PROGRAM MEMORANDUM CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. B-00-01 **Date JANUARY 2000**

This Program Memorandum re-issues Program Memorandum B-99-12, Change Request 783 dated March 1999. The only change is the discard date; all other material remains the same.

CHANGE REQUEST #783

SUBJECT: Paramedic Intercept Provisions of the Balanced Budget Act (BBA) of 1997

Paramedic intercept services are advanced life support (ALS) services delivered by paramedics that operate separately from the agency that provides the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only basic life support (BLS) level service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide their services to the patient.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to the effective date of this Program Memorandum (PM), Medicare payment could be made for these services, but only when the claim was submitted by the ambulance provider (that is, the actual transporting unit). Payment could not be made directly to the intercept service supplier. In those areas where State laws prohibit volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service.

Per the authority provided in §4531© of the BBA of 1997, program payment may be made directly to the intercept supplier for intercept services provided on or after the effective date of this PM, subject to the requirements specified below.

The intercept service(s) is:

- Provided in a rural area;
- Provided under a contract with one or more volunteer ambulance services; and,
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

In addition, the volunteer ambulance service involved must:

- Be certified as qualified to provide ambulance services in accordance with CFR 410.41 of the regulations;
- Provide services only at the BLS level at the time of the intercept; and,
- Be prohibited by State law from billing for any service.

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

- Be certified as qualified to provide ALS services in accordance with CFR 410.41(b)(2) of the regulations, and,
- Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

A rural area is defined in the same way it is defined for purposes of the Medicare hospital inpatient prospective payment system (§412.62(f) of the regulations). That is, a rural area is any area outside of a Metropolitan Statistical Area or New England County Metropolitan Area as defined by the Office of Management and Budget. The current list of these areas is published in the Federal Register for July 31, 1998 at 63 FR 41052-41059.

Payment

Payment for intercept services is made only in the case of an emergency. The payment amount is based on the difference between the emergency ALS ambulance service rate and the emergency BLS ambulance service rate for the locality in which the service was furnished. This places a value on the intercept service consistent with the fact that the full ALS service is comprised of two components: the intercept service and the transport service. The transport is valued at the BLS rate and the intercept service is valued at the difference between the ALS rate and the BLS rate.

Therefore, the total allowed charge for a rural intercept service is equal to the allowed charge for the corresponding ALS service minus the allowed charge for the corresponding BLS service. When determining this amount, use the allowance for Health Care Finance Administration Common Procedure System (HCPCS) code A0330 (ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed) minus the allowance for A0322 (BLS, emergency transport, supplies included, mileage separately billed) for the locality in which the service was furnished.

Billing Requirements

Services performed on or after February 24, 1999 are eligible for payment under this benefit. Deny claims for services furnished before this date.

This PM provides the instructions to process these claims until your systems are updated. Change Request (CR) 784 will be issued to provide those instructions. The update will include the new HCPCS code which will allow the claim to pass Common Working File (CWF) edits.

To bill this service, the ALS company providing the paramedic intercept service must use HCPCS code Q0186, which is defined as: paramedic intercept, rural area, transport furnished by a volunteer ambulance company which is prohibited by State law from billing third party payers.

We are requiring the supplier to use the new code even though your system and CWF will not recognize the new code. This causes less confusion than having to change the codes when the system is updated. The procedure below should take care of allowing the new code into your processing system and then into CWF.

Carrier Billing Requirements

ALS companies which will provide the paramedic intercept service must provide the area carrier with copies of the signed and dated contracts with the volunteer BLS ambulance companies. This contract must include a statement that the entity providing the ALS paramedic intercept services will bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries. Names of both companies, legal and D/B/A names, must be included on the contract. ALS companies may not bill Medicare for these services before the effective date of the contract for each BLS ambulance company affected by this regulation. ALS companies should submit copies of the contracts to the carrier.

The only acceptable code for the supplier to use is the new HCPCS Q0186. This is the only way to bill for the paramedic intercept service to BLS companies which are prohibited from billing insurance companies for the transport service. To bill as a ALS ambulance service which includes transport could be considered fraud or abuse.

The other items on the claim should be coded the same way as any other ambulance claim.

The new HCPCS code will suspend in your system since it will not be recognized as valid. At this point, review the claim to verify that the ALS biller has a contract for the BLS transport. Calculate the reasonable charge, i.e., subtract the BLS locality rate from the ALS rate, as described above. The result is the reasonable charge for the paramedic intercept service. Change the submitted HCPCS code to A0999 since this code is an acceptable ambulance HCPCS code and will allow an approved claim to process through your system and CWF.

Use this procedure until you receive CR784. This PM will be issued to document the system change for the appropriate quarterly release.

To ensure that the notice to the beneficiary indicates the proper reason for denial of payment, include language in the notice appropriate to the circumstances.

These instructions should be implemented within your current operating budget.

The effective date for this PM is March 1, 1999.

* **This PM may be discarded after July 31, 2000.**

If you have questions about the payment policy, call Robert Niemann on (410)786-4569. For policy questions, call Margot Blige on (410)786-4642. For claims processing questions, call Dolores Crujeiras on (410)786-7169.