CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 220 **Date: JUNE 25, 2004**

CHANGE REQUEST 3099

This CR was originally communicated as a Confidential Requirement on June 18, 2004 as Transmittal 212. This document replaces Transmittal 212 and is no longer confidential.

I. SUMMARY OF CHANGES: This transmittal reissues Change Request (CR) 3099, Transmittal 88, to announce the bonus amount for ambulance transports originating in certain low-density population areas. The transmittal also includes the addresses for the Ambulance Fee Schedule files and makes technical corrections to the manual to clarify the ground mileage calculations that apply for claims with dates of services after June 30, 2004. All other material remains the same as it appeared in the original transmittal.

Transmittal 88 implements changes to the payment for ground ambulance services, in accordance with Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Specifically, this provision establishes a floor amount for the fee schedule portion of the payment, provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low density population areas, and implements a 25 percent bonus on the mileage rate for ground miles 51 and greater. These payment changes apply to ground ambulance transports only. Air ambulance base rates and mileage rates remain unchanged. The transmittal also makes technical corrections to the manual and incorporates previous issuances to provide a comprehensive understanding of Medicare payment for ground ambulance services.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/Table of Contents
R	15/10/General Coverage and Payment Policies
R	15/10.2/Billing Methods

R	15/10.3/Definitions
R	15/20/Carrier Calculation of Payment Amount
R	15/20.1.1/General
R	15/20.1.4/Components of the Ambulance Fee Schedule
R	Chapter 15/20.1.5/ZIP Code Determines Fee Schedule Amounts
R	Chapter 15/20.1.6/Transition Overview

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment – Business Requirements

Pub. 100-04	Transmittal: 220	Date: June 25, 2004	Change Request 3099

This CR was originally communicated as a Confidential Requirement on June 18, 2004 as Transmittal 212. This document replaces Transmittal 212 and is no longer confidential.

SUBJECT: Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003

Summary of Changes: This transmittal reissues Change Request (CR) 3099, Transmittal 88, to announce the bonus amount for ambulance transports originating in certain low-density population areas. The transmittal also includes the addresses for the Ambulance Fee Schedule files and makes technical corrections to the manual to clarify the ground mileage calculations that apply for claims with dates of services after June 30, 2004. All other material remains the same as it appeared in the original transmittal.

I. GENERAL INFORMATION

Section 4531 (b) (2) of the Balanced Budget Act (BBA) of 1997 added section 1834 (1) to the Social Security Act, which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. On April 1, 2002, CMS implemented a new fee schedule (FS) that applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals, and skilled nursing facilities. The fee schedule is effective for claims with dates of service on or after April 1, 2002. Under the fee schedule, ambulance services covered under Medicare are paid based on the lower of the actual billed amount or the Ambulance Fee Schedule amount.

As discussed in previously issued instructions, the FS will be phased in over a 5-year period. When fully implemented, the FS will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

A. Background:

Section 414 of the MMA of 2003 provides for additional payments for ground ambulance services. The following changes to the payment rates for rural and urban ground ambulance transports become effective on July 1, 2004:

- Phase-In Providing Floor Using Blend of Fee Schedule and Regional Fee Schedules (Transition Period effective July 1, 2004 - December 31, 2009):

  Under the current Ambulance FS, effective for claims with dates of service on or after April 1, 2002, ambulance providers/suppliers are reimbursed using a blended

payment of the reasonable cost/charge amount and the applicable FS amount. The blended percentages change each year during the 5-year transition period, ending December 31, 2005. Providers/suppliers will be reimbursed using the FS amount only beginning on January 1, 2006.
This provision of MMA establishes a floor amount for the FS portion of the payment. For the period July 1, 2004 to December 31, 2009, the FS portion of the payment will be either the regular (national) fee schedule amount, or a blended amount of the national rate and the regional fee schedule amount calculated by CMS. Providers/suppliers will be reimbursed using the higher of these two amounts.

- Adjustment in Payment for Certain Long Trips (Effective July 1, 2004 to December 31, 2008):

  This provision of the MMA establishes a 25 percent bonus on the mileage rate for ground miles 51 and greater. This bonus amount is payable for ground transports originating in both rural and urban areas.

- Improvement in Payments to Retain Emergency Capacity for Ambulance Services in Rural Areas (Effective July 1, 2004 to December 31, 2009):

  This provision of the MMA directs the Secretary to provide an increase in the base payment rate for ground ambulance trips that originate in a rural area with a population density in the lowest quartile of all rural county populations, through 2009. The bonus amount to be applied for the designated rural areas will be a multiplier determined by CMS and applied by Medicare contractors where the point of pickup (POP) is in one of a group of designated rural ZIP codes.

- Temporary Increase for Ground Ambulance Services (Effective July 1, 2004 to December 31, 2006):

  This provision of MMA establishes an overall increase of 1 percent for ground transports originating in urban areas and 2 percent for ground transports originating in rural areas. The percentage increase applies to both the base rate and the mileage amount for the FS portion of the payment for ground ambulance services.

B. Policy:

Contractor instructions for implementing the provisions of Section 414 of MMA are as follows:

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

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground ambulance transports is subject to a minimum amount. This minimum amount depends upon the area of the country in which the service is furnished. The country is divided into 9

census divisions and each of the census divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national rate and the regional rate in accordance with the following schedule:

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

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. This floor amount is calculated by CMS Central Office 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 carrier or intermediary in order to implement this provision. However, carriers and intermediaries must continue to apply the appropriate FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.

2. Adjustment to the Ground Mileage Payment Amount for Miles Greater than 50

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

3. Adjustments for FS Payment Rate for Certain Rural 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 FS for ground ambulance transports furnished in certain rural areas is increased by an amount determined by CMS centrally. 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. CMS will determine the bonus amount to be applied for ground transports originating in the designated POP rural ZIP codes. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a "B" indicator on the national ZIP code file. (See Chapter 15 of the Pub. 100-04 Medicare Claims Processing Manual, "A. Special Instructions for Transition (Intermediaries and Carriers)," in Section §20.1.6 for the national ZIP code file layout and further directions for downloading the file.) Contractors must apply

the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP codes.

4. Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006. For services furnished where the POP is urban, the rates are increased by 1 percent, and for services furnished where the POP is rural, the rates are increased by 2 percent. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the carrier or intermediary in order to implement this provision.

The following chart summarizes the MMA payment changes for ground ambulance services that become effective on July 1, 2004:

Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA

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

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

******** *Carrier/intermediary systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file. However, carriers and intermediaries must continue to apply the applicable FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.*

C. Provider Education:

A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article to their website, and include it in a listserv message if applicable, within one week of the availability of the provider education article. In

addition, the provider education article must be included in your next regularly scheduled bulletin. Prior to July 1, 2004, CMS will also provide Medicare contractors with a provider education website for further information concerning the regional FS associated with each of the 9 census divisions.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3099.1	Standard System Maintainers shall create and provide to their contractors a table containing the CMS-specified bonus multiplier amount to be applied to the FS base rate for ground transports originating in designated rural POP Zip Codes between July 1, 2004 and December 31, 2009. (See Section B. Policy, item 3.)	Standard System Maintainers
3099.2	For all rural and ground ambulance service claims with dates of service between July1, 2004 and December 31, 2009, intermediaries and carriers shall apply a CMS-specified bonus amount as a multiplier to the FS base rate for transports originating in rural POP Zip Codes designated with a "B" indicator on the CMS-supplied National Zip Code File. (See Section B. Policy, item 3.)	Intermediaries and Carriers
3099.3	For claims with dates of service between July 1, 2004 and December 31, 2008, intermediaries and carriers shall apply a 25 percent increase to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater) when the beneficiary is onboard the ambulance. (See Section B. Policy, item 2.)	Standard System Maintainers, Intermediaries, and Carriers
3099.4	For calendar year 2004: Claims with a date of service January 1, 2004 through June 30, 2004 must be paid using the Ambulance Fee Schedule issued in December 2003. Claims with a date of service July 1, 2004 through December 31, 2004 must be paid using the fee schedule issued for claims with date of service beginning July 1, 2004. (See Section B. Policy, items 1-4.)	Standard System Maintainers, Intermediaries, and Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3099.1, 3099.2	Beginning on July 1, 2004, CMS will designate ZIP Code POPs that qualify for the additional MMA rural bonus amount with a "B" indicator on the CMS-supplied Ambulance Zip Code File.
3099.1-3099.4	Beginning on July 1, 2004, CMS will add an 8-digit date (MMDDYYYY) at the end of the Ambulance National Fee Schedule File to identify the effective date for the fee schedule file.

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date:** July 6, 2004 **Pre-Implementation Contact(s):** Susan Webster (410) 786-3384 **Post-Implementation Contact(s):** Susan Webster (410) 786-3384	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 15 - Ambulance

Table of Contents

(Rev. 220, 06-25-04)

10 - General Coverage and Payment Policies

(Rev. 220, 06-25-04)

A3-3114, A3-3138, B3-2120, HO-236, SNF-262, A-01-52, PMs AB-00-88, AB-01-118, AB-00-127, AB-02-036, AB-02-48, AB-00-103, AB-01-185, AB-00-103

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

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

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

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building. *See section 10.3.3 of Chapter 10 of the Medicare Benefit Policy Manual for further details.*

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

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

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

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

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

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

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

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

10.2 - Billing Methods

(Rev. 220, 06-25-04)

AB-00-118, AB-94-8, AB-01-165

As described above, during the transition period ambulance claims are paid based on a blended rate. The FS portion of the rate and the reasonable cost portion of the rate for providers are always billed and paid on the basis of Method 2, as described in the following chart. The reasonable charge portion of the rate for suppliers is paid based on one of the four billing methods shown in the following chart.

Method	Payment
1	Suppliers are paid at an all-inclusive base rate reflecting all services, supplies, and mileage.
2	Suppliers are paid at a base rate to include supplies with a separate charge for mileage.
3	Suppliers are paid at a base rate to include mileage and services but separate charges for supplies.
4	Suppliers are paid at a base rate with separate charges for supplies and mileage.

Effective for dates of service on or after April 1, 2002, with the implementation of the *ambulance FS*, carriers must ensure that each supplier uses only one billing method. Carriers must give suppliers at least 30 days to make an election. Carriers must convert suppliers using multiple billing methods to one of their current billing methods which the claims processing system supports. In the absence of an election, carriers convert the suppliers using multiple billing methods to billing Method 2.

10.3 - Definitions

(Rev. 220, 06-25-04)

AB-02-130

The following are definitions and applications of items used throughout the ambulance chapter. Refer to the Medicare Benefit Policy Manual, Chapter 10, “Ambulance,” for definitions of the levels of service.

Adjusted Base Rate

Definition: Adjusted base rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.

Application: With respect to ground service levels, the adjusted base rate is the payment amount that results from multiplying the conversion factor (CF) by the applicable relative value unit (RVU) and applying the geographic adjustment factor (GAF). With respect to fixed wing and rotary wing services, the adjusted base rate is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the *FS* and is not calculated by means of a CF and RVU) adjusted by the provider's/supplier's GAF.

Basic Life Support

Definition: 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.

Advanced Life Support Assessment

Definition: Advanced life support (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 an ALS level of service.

Application: 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 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.

Advanced Life Support Intervention

Definition: 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.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS intervention applies only to 4ground transports.

EMT-Intermediate

Definition: EMT-Intermediate is an individual who is qualified, in accordance with State and local laws, as an EMT-Basic **and** who is certified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic

Definition: EMT-Paramedic possesses 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.

Geographic Adjustment Factor

Definition: Geographic adjustment factor (GAF) is a value that is applied to a portion of the unadjusted base rate amount in order to reflect the relative costs of furnishing ambulance services from one area of the country to another. The GAF is equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) from the physician fee schedule.

Application: For ground ambulance services, the GAF is applied to 70 percent of the unadjusted base rate. For air ambulance services, the GAF is applied to 50 percent of the unadjusted base rate.

Goldsmith Modification

Definition: Goldsmith modification is the methodology for the identification of rural census tracts that are located within large metropolitan counties of at least 1,225 square miles but are so isolated from the metropolitan core of that county by distance or physical features as to be more rural than urban in character.

Loaded Mileage

Definition: Loaded mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.

Application: Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates:

1. For ground and water;
2. For *fixed wing (FW)*; and
3. For rotary wing (RW).

For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Point of Pickup *(POP)*

Definition: Point of pickup is the location of the beneficiary at the time he or she is placed on board the ambulance.

Application: The ZIP code of the *POP* must be reported on each claim for ambulance services so that the correct GAF and Rural Adjustment Factor (RAF) may be applied, as appropriate.

Relative Value Units

Definition: Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.

Application: The RVUs for the ambulance *FS* are as follows:

Service Level	**RVUs**
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1 - Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

RVUs are not applicable to FW and RW services.

Rural Adjustment Factor (RAF)

Definition: RAF is an adjustment applied to the payment amount for ambulance services when the *POP* is in a rural area.

Application: For ground ambulance services:

> *For services furnished before July 1, 2004, a* 50 percent increase is applied to the urban ambulance *FS* mileage rate for each of the first 17 miles of a rural POP. *For services furnished on or after July 1, 2004, a 50 percent increase is applied to the rural ambulance FS mileage rate for each of the first 17 miles of a rural POP;*
>
> For services furnished before January 1, 2004, a 25 percent increase is applied to the urban ambulance *FS* mileage rate for mileage between 18 and 50 miles of a rural POP; and the urban ambulance *FS* mileage rate applies to every mile of a rural POP over 50 miles.

For services furnished *during the period January 1, 2004 through June 30, 2004, the urban ambulance FS mileage rate applies to every mile of a rural POP over 17 miles. For services furnished on or after July 1, 2004, the rural ambulance FS 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).*

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the FS 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.

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

For rural air ambulance services, a 50 percent increase is applied to the total air ambulance fee schedule amount for air services; that is, the adjustment applies to the sum of the adjusted base rate and ambulance fee schedule rate for all of the loaded air mileage.

Services in a Rural Area

Definition: Services in a rural area are services that are furnished:

1. In an area outside a Metropolitan Statistical Area (MSA) except in New England;

2. In New England, outside a New England County Metropolitan Area (NECMA); or,

3. In an area identified as rural using the Goldsmith modification even though the area is within an MSA or NECMA.

Unadjusted Base Rate

Definition: Unadjusted base rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them.

Application: The unadjusted base rate is the payment amount that results from multiplying the CF by the RVU without applying the GAF.

20 – *Intermediary and* Carrier Calculation of Payment Amount

(Rev. 220, 06-25-04)

B3-4115, 5116, PM AB-02-131

Medicare covered ambulance services are paid based on the Medicare ambulance fee schedule. The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. There is a transition period, during which time payment will be based on a blended amount based in part on the ambulance fee schedule and in part on reasonable cost (for intermediaries) or reasonable charge (for carriers).

The following subsections describe how *intermediaries and* carriers calculate the payment amount. Section 20.1 and its subsections describe how the payment amount is calculated for the fee schedule and the transition to the fee schedule. Section 20.2 provides information for payment calculations for claims with dates of service prior to April 1, 2002. The other subsections in §20 provide information on certain components of the payment amount (e.g., mileage) or specialized payment amounts (e.g., air ambulance).

20.1.1 - General

(Rev. 220, 06-25-04)

*P*ayment under the fee schedule for ambulance services:

- Includes a base rate payment plus a separate payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Precludes a separate payment for items and services furnished under the ambulance benefit. (An exception to this preclusion exists *for carriers* during the transition period for those *suppliers* billing under Methods 3 and 4.)

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

For additional information on the fee schedule and its implementation, carriers and intermediaries may refer to “Ambulance Services Education” on the CMS Web site at http://www.cms.hhs.gov/medlearn/refamb.asp.

20.1.4 - Components of the Ambulance Fee Schedule

(Rev. 220, 06-25-04)

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

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

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

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

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

  4. A nationally uniform loaded mileage rate*;*

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

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

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

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

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

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

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

A. Ground Ambulance Services

1. Conversion Factor

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

2. Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, e.g., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

The RVUs are as follows:

Service Level	**RVU**
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
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 nonfacility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the ambulance *FS* are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance *(POP)* establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the *POP* establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70 percent of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the ground mileage rate.

4. Mileage

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

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

The payment rate is greater for certain mileage where the *POP* is in a rural area to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period.

If the *POP* is a rural ZIP code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. The rural adjustment for ground mileage is 1.5 times the urban mileage allowance for the first 17 loaded miles, and for services furnished before January 1, 2004, 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. *For services furnished before July 1, 2004* for all ground miles greater than 50 and *for services furnished during the period from January 1, 2004 through June 30, 2004*, all ground miles greater than 17, payment is based on the urban rate per mile. *For services furnished on or after July 1, 2004 for all ground miles greater than 17, payment is based on the rural rate per mile (and this amount is used when applying the bonus amount for long rural trips, as described below).*

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

The *POP*, as identified by ZIP code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the ZIP code of the *POP* establishes whether a rural adjustment applies to such second (or subsequent) transport.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service (USPS) ZIP Code that is located, in whole or in part, outside of either a Metropolitan Statistical Area

(MSA) or in New England, a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith modification." (The Goldsmith modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

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

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

See §30.1.1 of Chapter 10 of the Medicare Benefit Policy Manual for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

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

The CMS furnishes the ambulance *FS* files electronically, including whether a particular ZIP code is rural or urban.

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

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

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

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. Note that this provision affects only the FS portion of the blended transition payment rate. This floor amount is calculated by CMS centrally and is incorporated into the FS amount that appears in the FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision. However, carriers and intermediaries must continue to apply the appropriate FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period. See section §20.1.6 for the blended percentages to apply during each year of the FS transition period.

7. Adjustments for FS Payment Rate for Certain Rural 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 FS for ground ambulance transports furnished in certain rural areas is increased by a percentage amount determined by CMS centrally. This increase applies if the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. CMS will determine this bonus amount and the designated POP rural ZIP codes in which the bonus applies. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a "B" indicator on the national ZIP code file. (See Section §20.1.6, "A. Special Instructions for Transition (Intermediaries and Carriers)" for the national ZIP code file layout and further directions for downloading the file.) Contractors must apply the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP codes.

8. Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006. For

services furnished where the POP is urban, the rates are increased by 1 percent, and for services furnished where the POP is rural, the rates are increased by 2 percent. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that become effective on July 1, 2004:

Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA

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

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

***Carrier/intermediary systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file. However, carriers and intermediaries must continue to apply the applicable FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.*

B. Air Ambulance Services

1. Base Rates

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

2. Geographic Adjustment Factor (GAF)

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

3. Mileage

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

4. Adjustment for Services Furnished in Rural Areas

The payment rates for air ambulance services where the *POP* is in a rural area are greater than in an urban area. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted *FS* amount, e.g., the applicable air service base rate multiplied by the GAF plus the mileage amount or, in other words, 1.5 times both the applicable air service base rate and the total mileage amount.

The basis for a rural adjustment for air ambulance services is determined in the same manner as for ground services. That is, whether the POP is within a rural ZIP code as described above for ground services.

20.1.5 - ZIP Code Determines Fee Schedule Amounts

(Rev. 220, 06-25-04)

PMs AB-00-88, AB-01-165, Training Book-CH 3, AB-02-131

The *POP* determines the basis for payment under the *FS*, and the POP is reported by its 5-digit ZIP code. Thus, the ZIP code of the POP determines both the applicable GPCI and whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the ZIP code of the POP of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the ZIP code of the POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment. Carriers must report the POP ZIP code, at the line item level, to CWF when they report all other ambulance claim information. CWF must report the POP ZIP code to the national claims history file, along with the rest of the ambulance claims record.

A - No ZIP Code

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

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

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

If the ZIP code entered on the claim is not in the CMS-supplied ZIP Code File, manually verify the ZIP code to identify a potential coding error on the claim or a new ZIP code established by the U.S. Postal Service (USPS). ZIP code information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. All such ZIP codes are to be considered urban ZIP codes until CMS determines that the code should be designated as rural, unless the contractor exercises its discretion to designate the ZIP code as rural. (See Section §20.1.5.B – New ZIP Codes.) If this process does not validate the ZIP code, the claim must be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

B - New ZIP Codes

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

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

If the provider or supplier believes that a new ZIP code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare *FS*

regulation), it may request an adjustment from the intermediary or appeal the determination with the carrier, as applicable, in accordance with standard procedures.

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

C - Inaccurate ZIP Codes

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

D - Claims Outside of the U.S.

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

- Ground transports with pickup and drop off points within Canada or Mexico will be paid at the fee associated with the U.S. ZIP code that is closest to the *POP*;
- For water transport from the territorial waters of the U.S., the fee associated with the U.S. port of entry ZIP code will be paid;
- Ground transports with pickup within Canada or Mexico to the U.S. will be paid at the fee associated with the U.S. ZIP code at the point of entry; and
- Fees associated with the U.S. border port of entry ZIP codes will be paid for air transport from areas outside the U.S. to the U.S. for covered claims.

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

20.1.6 - Transition Overview

(Rev. 220, 06-25-04)

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

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

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

Calculating the Blended Rate During the Transition

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

- Suppliers (carrier claims) were paid based on a reasonable charge methodology; or

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

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

- For suppliers, the blended rate includes both a portion of the reasonable charge and the *FS* amount. For the purpose of implementing the transition to the *FS*, the reasonable charge for each supplier is the reasonable charge for 2000 (i.e., the lowest of the customary charge, the prevailing charge, or the inflation indexed charge (IIC) previously determined for 2000) adjusted for each year of the transition period by the ambulance inflation factor as published by CMS.

- For services furnished during the transition period, suppliers using Method 3 or Method 4 may bill HCPCS codes A0382, A0384, A0392 through A0999, J-codes, and codes for EKG testing. These Method 3 and Method 4 HCPCS codes are subject to the phase-in blending percentages. Therefore, carriers apply the appropriate transition year blending percentage to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the *FS*, there is no FS portion for these codes.) A similar payment may be made

during the transition period for HCPCS codes A0420 and A0424 if billed by a Method 1 biller or Method 2 biller. Carriers do not change any Method 1 or Method 2 biller to Method 3 or 4.

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

A. Special Instructions for Transition (Intermediaries and Carriers)

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

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

The following is a record layout of the zip code file:

ZIP CODE FILE RECORD DESCRIPTION

Field Name	***Position***	***Format***	***COBOL Description***
State	*1-2*	*X(02)*	*Alpha State Code*
ZIPCODE	*3-7*	*X(05)*	*Postal ZIPCODE*
Carrier	*8-12*	*X(05)*	*Medicare Part B Carrier Number*
Locality	*13-14*	*X(02)*	*Pricing Locality*
*Rural**	*15*	*X(01)*	*R = Rural ZIPCODE, B = Rural ZIPCODE qualifying for additional rural bonus amount (Amount to be determined by CMS, effective July 1, 2004)*
Year	*16-19*	*X(04)*	*Pricing Year*
Quarter	*20*	*X(01)*	*Release Quarter*

**Effective July 1, 2004, CMS will add a "B" indicator to the Zip Code File.*

A ZIP code located in a rural area will be identified with either a letter "R" or a letter "B." Some zip codes will be designated as rural due to the Goldsmith Modification even though the zip code may be located, in whole or in part, within an MSA or NECMA. A"B" designation indicates that the ZIP code is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. Effective for claims with dates of service between July 1, 2004 and December 31, 2009, contractors must apply a bonus amount to be determined by CMS to the base rate portion of the payment under the FS for ground ambulance services with a POP "B" ZIP code. This amount is in addition to the rural bonus amount applied to ground mileage for ground transports originating in a rural POP ZIP code.

Each calendar quarter beginning April 2002, CMS will upload an updated ZIP code file to the Direct Connect (formerly the Network Data Mover). Approximately 6 weeks prior to the beginning of each calendar quarter (i.e., approximately 6 weeks prior to January 1, April 1, July 1, and October 1), an e-mail will be be sent out notifying all carriers, intermediaries and systems maintainers of the availability of the updated file. The updated file will be available in the early November for the January 1 realease, early February for the March 1 release, early May for the July 1 release, and early August for the September 1 release.

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

1. *Upon e-mail notification of the availability of an updated ZIP Code file, go to the Direct Connect and search for the file. Confirm that the release number (last 5 digits) corresponds to the upcoming calendar quarter. If the release number (last 5 digits) does not correspond to the upcoming calendar quarter, notify CMS.*

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

   *The name of the file will be in the following format: MU00.AAA2390.LOCALITY.VCCYYQ. Only the last 5 positions of the name (i.e., "CCYYQ") will vary(for century, year, and quarter). So, for example, the name of the file update for April 2002 is **MU00.@AAA2390.ZIP.LOCALITY.V20022**. The release number for this file is 20022, release 2 for the year2002.*

   When the updated file is loaded to the Direct Connect, it will overlay the previous zip code file.

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

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

The addresses for the Fee Schedule Files are as follows:

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

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

AMBULANCE FEE SCHEDULE FILE RECORD DESCRIPTION

Field Name	*Position*	*Format*	*Description*
HCPCS	*1-5*	*X(05)*	*Healthcare Common Procedure Coding System*
Carrier Number	*6-10*	*X(05)*	
Locality Code	*11-12*	*X(02)*	
Base RVU	*13-18*	*s9(4)v99*	*Relative Value Unit*
Non-Facility PE GPCI	*19-22*	*s9v9(3)*	*Geographic Adjustment Factor*
Conversion Factor	*23-27*	*s9(3)v99*	*Conversion Factor*
Urban Mileage/Base Rate	*28-34*	*s9(5)v99*	*Urban Payment Rate or Mileage Rate (determined by HCPCS)*
Rural Mileage/Base Rate	*35-41*	*s9(5)v99*	*Rural Payment Rate or Mileage Rate (determined by HCPCS)*
Current Year	*42-45*	*9(04)*	*YYYY*
Current Quarter	*46*	*9(01)*	*Calendar Quarter – value 1-4*
*Effective Date**	*47-54*	*9(8)*	*Effective date of the fee schedule file (MMDDYYYY)*
Filler	*55-80*	*X(26)*	*Future use*

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

B. Special Carrier Instructions for Transition

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

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

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

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

Claims are processed using the new HCPCS codes created for the ambulance *FS*. Carriers must crosswalk HCPCS codes to determine the reasonable charge amount attributable to the new HCPCS codes. *If a carrier currently uses local codes, the carrier must establish their own supplemental crosswalk with respect to any such local codes.* If a supplier bills a new HCPCS code for which there is insufficient actual charge data, carriers follow the instructions for gap filling in the Medicare Claims Processing Manual, Chapter 23, "Fee Schedule Administration and Coding Requirements."

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

To establish a supplier specific reasonable charge for the new HCPCS mileage code A0425, carriers develop an average, e.g., a simple average, not a weighted average, from the supplier specific reasonable charges of the old mileage codes A0380 and A0390. The average amount is used as the reasonable charge for 200*1* and updated by the Ambulance Inflation Factor.

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

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

C. Carrier/*Intermediary* Determination of Fee Schedule Amounts

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

- If an urban ZIP code is reported with a ground or air HCPCS code, the carriers/*intermediaries* determine the amount for the service by using the *FS* amount for the urban base rate. To determine the amount for mileage, multiply the number of reported miles by the urban mileage rate.

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

    - *For services furnished before July 1, 2004,* for rural miles 1-17, the rate equals 1.5 times the urban ground mileage rate per mile. Therefore, multiply 1.5 times the urban mileage rate amount on the *FS* to derive the appropriate FS rate per mile;

    - *For services furnished on or after July 1, 2004, for rural miles 1-17, the rate equals 1.5 times the rural ground mileage rate per mile. Therefore, multiply 1.5 times the rural mileage rate amount on the FS to derive the appropriate FS rate per mile;*

    - *For services furnished before January 1, 2004, for rural miles 18-50 the rate equals 1.25 times the urban ground mileage rate per mile. Therefore, multiply 1.25 times the urban mileage rate amount on the FS to derive the appropriate FS rate per mile. For all ground miles greater than 50 the FS rate equals the urban mileage rate per mile;*

    - *For services furnished during the period January 1, 2004 through June 30, 2004, for all ground miles greater than 17, the FS rate equals the urban mileage rate per mile; and*

    - *For services furnished during the period July 1, 2004 through December 31, 2008, for all ground miles greater than 50 (i.e., miles 51+), the FS rate equals 1.25 times the applicable mileage rate (urban or rural).*

Therefore, multiply 1.25 times the urban or rural, as appropriate, mileage rate amount on the FS to derive the appropriate FS rate per mile.

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

D. Summary of Claims Adjudication Under the Transition

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

- The supplier's 2002 reasonable charge for each HCPCS code for each reasonable charge locality is established by adjusting the reasonable charge for 2000 by the 2001 and 2002 ambulance inflation factors. Refer to the chart in the beginning of this section for additional years;

- The carrier must establish a crosswalk for each new HCPCS code to each applicable old HCPCS code for each billing method the carrier currently supports. If a carrier currently uses local codes, the carrier must establish their own supplemental crosswalk with respect to any such local codes. If practical, carriers may convert all suppliers to one billing method. By the full implementation of the *FS*, all suppliers will bill using the former method 2 for all services. During the transition period, each supplier must select and bill only one method in a carrier's jurisdiction. Providers billing intermediaries use only Method 2;

- For each ambulance claim, the carrier accesses the ZIP code file provided by CMS to determine both the appropriate locality code for the *FS* and the rural adjustment indicator, if any;

- For each mileage line item with an urban ZIP code, the carrier uses the mileage HCPCS code and the number of reported miles and multiplies the number of miles by the urban mileage rate specified in the *FS* file;

- If the HCPCS code is a ground service with a rural ZIP code (as indicated in the ZIP code file), then the carrier multiplies the number of miles reported (not to exceed 17 miles) by the urban mileage rate specified in the *FS* file, then this is multiplied by 1.5. For services furnished before January 1, 2004, *for* any mileage between 18 and 50 the carrier multiplies the number of miles reported (not to exceed 50 miles) by the urban mileage rate specified in the *FS* file, then this is multiplied by 1.25; any miles in excess of 50 are multiplied by the urban rate. For services furnished *during the period January 1, 2004 through June 30, 2004*, any miles in excess of 17 are multiplied by the urban rate.

  - *For services furnished during the period July 1, 2004 through December 31, 2008, the carrier multiplies the number of miles reported that exceed 50 miles*

(i.e., mile 51 and greater) for both urban and rural ZIP codes by the applicable mileage rate specified in the FS file (urban or rural), then this is multiplied by 1.25.

- *For services furnished during the period January 1, 2004 through June 30, 2004, any miles reported in excess of 17 miles are multiplied by the urban rate; For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).*

- If the HCPCS code is an air service with a rural ZIP code, then the carrier uses the rural service amount and the rural mileage amount;

- The carrier must then add the appropriate transitional blending percentage of the *FS* amount for the service and the appropriate transitional blending percentage of the reasonable charge for the service. The resulting sum is the blended amount for the service. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge;

- The carrier must then add the appropriate transitional blending percentage of the *FS* amount for the mileage and the appropriate transitional blending percentage of the reasonable charge for the mileage (if any). The resulting sum is the blended amount for the mileage. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge;

- If the supplier submits a charge for an allowed separately billable item or service as described in the beginning of this section, §20.1.6, the carrier determines the reasonable charge for that year for the reported HCPCS code for the item and multiplies that amount by the appropriate transitional blending percentage. The carrier then compares that amount (because there is no blended *FS* amount for separately billable line items) to the submitted charge for that HCPCS code and carries forward the lower of the two amounts;

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

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