MEDICARE PART A BULLETIN

January 24, 1997 General Medicare Bulletin G-266

TO: All Medicare Providers

FROM: Andy DePirro, Director, Program Relations

SUBJECT: **BILLING INSTRUCTIONS FOR AMBULANCE SERVICES: REQUIRED HCPCS CODES AND MODIFIERS, EFFECTIVE FOR SERVICES RENDERED ON AND AFTER JANUARY 1, 1997**

ATTENTION MEDICARE BUSINESS OFFICE: Please distribute to all appropriate health care facility personnel.

General Medicare Bulletin G-249, dated December 10, 1996, published new billing requirements for ambulance services. Hospital providers were originally notified of this change via the Medicare Hospital Manual (HCFA-Publication 10), Transmittal No. 700, dated September, 1996. The purpose of this bulletin is to provide additional billing instructions for ambulance services.

Specifically, the Health Care Financing Administration's (HCFA's) revised reporting instructions require the use of HCPCS and modifiers when billing for ambulance services. In order to enhance consistency in the reporting of ambulance services, and to make accurate medical necessity determinations without obtaining additional medical information, providers are required to report HCFA Common Procedure Coding System (HCPCS) Level II codes and modifiers on all ambulance claims. This reporting requirement is effective for ambulance services rendered on and after January 1, 1997.

HCFA's revised instructions eliminate the optional requirement for hospitals and adds the requirement for all providers to report HCPCS codes and modifiers when billing for ambulance services, effective for services rendered on and after January 1, 1997. Providers are required to report HCPCS and modifiers to describe the type of ambulance services, pickup-origins, and destinations.

The revised instructions also require providers to report new HCPCS modifiers (**QM or QN**) to distinguish between ambulance services provided under arrangement or ambulance services furnished directly by the provider. This requirement adds consistency to the reporting of ambulance services and assists in medical review.

AMBULANCE SERVICES:

The Medicare Part A intermediary processes claims for ambulance services provided under arrangements between a provider (including rural primary care hospitals) and an ambulance company or ambulance services furnished directly by a provider. Whether or not the patient is subsequently admitted as an inpatient, the provider bills ambulance services as an outpatient service, via the HCFA-1450 (UB-92) billing format. (See "Reporting Exception," page 8, when services are

provided while the patient is an inpatient.)

HCPCS Reporting Requirement:

Providers are required to bill HCPCS (Level II) codes and modifiers on the HCFA-1450 (UB-92) in Form Locator (FL) 44, "HCPCS/Rates," to report:

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- **Ambulance services = HCPCS code (FL 44) with associated revenue code (FL 42),**
- **Pick-up origins = Modifier with associated HCPCS code (FL 44), and**
- **Destinations = Modifier with associated HCPCS code (FL 44).**

In addition, one of the following modifiers must be reported to describe whether the service was provided under arrangement or directly, when billing for ambulance services:

- **QM : Ambulance service provided under arrangement by a provider of services; or**
- **QN : Ambulance service furnished directly by a provider of services.**

The intermediary has installed edits in the automated claims processing system (Florida Shared System/FSS) to ensure the presence of HCPCS coding and one of the above HCPCS modifiers on all ambulance claims (i.e., any bill reflecting revenue code 54X "Ambulance").

Methods for Reporting Ambulance Services:

To ensure a smooth transition to the use of the new coding structure, HCFA established four methods for reporting covered ambulance services. These methods attempt to accommodate all billing patterns currently used across the United States for ambulance transportation and are as follows:

- **Method 1** is a single, all-inclusive charge reflecting all services, supplies and mileage.
- **Method 2** is one charge reflecting all services and supplies, with a separate charge for mileage.
- **Method 3** is one charge for all services and mileage, with a separate charge for supplies.
- **Method 4** is separate charges for services, mileage and supplies.

In areas where separate charges are recognized for specialized, generally advanced life support (ALS) services (e.g., intubation, intravenous (IV) drug administration, and defibrillation), those separate payments recognize only the cost of specialized supplies. Personnel, reusable supplies, and capital equipment costs are all considered to be part of the basic ambulance services and are expected to be included in the transport and/or mileage charge.

Subsequent to establishing these four payment methods, HCFA instructed all Medicare contractors (Part A Intermediaries and Part B Carriers) to implement the method which most closely conforms to the billing patterns they currently accept. Although intermediary manual instructions (HCFA Publication 13-3, Rev. 1688) advise that ambulance claims will be paid at "reasonable cost," **Method**

4 (which is separate charges for services, mileage, and supplies) will be utilized for billing ambulance services to this fiscal intermediary, via the HCFA-1450 (UB-92) billing format.

Method 4 HCPCS (Level II) Codes and Nomenclature:
Under Method 4, the only HCPCS codes that may be billed for ambulance services, via the HCFA-1450 (UB-92) billing format, are as follows:

HCPCS CODE	NOMENCLATURE/NARRATIVE DESCRIPTION
A0360	Ambulance service, basic life support (BLS), non-emergency transport, mileage and disposable supplies separately billed
A0362	Ambulance service, BLS, emergency transport, mileage and disposable supplies separately billed
A0364	Ambulance service, advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed
A0366	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed
A0368	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed
A0370	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed
A0380	BLS mileage (per mile)
A0382	BLS routine disposable supplies
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0390	ALS mileage (per mile)
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)
A0394	ALS specialized service disposable supplies; IV drug therapy
A0396	ALS specialized service disposable supplies; esophageal intubation
A0398	ALS routine disposable supplies

HCPCS CODE	NOMENCLATURE/NARRATIVE DESCRIPTION
A0420	Ambulance waiting time (ALS or BLS), one half («) hour increments

Waiting Time Table:

Units	Time
1	« to 1 hour
2	1 to 1-1/2 hours
3	1-1/2 to 2 hours
4	2 to 2-1/2 hours
5	2-1/2 to 3 hours
6	3 to 3-1/2 hours
7	3-1/2 to 4 hours
8	4 to 4-1/2 hours
9	4-1/2 to 5 hours
10	5 to 5-1/2 hours

A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra ambulance attendant, ALS or BLS (requires medical review)
A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)
A0999	Unlisted ambulance service

Mileage: The codes reflected above for "BLS" and "ALS" mileage are used to report covered mileage that represents ambulance transport to the nearest appropriate facility. Code A0888 (Noncovered ambulance mileage) was added to the coding structure primarily to facilitate supplemental insurance billing.

HCPCS Code Modifiers for Ambulance Billing:

HCFA's reporting instructions, for services rendered on and after January 1, 1997, require the reporting of **HCPCS code modifiers** for ambulance **pickup-origins and destinations**.

MODIFIERS: Report the appropriate modifier(s) via the HCFA-1450 (UB-92) billing format. When reporting both ORIGIN and DESTINATION in combination, the first digit should indicate the origin and the second digit the destination of the ambulance.

HCPCS Level II Modifier (Origin/Destination)	Narrative Description
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes.

E	Residential, domiciliary, custodial facility

HCPCS Level II Modifier (Origin/Destination)	**Narrative Description**
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X*	Intermediate stop at physician's office en route to the hospital (includes HMO non-hospital facility, clinic, etc.) [*Destination code only]

In addition, **one of the following modifiers must be reported** to describe whether the service was provided under arrangement or provided directly, when billing for ambulance services:

MODIFIERS: Report one of the appropriate modifiers to indicate whether the ambulance service was provided "directly" or "under arrangements." NOTE: If ambulance services are billed directly to the Medicare Part B Carrier by the ambulance "supplier" (via the HCFA-1500 billing format), the Part A provider does not bill for ambulance services.

QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

Although the five-digit HCPCS code (e.g., A0360) is always reported first, modifiers (two-digit origin and destination combinations, plus two-digit QM -under arrangement or QN-direct) may be reported in any order/sequence on the claim.**

For example, HCPCS code "A0360"; plus Origin/Destination Code "SH"; plus "QM" (under arrangement) or "QN" (direct) may be reported as any of the following:

A0360SHQM or **A0360QMSH** **A0360SHQN** or **A0360QNSH**

**** Origin/Destination (Two-Digit) Combination Codes:** The first digit represents the origin and the second digit the destination; therefore, these two-digit combinations must be reported in appropriate order either before or after the QM/QN modifier. For example: Origin = Residence (R), Destination = Hospital (H), and Ambulance = Under Arrangements (QM);

Modifier may be reported as: RHQM (or) QMRH.
Revenue Code(s) for Ambulance Billing:

The intermediary has installed edits in the automated claims processing system (Florida Shared System/FSS) to ensure the presence of HCPCS coding and the appropriate HCPCS modifier combinations on all ambulance claims (i.e., all bills reporting revenue code 54X "Ambulance").

The following are billable revenue codes for ambulance services, via the HCFA-1450 (UB-92) billing format:

REVENUE CODE	DESCRIPTION
540	Ambulance: General Classification
541	Supplies
542	Medical Transport
543	Heart Mobile
544	Oxygen
545	Air Ambulance
547	Pharmacy
548	Telephone Transmission EKG
549	Other

For billing purposes, providers must align the HCPCS and modifier billing requirements with the appropriate allowable revenue code(s) for ambulance services.

HCFA-1450 (UB-92) Billing Example by Form Locator (FL), with narrative descriptions: Patient transported via ambulance in an emergency situation from the patient's home to the nearest appropriate hospital facility; ambulance services furnished directly by the hospital.

FL 42* (Rev Code)	FL 43 (Rev Cd Descriptor)	FL 44* (HCPCS/Rate)	HCPCS/Modifier Narrative Description
540	General Classification	A0370RHQN (or) A0370QNRH	Ambulance service, ALS,emergency (Residence to Hospital; Direct)
541	Supplies	A0398RHQN (or) A0398QNRH	ALS Routine disposable supplies (Residence to Hospital; Direct)
542	Medical Transport	A0390RHQN (or) A0390QNRH	ALS mileage (per mile)
544	Oxygen	A0422RHQN (or) A0422QNRH	Ambulance (ALS or BLS) oxygen/ oxygen supplies (Residence toHospital; Direct)

***NOTE: In the above example, only FL 42 and FL 44 are required billing elements, revenue code narrative descriptions (FL 43) are optional entries.**

Emergency Services:

The HCPCS codes designated for ambulance billing are characterized as "emergency" and "non-emergency." For ambulance billing purposes, the needs to be an established definition of "emergency." HCFA suggests using the following definition that parallels the statutory definition of emergency services in hospital emergency rooms. The term "emergency" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Conversely, any ambulance trip that does not meet criteria would be determined to be a non-emergency service. This includes all scheduled runs (regardless of origin and destination), as well as transport to nursing homes or to the patient's residence. Transports to and from ESRD facilities for maintenance dialysis are scheduled and, therefore, are non-emergency ambulance services. In contrast, transport to ESRD facilities for patients experiencing acute renal failure would be appropriately considered emergency ambulance services. Because local governments are increasingly mandating ALS as the minimum level of ambulance response, there has been rapid growth in the use of ALS vehicles for routine or non-emergency transports. Therefore, it is important that provider's pay particular attention to the patient's condition, special services furnished, and origin and destination information, as appropriate to determine whether billings for ALS emergency services are accurate.

Currently, ambulance claims submitted via the HCFA-1450 (UB-92) billing format are processed via this intermediary's Artificial Intelligence (AI) System, in compliance with the HCFA regulations published in the Medicare Hospital Manual (HCFA Publication 10, Section 236). This information was communicated to hospital providers via Hospital Medicare Bulletin H-60, dated April 29, 1996. In addition, the Medicare contractor (Part A Intermediary/Part B Carrier) is in the process of developing Local Medical Review Policy (LMRP) for ambulance services. Once the LMRP is finalized, the Medicare Part A Medical Policy Procedure will be released to the provider community via Medicare Bulletin.

Reporting Exception - Transportation Services While Patient is an Inpatient:

All items and non-physician services furnished to inpatients must be furnished directly by the inpatient provider or billed by the inpatient provider under arrangements. This provision applies to all hospitals, regardless of whether they are subject to Prospective Payment System (PPS) reimbursement.

Transportation is not an *"ambulance service;"* therefore, such charges are included or bundled into the inpatient bill. All transportation, *including transportation by ambulance*, to and from another

hospital or freestanding facility to received specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient, is covered as part of the inpatient bill.

Providers must include the cost of these services in the appropriate ancillary service cost center (i.e., in the cost of the diagnostic or therapeutic service). These charges may not be billed separately on the inpatient bill (i.e., do not report revenue code 54X "Ambulance" on the inpatient bill). Further, these services may not be billed as an outpatient claim, either to the Part A intermediary via the HCFA-1450 (UB-92) or the Part B Carrier via the HCFA-1500, since "transportation services" must be bundled into the inpatient bill.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904)355-8899.