Medicare B Update!
A Newsletter for Florida Medicare Part B Providers

Special Issue

Ambulance Fee Schedule

At press time, HCFA has announced a delay in the implementation of certain components of the Ambulance Fee Schedule. Important information regarding this delay may be found on page 7.

The Health Care Financing Administration (HCFA) plans to implement a new payment system for medically necessary transports effective for services provided **on or after January 1, 2001** based on section 4531 (b) (2) of the Balanced Budget Act of 1997 (which added a new section [1834 (l)] to the Social Security Act). **This new payment system will involve new HCPCS codes, payment methods, and claim requirements.** HCFA will no longer pay for these services based on reasonable charges or reasonable cost. Instead, payment will be made from a fee schedule. The fee schedule applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers (i.e., hospitals, critical access hospitals, skilled nursing facilities and home health agencies).

This publication provides a basic overview of the new Ambulance Fee Schedule payment system, including the transition schedule and delayed implementation of certain components. Please refer to HCFA Program Memoranda (PM) AB-00-88 and AB-00-118, issued on September 18, 2000 and November 30, 2000 respectively, for more information. Copies of these PMs may be downloaded at **www.hcfa.gov/medlearn/refamb.htm.**

Ambulance services will be reported on claims using new HCPCS codes that reflect the seven categories of ground service and two categories of air service.

Mandatory assignment is required for all ambulance services when the fee schedule is implemented.

The fee schedule will be phased in over a four-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

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Routing Suggestions:

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____

_____

_____

Categories of Ambulance Services

There are **seven** categories of ground ambulance services and **two** categories of air ambulance services under the new fee schedule. The ground service categories refer to both land and water transportation and are listed below:

The **ground** service categories include:

1. Basic Life Support
2. Basic Life Support – Emergency
3. Advanced Life Support, Level 1
4. Advanced Life Support, Level 1 – Emergency
5. Advanced Life Support, Level 2
6. Specialty Care Transport
7. Paramedic Intercept

The **air** service categories include:

1. Fixed Wing Air Ambulance (airplane)
2. Rotary Wing Air Ambulance (helicopter)

The HCPCS codes used to report these services may be found on page 3.

Ground Services

Ground services are reimbursable if they meet Medicare medically necessary coverage guidelines. An emergency response is one that, at the time the ambulance is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

Ground Services Category Definitions

Basic Life Support (BLS) — The provision of basic life support services as defined by the National EMS Education and Practice Blueprint from EMT, including the establishment of a peripheral intravenous (IV) line.

Basic Life Support (BLS) – Emergency — The provision of BLS services as described above, in the context of an emergency response.

Advanced Life Support, Level 1 (ALS1) — The provision of an assessment by an advanced life support (ALS) provider or supplier or the provision of one or more ALS interventions. An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

Advanced Life Support, Level 1 (ALS1 – Emergency) — The provision of ALS1 services, as specified above, in the context of an emergency response.

Advanced Life Support, Level 2 (ALS2) — The administration of three or more different medications **or** the provision of at least one of the following ALS procedures:

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

Advanced life support (ALS) assessment is an assessment performed by an ALS crew that results in the determination that the patient's condition requires an ALS level of care, even if no other ALS intervention is performed.

Specialty Care Transport (SCT) — A level of inter-facility service, for a critically injured or ill beneficiary, provided beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training. Florida Medicare processes all claims for SCT on an individual consideration (IC) basis.

Paramedic Intercept (PI) — Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. *NOTE: the Paramedic Intercept provision is not applicable in most geographical areas, including all of Florida.*

Air Services

Air services are reimbursable when transport meets Medicare coverage requirements, and the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Florida Medicare processes all claims for air services on an IC basis.

Higher operational costs for the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

Air Services Category Definitions

Fixed Wing Air Ambulance (FW) — Transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (e.g., heavy traffic) preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Rotary Wing Air Ambulance (RW) — Transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (e.g., heavy traffic) preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Crosswalk to New HCPCS Codes for Ambulance Services

As a result of the implementation of the national ambulance fee scheduled initiative, claims for ambulance services furnished on or after January 1, 2001, must be reported using the new HCFA common procedure coding system (HCPCS) codes.

The following table provides a crosswalk of the new HCPCS codes to the old codes. This list, including descriptors, is in Attachment B of HCFA PM AB-00-88.

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)	A0030
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)	A0040
A0429	Ambulance service, basic life support (BLS), emergency transport, water, special transportation services	A0050
A0428	Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed	A0320
A0429	Ambulance service, BLS, emergency transport, supplies included, mileage separately billed	A0322
None	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0324
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0326
None	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0328
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0330
A0433	Ambulance service, ALS2, supplies included, mileage separately billed	A0330
A0434	Ambulance service, SCT, supplies included, mileage separately billed	A0330
A0425*	BLS mileage (per mile) ** A0425 should not be used at this time. Providers should continue to bill for mileage using code A0380 or A0390, as appropriate. See page 7 for more information regarding the delay in implementation of code A0425.*	A0380 (averaged with A0390)
A0425*	ALS mileage (per mile) ** See note above.*	A0390 (averaged with A0380)
None	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	A0420
None	Extra ambulance attendant, ALS or BLS (requires medical review)	A0424
A0999	Unlisted ambulance service	A0999
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.	Q0186
A0435	Air mileage; FW, (per statute mile)	Local Carrier Code
A0436	Air mileage; RW, (per statute mile)	Local Carrier Code

Fees for the new HCPCS codes and updated fees for mileage codes A0380 and A0390 were not available at the time this publication went to print, and will be provided to individual ambulance suppliers under separate cover.

Definitions of Level of Service	
BLS	Basic Life Support (BLS): Where medically necessary, the provision of basic life support (BLS) services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous (IV) line.
ALS1	Advanced Life Support, Level 1 (ALS1): Where medically necessary, the provision of an assessment by an advanced life support (ALS) provider and/or the provision of one or more ALS interventions. An ALS provider is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.
ALS2	Advanced Life Support, Level 2 (ALS2): Where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following ALS procedures: Manual defibrillation/cardioversion, Endotracheal intubation, Central venous line, Cardiac pacing, Chest decompression, Surgical airway, Intraosseous line.
SCT	Specialty Care Transport (SCT): Where medically necessary, in a critically injured or ill patient, a level of inter-facility service provided beyond the scope of the Paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (nursing, medicine, respiratory care, cardiovascular care, or a paramedic with additional training).
PI	Paramedic Intercept (PI): These services are defined in 42 CFR 410.40. They are ALS services provided by an entity that does not provide the ambulance transport. Under limited circumstances, these services can receive Medicare payment.
FW	Fixed Wing Air Ambulance (FW): Fixed wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, fixed wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.
RW	Rotary Wing Air Ambulance (RW): Rotary wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, rotary wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.

NOTE: As a clarification, the following is the definition of "emergency" for the BLS and ALS1 levels of service: *"An ambulance service that qualifies as an emergency response will be assigned a higher relative value to recognize the additional costs incurred in responding immediately to an emergency medical condition. An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call. There is no emergency modifier for PI, ALS2, or SCT."*

Changes Associated with the Ambulance Fee Schedule Initiative

When the ambulance fee schedule initiative is implemented, payment for ambulance services will be based on items and services provided, **not on the vehicle used.** Even if a local government requires an ALS response for all calls, Medicare pays only for the level of services provided and then only when the services are both medically necessary and covered by Medicare under the ambulance benefit.

Payment under the fee schedule for ambulance services is comprised of a base rate payment plus a separate payment for mileage. This base rate includes both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with the transport. The base rate precludes a separate payment for items and services. Such items and services include, but are not limited to items that are both medically necessary and Medicare-covered such as oxygen, drugs, extra attendants, and EKG testing.

When the ambulance fee schedule is implemented, services will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount (see page 7 for more information about the implementation date). The fee schedule will be phased in over a four-year period and when fully implemented will replace the current retrospective reasonable cost reimbursement system for providers and reasonable charge system for ambulance suppliers. Contractor reimbursement rates will be based on the supplier's current billing methodology during the transition period.

Claims jurisdiction remains unchanged for the duration of the transition to the fee schedule.

Ambulance Fee Schedule Components

Ground Ambulance Services

1. **Conversion Factor (CF) —** Money amount that serves as a nationally uniform base rate for all ground ambulance services and will be updated as necessary.
2. **Relative Value Unit (RVU) —** A numeric value assigned to each category of ground ambulance service relative to the value of a base level of ambulance service (the BLS level).

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 non-facility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule used to address regional differences in the cost of furnishing ambulance services for each ambulance fee schedule area. The location used is the one at which the beneficiary put in the ambulance.
4. **Mileage** — A nationally uniform loaded mileage rate of $5 per loaded statute mile except for the paramedic intercept (PI) category. Mileage is not billable for PI services.

5. **Rural Area Mileage Adjustment** — For services furnished in a rural area, an additional amount for mileage to account for higher costs typical to rural operations. The increase to the mileage rate is 50 percent (up to $7.50) per loaded statute mile for the first 17 miles. HCFA will provide files to contractors that identify rural/urban ZIP codes.

Air Ambulance Services

1. **Base Rate** — The national uniform base rate for fixed wing is $2213.00. The national uniform base rate for rotary wing is $2573.00. No conversion factor or RVU is applied.
2. **Geographic Adjustment Factor (GAF)** — Applied in the same manner as the ground ambulance services, except the applicable GPCI is applied to 50 percent of each of the base rates (fixed and rotary wing).
3. **Mileage** — A nationally uniform loaded mileage rate of $6 per loaded statute mile flown for fixed wing services and $16 per loaded statute mile flown for rotary wing services.
4. **Rural Area Mileage Adjustment** — For services furnished in a rural area, an additional 50 percent of the unadjusted fee schedule amount to account for higher costs typical to rural operations.

Point of Pickup

Point of pickup, as identified by the five-digit ZIP code, establishes if a rural adjustment applies. Each leg of multi-leg transports is separately evaluated for rural adjustment application determined by the point of pickup for each leg.

Rural Area, with the exception of the paramedic intercept category, is defined as a U.S. Postal Service ZIP Code that is located in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), or is an area wholly within a 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.)

Transition Schedule

When the ambulance fee schedule is implemented, payment under the schedule will be phased-in over a four-year period.

Initially, the fee schedule amount will comprise only 20 percent of the amount allowed from Medicare and the remaining 80 percent allowed by Medicare for a service furnished in year 1 of the transition will be based on the supplier's reasonable charge. Thereafter, the fee schedule amount will increase each calendar year as a percentage of the allowed amount until it reaches 100 percent in year 4. Thus, in year 1, year 2, and year 3, the amount allowed for an ambulance service will be the lower of the submitted charge or a blended rate that comprises both a fee schedule component and a provider's reasonable cost or a supplier's reasonable charge.

The phase-in schedule is as follows:

Fee Schedule Year	Fee Schedule Percentage	Reas. Charge Percentage
Year 1	20%	80%
Year 2	50%	50%
Year 3	80%	20%
Year 4	100%	0%

Calculating the Blended Rate during the Transition

Suppliers are currently paid based on a reasonable charge methodology. For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of both a fee schedule component and a provider or supplier's current payment methodology as follows:

The blended rate includes both a portion of the reasonable charge and the fee schedule amount. For the purpose of implementing the transition to the fee schedule, the reasonable charge for each supplier is adjusted for each year of the transition period by the ambulance inflation factor as published by HCFA.

A supplier specific charge will be established for the new HCPCS mileage code A0425 using a simple average (not weighted) from the supplier's specific reasonable charge for the old mileage codes A0380 and A0390. This average will be used as the reasonable charge for 2001 and updated by the Ambulance Inflation Factor.

New HCPCS Codes

- HCPCS codes A0426 through A0436 must be used effective with service dates on or after January 1, 2001. However, these codes are not valid for service dates prior to January 1, 2001.
- No grace period will be provided to transition the use of the new HCPCS codes (except A0380 and A0390 – see page 7 for more information).
- Claims submitted with old HCPCS codes for dates of service on or after January 1, 2001 will be returned as unprocessable.

Factors Impacting Payment

Categories of Service

Medicare pays only for the category of service provided and then only when it is medically necessary.

Multiple Patients

More than one patient may be transported; e.g., from the scene of a traffic accident. The fee should be prorated by the number of patients in the ambulance. Medicare Part B coinsurance, deductible, and mandatory assignment apply to this prorated amount.

Pronouncement of Death

The following two scenarios apply to payment for ambulance services when the beneficiary dies. No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called.

1. The beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene: Payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing

base rate, as applicable, if an air ambulance is dispatched. (For suppliers, there will be only one line item for this situation.) Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Suppliers continue to use the QL modifier.

2. The beneficiary is pronounced dead after being loaded into the ambulance (regardless of whether pronounced during or subsequent to the transport): Payment is made following the usual rules of payment as if the beneficiary had not died. This scenario includes a determination of "dead on arrival" (DOA) at the facility to which the beneficiary was transported.

   NOTE: Notwithstanding the beneficiary's apparent condition, the death of a beneficiary should be recognized only when the pronouncement of death is made by an individual who is licensed or otherwise authorized under State law to pronounce death in the State where such pronouncement is made.

Multiple Arrivals

When multiple units respond to a call for services, the entity that provides the transport for the beneficiary bills for all services furnished. If BLS and ALS entities respond to a call and the BLS entity furnishes the transport after an ALS assessment was furnished, the BLS entity will bill using the ALS1 rate. The BLS entity will be paid at the ALS1 rate. The BLS entity and the ALS entity settle payment for the ALS assessment.

HCPCS Codes for Service and Mileage

Individual HCPCS codes for service and mileage along with specific ZIP codes and number of miles must be reflected on the claim so accurate claim processing can occur.

Since the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Prepare a separate claim for each trip if the points of pickup are located in different ZIP codes.

Concepts Impacting Coding

The implementation of the Ambulance Fee Schedule has generated some new coding requirements. The following are the concepts that will now drive the ambulance coding requirements:

- Seven categories of ground ambulance services
- Two categories of air ambulance services
- Payment based on the condition of the beneficiary, not on the type of vehicle used
- Payment is determined by the point of pickup as reported by the five-digit ZIP code
- Increased payment for rural services
- New HCPCS codes effective for dates of service beginning January 1, 2001
- Services and supplies included in base rate
- No grace period for old HCPCS for dates of service after January 1, 2001 (except codes A0380 and A0390; see page 7 for more information)

HCFA-1500 Claim Form Coding Instructions

Medicare pays only for the category of service provided and then only when the service is medically necessary.

Generally, each ambulance trip will require two lines of coding; i.e., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

If mileage is billed, report the miles as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1" as the mileage for trips of less than a mile.

More than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Suppliers must prepare a separate claim for each trip if the points of pickup are located in different ZIP codes. Code the five-digit ZIP code of the point of pickup in item 23 of HCFA-1500 claim form.

Electronic billers using National Standard Format (NSF) are to report the origin information in record EA1:

EA1-06 = address information
EA1-08 = city name
EA1-09 = state code
EA1-10 = ZIP code

Electronic billers using X-12N 837 (3051) and (3032.2B) are to report the origin information in loop 2310.A (Facility Address):

NM1 is required:
  NM101 = value '61' (Performed At)
  NM102 = value '2' (Non-person entity)
N2 (Facility Name) is not required
N3 (Facility Address) is not required
N4 (Facility City/State/ ZIP) is required:
  N401 is used to report the city name
  N402 is used to report the state code
  N403 is used to report the ZIP code

HCFA-1491 Claim Form Coding Instructions

Form HCFA-1491 has not been revised for the new fee schedule. The following coding instructions should be followed for ambulance claims with dates of service on or after January 1, 2001 until the form is revised.

Medicare pays only for the category of service provided and then only when the service is medically necessary.

Generally, each ambulance trip will require two lines of coding; i.e., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

If mileage is billed, report the miles as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1" as the mileage for trips of less than a mile.

More than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Suppliers must prepare a separate claim for each trip if the points of pickup are located in different ZIP codes.

Generally, a claim for an ambulance service will require two entries; one HCPCS code for the service and one HCPCS code for the mileage. Suppliers who do not bill mileage would have an entry only for the service.

In item 22, enter the service HCPCS code, as well as any information necessary to describe the illness or injury.

In item 14, the mileage HCPCS code, as well as the number of loaded miles.

Implementation Date of the Ambulance Fee Schedule

On November 30, 2000, HCFA announced a delay in the implementation of the ambulance fee schedule. This means that payment for ambulance services will be made based on 100 percent of the allowance under the current payment rules (updated for inflation as described in PM AB-00-88) and **not** on the basis of the "80 percent current/ 20 percent fee schedule" blend methodology.

Although implementation of the fee schedule is delayed, implementation of the new HCPCS codes for ambulance services and requirement to report the ZIP code of the point of pickup on the claim is not delayed. Therefore, the new HCPCS codes and reporting the ZIP code of the point of pickup are effective with services **furnished on or after January 1, 2001.**

Delay Mandatory Assignment for Ambulance Services

Based on PM AB-00-88, "Implementation of the Ambulance Fee Schedule," released September 18, 2000, contractors were to make systems changes to assure that claims for ambulance services follow mandatory assignment rules. Contractors have been instructed not to revise their systems with regard to mandatory assignment until further notice. However; when mandatory assignment becomes effective, it may be necessary for contractors to enforce mandatory assignment for ambulance services through administrative actions.

ALS Vehicle used, but No ALS Service Furnished

Also based on PM AB-00-88, suppliers and providers using an ALS vehicle to furnish a BLS level of service are instructed to report on the claim HCPCS A0428 or A0429, the new HCPCS code for BLS and BLS emergency, respectively. This policy is not being implemented at this time. Until further notice, these claims must be submitted with the new HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency); contractors will process accordingly.

Payment for Mileage

Until further notice, suppliers should submit claims with the appropriate current codes, A0380 for BLS mileage and A0390 for ALS mileage. Contractors will not accept for processing any claim with the new code, A0425, until further notice.

The reasonable charge for services furnished in calendar year 2001 for A0380 and A0390 will be calculated on a supplier specific basis by multiplying each supplier's reasonable charge for 2000 by the ambulance inflation factor.

Payment Based upon the Condition of the Beneficiary

The regulation for ambulance fee schedule also includes a clarification of the policy for payment. Payment will be based on the condition of the beneficiary and the services rendered by the crew. The vehicle dispatched does not determine payment. This policy is also delayed until a final regulation implementing the fee schedule becomes effective.

Components of Ambulance Fee Schedule that are Effective January 1, 2001

Even though there is a delay in the implementation date of the fee schedule, most requirements from Program Memorandum AB-00-88 remain effective for January 1, 2001 except: payment using the fee schedule, ALS vehicle used but no ALS service rendered, mandatory assignment for carriers, and payments based on the condition of the beneficiary. These items are explained above.

The requirements that remain effective January 1, 2001 include:

- **New HCPCS codes**
- **No grace period for old ambulance codes (except A0380 and A0390)** - There will be no grace period for most ambulance codes. The only codes with a grace period are the mileage codes A0380 and A0390, which will be used until the fee schedule is implemented.
- **ZIP code on the claim -** Carriers will continue to pay ambulance claims on a reasonable charge basis until the fee schedule is implemented by a final rule. Although payment amount is not based on the ZIP code (since this is a facet of fee schedule), the ZIP code is required as part of the claim information. Submitted ZIP codes that are invalid will result in the claim being returned as unprocessable. Suppliers should use "00000" as the ZIP code for foreign claims.
- **ALS transportation but no ALS service allowed at ALS1 -** Until the fee schedule is implemented, there is a coding exception for ALS transport provided but no ALS service rendered; i.e., codes A0324, A0328, A0344 and A0348. When this occurs, the supplier should code ALS1 or ALS1 emergency. Once the fee schedule is implemented, ambulance services must reflect the service provided based on the condition of the beneficiary.

Further information regarding implementation of the Ambulance Fee Schedule will be provided on our provider Website – **www.floridamedicare.com** – and in future issues of the *Medicare B Update!* as it becomes available from HCFA. Suppliers may also call our Provider Customer Service department **toll-free** at 1-877-847-4992.

This publication was produced prior to the publication of the final rule implementing Medicare's Ambulance Fee Schedule Payment System. We have incorporated the best information available at the time of publication. Please refer to the final rule when published in the* Federal Register *for authoritative guidance on this new system. This publication should not be considered an authoritative source in making Medicare program policy determinations.

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