Program Memorandum Intermediaries/Carriers

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

Transmittal AB-02-131 **Date: SEPTEMBER 27, 2002**

CHANGE REQUEST 2297

SUBJECT: Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule

A. Scope

This Program Memorandum (PM) provides additional guidance on issues related to the implementation of the ambulance fee schedule.

B. Background

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen which require clarification. This PM provides additional guidance on these issues, and supplements previously issued instructions regarding the implementation of the ambulance fee schedule.

NOTE: This PM is not intended to replace previously issued instructions and does not encompass all issues that have been addressed to date through informal processes. Additional issues will be addressed in the future.

C. Policy

The following clarifications, organized by category, reflect Medicare's policy regarding the implementation of the ambulance fee schedule. If they have not already done so, intermediaries and carriers must implement these policies as specified in this PM.

D. Business Requirements

1. Issues Addressed in this PM:

    a. Implementation of the Ambulance Fee Schedule
    b. Sources of Additional Information
    c. No Transport
    d. HCPCS Codes
    e. Zip Codes
    f. Basic Life Support (BLS)/Advanced Life Support (ALS) Joint Responses
    g. Ground to Air Ambulance Transports
    h. Mileage
    i. Payment for Supplies and Ancillary Services

2. Policy Clarifications

    a. <u>Implementation of the Ambulance Fee Schedule</u>

    The ambulance final rule published on February 27, 2002, establishes a fee schedule for the payment of ambulance services under the Medicare program, thereby implementing section 1834(l) of the Social Security Act. The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. The final rule established a 5-year 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 or reasonable charge, as applicable.

During the transition period, the fee schedule amount, blended with a provider's reasonable cost or supplier's reasonable charge portion of the payment, will determine the ambulance fee schedule blended rate for each transition year.

The percentages for the blended rate during the transition period are as follows:

Transition Year	**Reasonable Charge/Cost Percent**	**Fee Schedule Percent**
Year One (4/01/2002-12/31/2002)	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

The fee schedule effective date is based on the date of service for the claim, and not the date of processing. Claims with a date of service prior to April 1, 2002, may not be resubmitted for processing under the new ambulance fee schedule guidelines. These claims are processed using the reasonable cost or reasonable charge methodology, as applicable, that was in place prior to the fee schedule.

b. Sources of Additional Information

i. *Fee Schedule Formula/Payment Calculations*

The ambulance fee schedule final rule, published in the **Federal Register** (67 FR 9100) on February 27, 2002, provides the formula for calculating the ambulance fee schedule amount and examples of payment rate calculations.

ii. *Zip Code File*

The zip code public use file posted on the CMS web site located at www.cms.hhs.gov/medlearn (under Ambulance Fee Schedule, Zip Code File for Ambulance Services) can be used to determine the locality that applies for a particular geographic area.

iii. *Fee Schedule File*

The ambulance fee schedule public use file is posted at the same location on the CMS Medlearn Web site.

c. No Transport

The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. This policy applies to situations in which the beneficiary refuses to be transported, even if medical services are provided prior to loading the beneficiary onto the ambulance (e.g., BLS or ALS assessment). However, the entity that furnishes a non-covered service to a Medicare beneficiary may bill the beneficiary for the service.

d. HCPCS Codes

i. *Local Codes*

For carriers that have eliminated local codes, bundle the amounts allowed for those items into the base rate, using a weighted average when calculating the reasonable charge amount.

ii. *Supplies and Ancillary Services*

In jurisdictions where separate billing for supplies and ancillary services was permitted prior to the implementation of the fee schedule, suppliers may continue to use supply codes A0382, A0384, A0392-A0999, as well as J-codes for drugs and codes for EKG testing until the end of the transition period (December 31, 2005), or until such codes are eliminated by the implementation of the Health Insurance Portability and Accountability Act (HIPAA) standards for electronic submission of claims, whichever is sooner. Note that HCPCS A0999 is valid for carrier claims only, and may not be used for intermediary billing.

e. Zip Codes

i. *Area without a Zip Code*

In areas without an apparent zip code, it is the provider's/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 provider/supplier has made a good-faith effort to confirm that no zip code for the point-of-pickup exists, it may use the zip code nearest to the point-of-pickup.

Providers and 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"). Providers and suppliers should maintain this documentation and provide it to their intermediary or carrier upon request.

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 point-of-pickup. Investigate and report any claims submitted with an inappropriate and/or falsified surrogate zip code.

ii. *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 fee schedule 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 point of pickup zip code that is not on the Medicare zip code file, search the USPS Web site, other governmental Web sites, and commercial Web sites, to validate the new zip code. (The Census Bureau Web site located at tier2.census.gov/ctsl/ctsl.htm 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.

iii. *Reporting Inaccurate Zip Code Information*

Alert providers and suppliers that if they 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.

f. 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 fee schedule definition of an ALS intervention (e.g., ALS assessment, Paramedic Intercept services, etc.), 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. Refer any issues that cannot be resolved to your Regional Office.

While there must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service, Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

g. Ground to Air Ambulance Transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance 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.

h. Mileage

i. *Local Billing Practices for Carrier-Based Mileage Calculations*

Payment is allowed for all medically necessary mileage. That is, Medicare allows payment for mileage incurred transporting the beneficiary to the nearest appropriate facility (or transfer point in the case of an air to ground or ground to air transfer).

ii. *Rural Adjustment Versus Lower of Submitted Charge or Fee Schedule Amount*

Although a transport with a point-of-pickup 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 fee schedule amount for mileage. Thus, when rural mileage is involved, compare the fee schedule rural

mileage payment rate blended with the reasonable cost/charge mileage amount to the provider's/supplier's actual charge for mileage, and pay the lesser amount.

iii. *Billing Rural Mileage*

Instruct providers and suppliers to report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item on the CMS-1500/CMS-1491/CMS-1450/electronic claim form.

iv. *Calculating the Rural Adjustment*

If the point-of-pickup is a rural zip code, use the following calculations 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 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. The rural adjustment for air ambulance services (fixed wing or rotary wing) is 1.5 times both the applicable air service base rate and the total mileage amount.

v. *Additional Air Mileage*

Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions.
- Hazardous weather.
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

i. Payment for Supplies and Ancillary Services

Under the ambulance fee schedule, payment for supplies and ancillary services furnished incident to the ambulance transport are included in the ground base rates and in the two air base rates. Medicare will not make a separate, additional payment for supplies and services under the fee schedule.

This policy is unchanged with respect to providers that bill intermediaries. This policy is also unchanged with respect to suppliers that have previously submitted claims to carriers under Billing Methods 1 & 2. This policy change affects only those suppliers that submit claims to carriers under Billing Methods 3 or 4 in those jurisdictions where such billing methods were supported prior to the fee schedule implementation and where those billing methods continue to be supported.

During the 4-year transition to the full ambulance fee schedule, Method 3 and Method 4 billers may continue to submit claims to bill separately for medically necessary supplies and ancillary services furnished incident to the ambulance transport in those jurisdictions where it was permissible to do so prior to the fee schedule implementation. Such items and services include, but are not necessarily limited to: drugs, supplies, EKGs, waiting time, and extra

attendants. See the instruction on HCPCS codes that relate to separately billable supplies and ancillary services.

During the transition period, payment for separately billable supplies and ancillary services is calculated on the basis of the reasonable charge portion of the blended rate. That is, in each year of the transition, the Medicare allowed amount for such items and services is subject to the percentage allowed for the reasonable charge portion of the blended rate for the year in which such item or service was furnished.

Thus, for 2002, the Medicare allowed amount for a separately billable supply or service would be 80 percent of the reasonable charge for the item or service. In 2003, the Medicare allowed amount would be 60 percent of the reasonable charge; in 2004 it would be 40 percent; in 2005 it would be 20 percent.

Beginning in 2006, supplies and ancillary services will no longer be separately billable.

E. Provider Education

Notify providers and suppliers of these policy clarifications in the next scheduled newsletter and update your Web site with this information.

The *effective date* for this PM is not applicable.

The *implementation date* for this PM is not applicable.

These instructions should be implemented within your current operating budget.

This PM may be discarded after September 30, 2003.

Contact the appropriate Regional Office for additional guidance.