions from Medicare Benefits (NEMB) is an optional form that CMS developed to assist suppliers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. When an ABN is not appropriate to use because medical necessity is not the basis for the expected denial, an NEMB may be used. Ambulance suppliers may develop their own process to communicate to beneficiaries that they will be billed for excluded services.

## NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative  
Correct Coding Solutions LLC  
P.O. Box 907  
Carmel, IN 46082-0907

FAX: 317-571-1745

### MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

[http://www.cms.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage)

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative  
Correct Coding Solutions, LLC  
P.O. Box 907  
Carmel, IN 46082-0907  
FAX: 317-571-1745

### LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://www.cms.gov/BNI/>

### ABN Modifiers

- GA Waiver of liability statement issued, as required by payer policy, individual case
- GX Notice of liability issued, voluntary under payer policy
- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)  
**Note:** All claim line items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review

### LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

[http://www.medicarenhic.com/ne\\_prov/policies.shtml](http://www.medicarenhic.com/ne_prov/policies.shtml)

### NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>

### MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

**Fraud** is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to

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entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

**Abuse** describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to SafeGuard Services (SGS).

The contact for the SafeGuard Services (SGS) is:

Maureen Akhouzine, Benefit Integrity Manager

SafeGuard Services - NEBISC

75 Sgt. William B. Terry Drive

Hingham, MA 02043

Phone 1-781-741- 3282

Fax 1-781-741-3283

[maureen.akhouzine@hp.com](mailto:maureen.akhouzine@hp.com)

If you wish to report fraud please contact the national OIG fraud hot line at **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

## RECOVERY AUDIT PROGRAM

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit (RA) program for Region A. The RA program is mandated by Congress aimed at identifying Medicare improper payments. DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of

underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

### COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

**CERT DOCUMENTATION CONTRACTOR (CDC)** - The CDC requests and receives medical records from providers.

**CERT REVIEW CONTRACTOR (CRC)**-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

For more information please click on <http://www.cms.gov/CERT/>

### Provider Interactive Voice Response (IVR) Directory

**All actively enrolled providers must utilize the IVR for: Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date.** The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or social security number (SSN) of the provider to utilize the IVR system.

**Available 24 hours/day, 7 days/week (including holidays)**

**888-248-6950**

### Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

**Hours of Operation:**  
8:00 a.m. to 4:00 p.m. Monday – Thursday  
10:00 a.m. to 4:00 p.m. - Friday  
866-801-5304

**Dedicated Reopening Requests Only**  
**Hours of Operation:**  
8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday – Thursday  
10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday  
877-757-7781

### PROVIDER ENROLLMENT HELP LINE

A Customer Service Enrollment Specialist will be able to assist with your CMS-855 application inquiries. To help expedite your call, please have your CCN, PTAN and/or NPI number available.

Through the Provider Enrollment Help Line you can:

- Resolve your complex enrollment inquiries
- Schedule an appointment with a Provider Enrollment Specialist
- Receive individual assistance as you complete your PECOS Web Application

**Toll Free Number (888) 300-9612**

Phone Options:

- **Press 1** for Part B Application Inquiries
- **Press 2** for Part A and RHHI Application Inquiries
- **Press 3** if you are returning an application verification call
- **Press 4** if you need assistance completing your PECOS Web Application
- Or stay on the line for the next available representative.

**Please note:** The Provider Enrollment Help Line should not be used for checking status of your application. For application status inquiries, please visit our website at [www.medicarenhic.com](http://www.medicarenhic.com) and go to "check enrollment status".

### PROVIDER ENROLLMENT STATUS INQUIRY TOOL

This inquiry tool can be used to check on the status of your CMS-855 application.  
[http://www.medicarenhic.com/ne\\_prov/PartB\\_enrollment\\_search\\_form.shtml](http://www.medicarenhic.com/ne_prov/PartB_enrollment_search_form.shtml)

The possible statuses would be:

- Screening:** The application is being reviewed for signatures, missing sections/documents
- Processing:** Information on the application is being verified or request for additional information is in progress
- Approved:** The application has been approved; you will receive a detailed letter from NHIC in the near future
- Denied:** The application has been denied; you will receive a detailed letter from NHIC in the near future
- Rejected:** The application has been rejected; you will receive a detailed letter from NHIC in the near future
- Returned:** The application has been returned; you will receive a detailed letter from NHIC in the near future

#### How to Search:

Individual Application: Type in your last name and first name  
Group Application: Type in your Group Name

**Note:** The search results will be limited to the last six months of application activity. For any information beyond this timeframe, please contact [Customer Service](#)

### MAILING ADDRESS DIRECTORY

Initial Claim Submission	
Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044

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Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 809150 Chicago, IL 60680-9150
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare SafeGuard Services	P.O. Box 4444 Hingham, MA 02044

**\*\*Note:** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the NHIC Corp. Clerical Error Reopening Request Form that can be downloaded from our Web site:

[http://www.medicarenhic.com/ne\\_prov/forms.shtml](http://www.medicarenhic.com/ne_prov/forms.shtml)

## PROVIDER SERVICES PORTAL (PSP)

The Provider Services Portal (PSP) is a website tool that offers the provider community an alternative to the IVR or Customer Service Toll Free line.

This tool offers the following information through lookup transactions **and there is no charge to access the PSP:**

- Beneficiary Eligibility
- Claim Status
- Standard Paper Remittances with the ability to select and print SPR's locally
- Provider Summary
- Provider Enrollment Status

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The PSP has superior search capability and will allow you to research your claims quickly and efficiently! The PSP is available 24 hours a day, 7 days a week, except during scheduled maintenance windows.

How To Get Started: [http://www.medicarenhic.com/ne\\_prov/psphome\\_index.shtml](http://www.medicarenhic.com/ne_prov/psphome_index.shtml)

## DURABLE MEDICAL EQUIPMENT (DME)

**Durable Medical Equipment (DME) Medicare Administrative Contractor:**

NHIC, Corp.

**Provider Service Line:** 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

## RECONSIDERATION (SECOND LEVEL OF APPEAL)

C2C Solutions, Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

### INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

#### **NHIC, Corp.**

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

#### **Provider Page Menus/Links**

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

#### **Medicare Coverage Database**

<http://www.cms.gov/center/coverage.asp>

<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

### Medicare Learning Network

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

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

### Open Door Forums

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

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

### Publications and Forms

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

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

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

CMS Correct Coding Initiative

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

CMS Physician's Information  
Resource for Medicare

<http://www.cms.gov/center/physician.asp>

Clinical Lab Improvement Amendment [http://www.cms.gov/CLIA/01\\_Overview.asp#TopOfPage](http://www.cms.gov/CLIA/01_Overview.asp#TopOfPage)

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Electronic Prescribing	<a href="http://www.cms.gov/erx incentive/">http://www.cms.gov/erx incentive/</a>
Electronic Health Records	<a href="http://www.cms.gov/ehrincentiveprograms/">http://www.cms.gov/ehrincentiveprograms/</a>
Evaluation and Management Documentation Guidelines	<a href="http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp">http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp</a>
Federal Register	<a href="http://www.archives.gov/federal-register">http://www.archives.gov/federal-register</a> <a href="http://www.gpoaccess.gov/index.html">http://www.gpoaccess.gov/index.html</a>
HIPAA	<a href="http://www.cms.gov/HIPAA GenInfo/">http://www.cms.gov/HIPAA GenInfo/</a>
ICD-10	<a href="http://www.cms.gov/icd10/">http://www.cms.gov/icd10/</a>
National Provider Identifier (NPI)	<a href="http://www.cms.gov/NationalProvIdentStand/">http://www.cms.gov/NationalProvIdentStand/</a>
NPI Registry	<a href="https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do">https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do</a>
Physicians Quality Reporting System	<a href="http://www.cms.gov/PQRS//">http://www.cms.gov/PQRS//</a>
Provider Enrollment, Chain, and Ownership System (PECOS)	<a href="http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag">http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag</a>
Provider Enrollment	<a href="http://www.cms.gov/MedicareProviderSupEnroll/">http://www.cms.gov/MedicareProviderSupEnroll/</a>
Skilled Nursing Facility Consolidated Billing	<a href="http://www.cms.gov/snfconsolidatedbilling/01_overview.asp">http://www.cms.gov/snfconsolidatedbilling/01_overview.asp</a>
U.S. Government Printing Office	<a href="http://www.gpoaccess.gov/index.html">http://www.gpoaccess.gov/index.html</a>
Washington Publishing Company	<a href="http://www.wpc-edi.com/reference/">http://www.wpc-edi.com/reference/</a>
5010	<a href="http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage">http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage</a>

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### Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Sue Kimball	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal
2.0	01/05/2011	Sue Kimball	Ayanna Yancey Cato	<b>Annual Review</b> Added PE Helpline, PE status Inquiry, and PSP. Checked all websites and added EHR, ICD-10, 5010, SNFCB.
3.0	05/10/11	Susan Kimball	Ayanna Yancey-Cato	Added fax to NCCI and MUE, GZ auto denials, updated some Web sites, address for refunds, added CLIA and WPC web sites.
4.0	06/06/11	Phyllis McLaughlin	Ayanna Yancey Cato	<b>Annual Review</b> , Updated NHIC links, Verbiage for Air Ambulance Services, Definition of Applications
5.0	06/04/12	Eddy van Hunnik	Ayanna Yancey Cato	<b>Annual Review</b> Updated 5010 electronic submission, added FS Payment Rate Floor section, Added instructions to accept HCPCS codes, Added Ambulance Inflation Factor section.
6.0	07/30/2012	Gail O'Leary	Ayanna Yancey Cato	Added Condition Code information to 5010A1 Professional Health Care Claim.
7.0	12/19/12	Gail O'Leary	Ayanna Yancey Cato	Updated origin/destination modifier procedure code information
8.0	4/17/2013	M. Petruzzello	Faith Monroe	Updated CMS logo

# **NHIC, Corp.**

**75 Sgt. William Terry Drive  
Hingham, MA 02044**

**Website:**

**<http://www.medicarenhic.com>**

**CMS Websites**

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

**<http://www.medicare.gov>**