CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11365	**Date: April 28, 2022**
	Change Request 12707

SUBJECT: Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance

I. SUMMARY OF CHANGES: The purpose of this change request is to revise the Medicare Claims Processing Manual, Publication 100-04, Chapter 15, Section 30.2.

EFFECTIVE DATE: May 31, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 31, 2022

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. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/30/30.2/ Fiscal Intermediary Shared System (FISS) Guidelines

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11365	Date: April 28, 2022	Change Request: 12707

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EFFECTIVE DATE: May 31, 2022
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I. GENERAL INFORMATION

A. Background: The purpose of this change request is to revise the Medicare Claims Processing Manual, Publication 100-04, Chapter 15, Section 30.2.

B. Policy: There are no policy changes associated with this instruction.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12707.1	Contractors shall be in compliance with the updates to CMS IOM Publication 100-04, Chapter 15-Ambulance, Section 30.2	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12707.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Teira Canty, Teira.Canty@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 15 - Ambulance

30.2 - Fiscal Intermediary Shared System (FISS) Guidelines
(Rev. 11365; Issued: 04-28-22; Effective: 05-31-22; Implementation: 05-31-22)

For SNF Part A, the cost of medically necessary ambulance transportation to receive most services included in the RUG rate is included in the cost for the service. Payment for the SNF claim is based on the RUGs, which takes into account the cost of such transportation to receive the ancillary services.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 6 - SNF Inpatient Part A Billing, Section 20.3.1 - Ambulance Services, for additional information on SNF consolidated billing and ambulance transportation.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing, section 10.5 - Hospital Inpatient Bundling, for additional information on hospital inpatient bundling of ambulance services.

In general, the A/B MAC (A) processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill A/B MACs (A) using only Method 2.

The provider must furnish the following data in accordance with A/B MAC (A) instructions. The A/B MAC (A) will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);

- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. General

The reasonable cost per trip of ambulance services furnished by a provider of services may not exceed the prior year's reasonable cost per trip updated by the ambulance inflation factor. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997, and September 30, 1998). Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

The following instructions provide billing procedures implementing the above provisions.

B. Applicable Bill Types

The appropriate type of bill (13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.

C. Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance in the Value Code field. The value code is defined as "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance." Providers report the number in dollar portion of the form location right justified to the left of the dollar/cents delimiter.

More than one ambulance trip may be reported on the same claim if the ZIP Codes of all points of pickup are the same. However, since billing requirements do not allow for value codes (ZIP Codes) to be line item specific and only one ZIP Code may be reported per claim, providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different ZIP Codes.

For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

NOTE: Information regarding the claim form locator that corresponds to the Value Code field is found in Pub.100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

D. Revenue Code/HCPCS Code Reporting

Providers must report revenue code 054X and, for services **provided before January 1, 2001,** one of the following CMS HCPCS codes for each ambulance trip provided during the billing period:

A0030 (discontinued 12/31/2000); A0040 (discontinued 12/31/2000);
A0050 (discontinued 12/31/2000); A0320 (discontinued 12/31/2000); A0322 (discontinued 12/31/2000);
A0324 (discontinued 12/31/2000); A0326 (discontinued 12/31/2000); A0328, (discontinued 12/31/2000);
or A0330 (discontinued 12/31/2000).

In addition, providers report one of A0380 or A0390 for mileage HCPCS codes. No other HCPCS codes are acceptable for reporting ambulance services and mileage. Providers report one of the following revenue codes:
0540;
0542;
0543;
0545;
0546; or
0548.

Do not report revenue codes 0541, 0544, or 0547.

For claims with **dates of service on or after January 1, 2001**, providers must report revenue code 540 and one of the following HCPCS codes for each ambulance trip provided during the billing period:

A0426; A0427; A0428; A0429; A0430; A0431; A0432; A0433; or A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly. In addition, all providers report one of the following mileage HCPCS codes: A0380; A0390; A0435; or A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, providers must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

However, in the case where the beneficiary was pronounced dead after the ambulance is called/*dispatched* 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. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Providers *or suppliers* report the A0428 (BLS) *non-emergency or A0429 (BLS) emergency transport* HCPCS code *if an emergency response and* modifier QL (Patient pronounced dead after ambulance called) in "HCPCS/Rates" instead of the origin and destination modifier *for ground vehicles*. In addition to the QL modifier, *institutional-based* providers report modifier QM or QN. *If the time of death pronouncement is after takeoff to point of pickup but before the beneficiary is loaded on-board the air ambulance*, *air ambulance providers or suppliers bill the A0430 or A0431 depending on the type of aircraft and modifier QL.*

If the ambulance is called/dispatched but the beneficiary dies on the scene prior to the arrival of the ambulance: Payment may be made for 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. Neither mileage nor a rural adjustment would be paid. Providers or suppliers report the A0428 (BLS) non-emergency or A0429 (BLS) emergency transport HCPCS code if an emergency response and modifier QL for ground vehicles. Air ambulance providers or suppliers bill the A0430 or A0431 depending on the type of aircraft and modifier QL, if the time of death pronouncement is after takeoff to point of pickup but before the beneficiary is loaded on-board the air ambulance.

If the beneficiary dies after the ambulance is dispatched but before the beneficiary is loaded onboard the ambulance (before or after arrival at the point-of-pickup): Medicare payment determination is provider's or supplier's BLS base rate, no mileage or rural adjustment; providers or suppliers report the A0428 (BLS) non-emergency or A0429 (BLS) emergency transport HCPCS code if an emergency response and modifier QL. However, if the beneficiary dies after pickup, prior to or upon arrival at the receiving facility: Medically necessary level of service furnished will be the payment determination.

NOTE: Information regarding the claim form locator that corresponds to the HCPCS code is found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

E. Modifier Reporting

See the above Section 30 (A) (Modifiers Specific to Ambulance Service Claims) for instructions regarding the usage of modifiers.

F. Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in the Service Date field.

NOTE: Information regarding the claim form locator that corresponds to the Service Date is found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

G. Service Units Reporting

For line items reflecting HCPCS code A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001)** or code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**services on and after January 1, 2001**), providers are required to report in Service Units each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, the number of loaded miles must be reported. (See examples below.)

Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, A0435, or A0436, the number of loaded miles must be reported.

H. Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434**;**

Providers are required to report in Total Charges the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS code A0380, A0390, A0435, or A0436, report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units as a separate line

item. For the related charges, providers report $1.00 in FL48 for non- covered charges. A/B MACs (A) should assign remittance adjustment Group Code OA to the $1.00 non- covered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

Prior to submitting the claim to CWF, the A/B MAC (A) will remove the entire revenue code line containing the mileage amount reported in Non-covered Charges to avoid non-acceptance of the claim.

NOTE: Information regarding the claim form locator that corresponds to the Charges fields is found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form CMS-1450 Data Set.

EXAMPLES: The following provides examples of how bills for Part B ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by providers. Ambulance services provided under arrangement between the provider and an ambulance company are reported in the same manner except providers report a QM modifier instead of a QN modifier.

EXAMPLE 1: Claim containing only one ambulance trip:

Providers report as follows:

Revenue Code	HCPCS/ Modifiers	Date of Service	Units	Total Charges
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2: Claim containing multiple ambulance trips:

Providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00
0540	A0330	RH	QN	082901	1 (trip)	400.00
0540	A0390	RH	QN	082901	3 (mileage)	6.00

EXAMPLE 3: Claim containing more than one ambulance trip provided on the same day:

Providers report as follows:

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
0540	A0429	RH	QN	090201	1 (trip)	100.00

Revenue Code	HCPCS	Modifiers		Date of Service	Units	Total Charges
0540	A0380	RH	QN	090201	2 (mileage)	4.00
0540	A0429	HR	QN	090201	1 (trip)	100.00
0540	A0380	HR	QN	090201	2 (mileage)	4.00

I. Edits

FISS edits to assure proper reporting as follows:

- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes - A0435, A0436 or for claims with dates of service on or after April 1, 2002, A0425;

- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;

- The units field is completed for every line item containing revenue code 0540;

- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;

- Service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal “1"

For claims with dates of service on or after July 1, 2001, each 1-way ambulance trip, line- item dates of service for the ambulance service, and corresponding mileage are equal.