

APPENDIX A

AMBULANCE - MEDICARE PART B

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PREFACE

Because of the additional data elements that are required for Ambulance claims, you may be required to submit a test file. The services represented in the batch of test claims should include:

- Round trips on same day
- Hospital to hospital transfers
- Billings for EKG's
- Billings for supplies
- Transfer from SNF to outpatient or inpatient hospital
- Billings for extra charges
- Supplemental Policy Information

I. GENERAL CLAIM FILING REQUIREMENTS

Following are the general requirements for submitting Medicare Part B ambulance claims electronically.

- A. Ambulance transportation must be medically necessary according to the diagnosis. That is, the patient's condition is such that use of any other method of transportation is contraindicated.
- B. Transportation must be to the nearest appropriate facility or to the patient's home. An appropriate facility is an institution generally equipped to provide the needed care for the patient's illness or injury.
 - 1. Transfer to a veteran's (VA) hospital is not covered if there is a closer appropriate facility.
 - 2. Transfer to a more distant facility just to avail the patient of a personal physician's services is not covered.
 - 3. Transfer to a more distant facility to obtain services of a specific specialty not available at the nearest facility is covered.
 - 4. Transfer from the patient's residence or from a non-skilled nursing home to a dialysis center or to a free standing radiation therapy center is not covered.
 - 5. Transfer to the next nearest appropriate facility is covered if no beds are available at the nearest facility. The claim must indicate no beds are available at the nearest facility.
 - 6. Transfer from out-of-locality hospital or SNF to patient's home is covered if the out-of-locality hospital or SNF was the nearest institution with appropriate facilities.
- C. Multiple transfers on the same day must be submitted on a single claim.
- D. Aid Calls - When an ambulance crew does not transport a patient but only renders aid, this is a non-covered service because Medicare only covers ambulance transportation.

Example:

- Ambulance dispatched to the scene of an accident and crew renders aid until a helicopter can be sent;
- Ambulance sent and patient refuses care; or,
- Ambulance sent and only aid rendered.

The Code A9270, non-covered item or service, should be billed if it is necessary to bill Medicare.

II. SPECIFIC CLAIM FILING REQUIREMENTS

A. Ordering/Referring Physician- *TEXAS PROVIDERS ONLY*

A referring/ordering physician name and UPIN must be given. If a physician did not order the ambulance transfer, SELF REFERRAL and SLF000 must be used. The name of the physician/SELF REFERRAL must be entered in field EAO-20.0 and the physician's UPIN/SLF000 must be entered in field EAO-22.0.

B. Diagnosis Codes

- An ICD-9-CM diagnosis code must be associated with every billed procedure. The diagnosis indicator will be submitted in field FAO-14.0 and point to the appropriate diagnosis code (fields EAO-30.0, 31.0, 32.0, 33.0). Up to four diagnosis codes can be submitted on electronic claims. The diagnosis codes are to be entered without the decimal or a space.
- The diagnosis code used with the transfer must also be submitted on all services incidental to the transfer.
- When billing for an EKG, use the appropriate diagnosis code to specify why an EKG was done. The diagnosis indicator with the EKG must point to this diagnosis code. Note: Only Method 3 and 4 providers may bill for EKGs.

C. Place of Service

The valid Place of Service codes are:

- 41 - Ambulance - Land
- 42 - Ambulance - Air or water

D. Mileage - Single Transfers

- Mileage can be allowed to the nearest appropriate facility when the ambulance transfer is covered. The actual number of loaded miles from the origin (point where patient is picked up) to the point of destination can be reported as mileage charges.
- The number of miles billed is to be submitted in the Units of Svc field (FAO-18.0) on the mileage charge detail. (If the number of miles exceeds 99 miles, submit the miles on two detail records with the first detail showing 99 miles and the second detail showing the remainder.)

E. Mileage - Multiple Transfers

To bill for multiple transfers on the same day and to bill mileage for both transfers:

- Same mileage procedure code, number of miles and charge.
 - Enter mileage as one procedure with the mileage and charge being the total for both transfers.
 - Use appropriate modifiers to indicate two transfers.
- Different mileage procedure codes, number of miles or charge.
 - Enter each mileage procedure code separately.
 - Each mileage procedure code should have the appropriate mileage and charge.
 - Use appropriate modifier for each mileage charge.

F. EKG's (Procedure 93005) - Only valid for Method 3 and 4

Texas ambulance providers must provide the UPIN of the physician that was in communication with the ambulance and ordered the EKG on the claim and there must have been a medical need.

- **Texas** ambulance providers must enter the six digit UPIN of the physician who was in communication with the ambulance and ordered the EKG in the Referring Provider ID field FAO-24.0 on all details. **This information is not required for EKG's billed by Maryland, DCMA or Delaware ambulance companies.**

If the EKG was not ordered by a physician in communication with the ambulance, key 5F modifier in the second modifier field on the detail line with the charge for the EKG.

- **All ambulance claims must support the medical need for the transport.** Medical need is indicated if one of the following conditions is present. The appropriate diagnosis code is to be entered in field EAO-30.0 - 33.0 and referenced by the diagnosis indicator in field FAO-14.0.
- The following procedure codes include EKG, therefore, a separate charge should not be submitted for the EKG: A0346, A0350, A0366, A0370

4139	Angina pectoris
4275	Asystole
4273	Atrial fibrillation and flutter
4270	Atrioventricular tachycardia - AV Tach
4278	Bradycardia-Brady
7855	Cardiogenic shock
4275	Cardiac arrest (CPR administered)
4278	Cardiac arrhythmia
7865	Chest pain
4280	Congestive heart failure
4279	Dysrhythmia
42789	Ectopic beats

4109	Heart Attack
4265	Heart block
4109	Myocardial infarction
4270	Paroxysmal atrial tachycardia - PAT
4271	Paroxysmal ventricular tachycardia - V. Tach
42761	Premature atrial contractions - PAC
42769	Premature ventricular contractions - PVC
4269	Stokes - Adams attack
7850	Tachycardia - Tach
7855	Vascular collapse with shock
42741	Ventricular fibrillation
4271	Ventricular tachycardia

G. Extra Charges - Valid For All Billing Methods

- An extra charge for emergency call is not covered.
- An extra charge for night call (A0999) may be allowed for *Texas and Maryland* ambulance providers. One of the following modifiers must be in the second modifier field (field FAO-11.0). As long as one of the following modifiers is indicated, a description is not required for this service.

5B The call was made on any day from 8:00 p.m. to 8:00 a.m., or anytime on a weekend or holiday and ambulance provider is an "on call" operation or service is an "on call" service.

5F The above criteria is not met. This is a non-covered service.

- To submit charges for an additional attendant (A0424), i.e., in addition to the driver and one required attendant, use one of the following modifiers in the second modifier field (field FAO-11.0). A description will not be required for this service when one of the following modifiers are indicated.

5C CPR Administered/Intubation

5D Patient weighs over 300 pounds

5E Patient is carried up or down a long flight of stairs

-- None of the above; leave second modifier field blank. Use GAO-20.0 or 21.0 to provide a description and explain the circumstances.

H. Waiting Time (A0420)

- If the waiting time is 30 minutes or more, submit modifier 5H in the second modifier field (field FAO-11.0). Use GAO-20.0 or 21.0 to explain the reason for the wait.

If the waiting time is less than 30 minutes, use the modifier 5F in the second modifier field (field FAO-11.0).

- The waiting time is to be entered in the Units of Svc field (field FAO-18.0) according to the following table.

<u>Time</u>	Units of <u>Svc</u>
Up to 1 hour	0010
1 to 1½ hours	0020
1½ to 2 hours	0030
2 to 2½ hours	0040
2½ to 3 hours	0050
3 to 3½ hours	0060
3½ to 4 hours	0070
4 to 4½ hours	0080
4½ to 5 hours	0090
5 to 5½ hours	0100

III. MODIFIERS

A. HCPCS Origin/Destination Modifiers - Informational Only

The origin and destination for each ambulance transfer must be indicated by the use of a two-digit alpha HCPCS modifier created from the following. **Use these modifiers on the transport codes only in the second modifier field.** These codes are listed on pages A.21 thru A.24 under *Ambulance Transfer Codes*.

- D Diagnostic or therapeutic site/Free standing facility (i.e., dialysis center, radiation therapy center)
- E Residential/Domiciliary/Custodial Facility (i.e., non-skilled facility)
- G Hospital Based dialysis facility (hospital or hospital related)
- H Hospital (i.e., inpatient or outpatient)
- 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) - Meets the requirements of Section 1819 (formerly 1861(j)(1)) of the Social Security Act
- P Physician's Office (includes HMO, Non-hospital facility)
- R Residence (patient's home or any residence)
- S Scene of Accident or Acute Event
- X Intermediate Stop at Physician's Office en-route to the Hospital (Destination code only)

The first character of the modifier represents the point of origin and the second character represents the destination. The modifiers should be used in conjunction with the appropriate transfer code. **Texas** ambulance providers must also include the appropriate alpha-numeric modifier (see III.c).

Following are examples of procedure codes with the HCPCS alpha modifier and alpha-numeric modifiers required for **Texas** providers. Note that **Texas** providers must submit both modifiers on electronic claims on the transport codes. **Texas** ambulance providers must submit the alpha-numeric modifier on all ambulance service procedure codes.

- Method 2 - ALS all inclusive, emergency transport from patient's home to hospital:

TEXAS ONLY
A0328 4A RH

MARYLAND/DCMA/DE
A0328 RH

- Method 1 - BLS emergency transport from patient's residence, which is a non-skilled nursing facility, to a hospital:

TEXAS ONLY
A0322 4A EH

MARYLAND/DCMA/DE
A0322 EH

- Method 3 - ALS emergency transport from the scene of an accident to a physician's office for emergency treatment and then to the hospital:

TEXAS ONLY
A0350 4A SX

MARYLAND/DCMA/DE
A0350 SX

B. Modifier Origin/Destination Definitions

Hospital should be used when the patient is transferred to a hospital due to an emergency or for admission or from a hospital for discharge.

Outpatient Hospital should be used when the patient is transferred to or from the outpatient department of a hospital for non-emergency or routine care only, e.g., dressing changes, catheter changes, lab tests, EKG's, X-rays.

Note: The specific treatment rendered or facilities used is required in the explanation record (GAO-20.0 or 21.0). If X-ray or lab test, also include type.

Patient's Residence should be used for patient's residence, accident site, or relative's or friend's home.

Free Standing Facility should be used for physician's office or radiation therapy centers.

Hospital should be used for rehabilitation hospitals.

C. Origin/Destination Modifiers

TEXAS PROVIDERS: Every procedure code submitted on an ambulance claim must have one of the following alpha-numeric modifiers in the Modifier One field. An asterisk in front of the modifier indicates an explanation record (GAO-20.0 or GAO-21.0) is required. All base transport codes must also have one of the corresponding HCPCS origin/destination modifiers in the Modifier Two field.

MD/DCMA/DE PROVIDERS: Every procedure code submitted on an ambulance claim must have one of the following alpha-alpha modifiers in the Modifier One field. An asterisk in front of the modifier indicates an explanation record (GAO-20.0 or GAO-21.0) is required.

Corresponding
HCPCS O/D
Modifiers

- 4A RH,EH,SH, RX,EX,SX Patient's Residence (home or non-skilled facility) to Hospital
Will be evaluated based on diagnosis list #1 in this section.
- *4B RH,EH,RX, EX,RG,EG Patient's Residence (home or non-skilled facility) to Outpatient Hospital
Will be evaluated on claim by claim basis. Specify treatment the patient received. For example, if X-rays were taken, specify the type of X-ray.
- 4C RN,EN Patient's Residence (home or non-skilled facility) to SNF
Will be evaluated based on diagnosis list #1 in this section.
- 4D RE,RR,EE, ER Patient's Residence (home) to Non-skilled Nursing Home
This service is not covered by Medicare.
- 4E RD,ED,RP, SP,RJ,EJ, EP Patient's Residence (home or non-skilled facility) to Free Standing Facility
This service is not covered by Medicare.
- 4F DH,PH,DX JH Free Standing Facility to Hospital
Will be evaluated based on diagnosis list #1 in this section.
- *4G DH,PH,DX PG,JH Free Standing Facility (i.e., dialysis centers, radiation therapy centers, physician's office) to Outpatient Hospital (for routine care only, i.e. dressing changes, catheter changes, x-rays)
Will be evaluated on claim by claim basis. Specify treatment the patient received. For example, if X-rays were taken, specify the type of X-ray.
- 4H DR,DE,PR PE,JR,JE Free Standing Facility (i.e., radiation therapy centers, physician's office) to Patient's Residence (home or non-skilled facility)
This service is not covered by Medicare.

- *4I DN,PN,JN Free Standing Facility (i.e., radiation therapy centers, physician's office) to Skilled Nursing Facility
- Will be evaluated on a claim by claim basis. Specify reason for transfer.
- 4J HN Hospital to Skilled Nursing Facility
- Will be evaluated based on diagnosis list #2 in this section.
- *4K HN,GN Outpatient Hospital to Skilled Nursing Facility
- Will be evaluated on claim by claim basis. Specify reason for transfer.
- 4L HR,HE Hospital to Patient's Residence (home or non-skilled facility)
- Will be evaluated based on diagnosis list #2 in this section.
- *4M HR,HE,GR
GE Outpatient Hospital to Patient's Residence (home or non-skilled facility)
- Will be evaluated on claim by claim basis. Specify treatment the patient received. For example, if X-rays were taken, specify the type of X-ray.
- *4N HH,GH,HG Hospital to Hospital and not Returned to Original Hospital
- Will be evaluated based on diagnosis list #1 and facilities available. Specify what facilities or services are available at the second hospital that are not available at the first.
- *4O HH,HG Outpatient/Observation Unit to Hospital and not Returned to Original Hospital
- Will be evaluated based on diagnosis list #1 and facilities available. Specify what facilities or services are available at the second hospital that are not available at the first.
- *4P HD,HP,GP,
HJ Hospital to Free Standing Facility and not Returned to Original Hospital
- Will be evaluated on claim by claim basis. Specify treatment the patient received. For example, if X-rays were taken, specify the type of X-ray.

- *4Q HD,HP,HJ Outpatient/Observation Unit to Free Standing Facility
- Will be evaluated on claim by claim basis. Specify treatment the patient received. For example, if X-rays were taken, specify the type of X-ray.
- 4R HH,GH Hospital to Hospital with Return Trip to Original Hospital
- Use this modifier for both trips. This service is not covered by Medicare Part B. Should be billed by hospital.
- *4S HH Outpatient/Observation Unit to Hospital with Return Trip to Original Hospital
- Will be evaluated based on diagnosis list #1 and facilities available. Specify what facilities or services are available at the second hospital that are not available at the first. Use this modifier for both trips.
- 4T HD,HP,HG, Hospital to Free Standing Facility with Return to Original Hospital
HJ
DH(return),
PH(return)
JH(return)
- Use this modifier for both trips. This service is not covered by Medicare Part B. Should be billed by hospital.
- 4U NR,NE Skilled Nursing Facility to Patient's Residence (non-skilled facility or home)
- Will be evaluated based on diagnosis list #2 in this section.
- 4V NH,NX Skilled Nursing Facility (SNF) to Hospital
- Will be evaluated based on diagnosis list #1 in this section.
- *4W NH,NX,NG Skilled Nursing Facility to Outpatient Hospital
- Will be evaluated on claim by claim basis. Specify treatment the patient received. For example, if X-rays were taken, specify the type of X-ray.

- *4X NN Skilled Nursing Facility (SNF) to Skilled Nursing Facility
 Will be evaluated on claim by claim basis. Specify what facilities or services are available at the second facility that are not available at the first.
- *4Y ND,NP,NJ Skilled Nursing Facility to Free Standing Facility
 Will be evaluated on claim by claim basis. Specify treatment the patient received and whether the patient was in a Medicare participating skilled bed at the time of the transfer. For example, if X-rays were taken, specify the type of X-ray.
- *4Z Texas Ambulance to or from a Foreign (i.e., Canada or Mexico) or Out of State Hospital or Chest, TB or Mental Hospital
 Will be evaluated on a claim by claim basis. Specify reason for transfer, i.e., specific facilities or treatment needed.
- *5A No Transport or Air Ambulance
 Will be evaluated on claim by claim basis. Patient pronounced dead before/after Ambulance is called. Utilize this modifier for any services related to an Air Ambulance transport.

D. Special Charges Modifiers

These modifiers will be submitted in the second modifier field (FAO-11.0).

5F EKG's

Use when EKG was not ordered by a physician in communication with ambulance.

5B Extra Charge for Night Call

Use when call was made any day from 8:00 p.m. to 8:00 a.m. or anytime on a weekend or holiday and ambulance provider is an "on call" operation or service is an "on call" service.

5F Extra Charge for Night Call

When 5B does not apply, use 5F.

5C Extra Charge for Additional Attendant

Use when CPR administered/intubation.

5D Extra Charge for Additional Attendant

Use if patient weighs over 300 pounds.

5E Extra Charge for Additional Attendant

Use when patient is carried down/up a long flight of stairs.

5H Extra Charge for Waiting Time

Use when waiting time is for 30 minutes or more.

5F Extra Charge for Waiting Time

When 5H does not apply, use 5F; i.e., waiting time is less than 30 minutes.

E. Diagnosis List #1

Do not submit the decimal or leave a space on electronic claims.

Code	Description
7890	Abdominal pain, severe or acute (Ischemic bowel, acute abdomen, surgical abdomen, ruptured bowel, perforated bowel)
9953	Allergic reaction
9950	Anaphylactic shock
4131	Angina attack, angina pectoris
9947	Asphyxiation
4939	Asthmatic attack (status asthmaticus)
1919, 3489	Brain tumor
940, 9490	Burns
1991, 2349	Cancer, terminal, debilitating
	Cardiac problems:
410, 4109	Myocardial infarction, heart attack, MI
4275	Cardiac arrest, cardio-respiratory arrest
4274, 4273	Fibrillation
7850	Tachycardia
4278	Bradycardia
4265	Bundle branch block (BBB), conductive disorder, heart block
4279, 4278	Arrhythmia, Dysrhythmia
4341	Cerebral embolus, acute (head, brain)
431, 436	Cerebral hemorrhage, acute (head, brain)
435, 437	Cerebral ischemia, severe (head, brain)
434	Cerebral thrombosis, acute
7865	Chest pain, severe or acute
9331	Choking
780	Coma, semi-comatose, semi-conscious
995, 9958	Condition to be specified by "X" code
428, 4280	Congestive heart failure (CHF)
4109	Coronary occlusion
4275	CPR (Cardiopulmonary resuscitation) was administered
436, 438	CVA (recent, acute or with paralysis), Possible CVA, Possible heart attack, Possible stroke, Suspected CVA, Heart attack or Stroke
707	Decubitus ulcers, bed sores
780, 291	Delirium tremens (DT)
2508	Diabetes (uncontrolled)
2503	Diabetic coma or diabetic acidosis
7869, 493	Difficulty breathing, respiratory difficulties or failure
9952	Digitalis intoxication
839	Dislocation (possible dislocation that has not been set)
492	Emphysema, severe with difficult breathing
5303	Esophageal obstruction

Code	Description
Fracture or possible fracture/dislocation that has not been set:	
824	Ankle
818, 819	Arm
825	Foot
822	Knee
823	Leg
807	Ribs
803	Skull
812	Shoulder
820	Hip
805	Neck
808	Pelvis
806	Spine
810	Clavicle
5751, 5759	Gall bladder attack, severe, severe (cholecystitis, severe)
7854	Gangrene
920	Hematoma (epidural or subdural)
570, 5728	Hepatic failure (liver failure)
4590	Hemorrhage (severe bleeding), ruptured aneurysm
959	Injury (must specify type of injury in GA0 record)
251	Insulin shock
5608	Intestinal obstruction
592	Kidney stone (Nephrolithiasis)
977	Overdose of drugs, unconscious
451	Phlebitis (Thrombophlebitis)
514, 5184	Pulmonary edema, acute (lungs)
4151	Pulmonary embolism (lungs)
7860	Respiratory distress (Respiratory failure, A.R.D.S., adult respiratory distress syndrome), respiratory difficulty
7803	Seizures (convulsions)
780	Semi-conscious
780	Semi-comatose
7855	Shock, septic shock
552	Strangulated hernia (incarcerated hernia)
436, 438	Stroke (recent, acute or with paralysis)
4359	Transient Ischemic Attack (T.I.A.) (head)
780	Unconscious
585, 586	Uremia (renal failure)
7855	No vitals or vital signs

The following codes indicate conditions. These codes are not ICD-9-CM codes. They are special codes set up to be used by ambulance providers only. If one of the following conditions is applicable, the "995" ICD9-CM diagnosis code should be entered in the diagnosis field EAO-30.0 - 33.0 and the applicable condition code/s from below should be the first entry in the explanation record (GAO-20.0 or 21.0).

<u>Code</u>	<u>Description</u>
X02	Restraints were used
X03	Back injury
X04	Oxygen was administered
X08	Bed confined/bedfast/bedridden
X09	Stretcher (patient could only be moved by stretcher)

If one of the following conditions is applicable, the "9958" ICD9-CM diagnosis code should be entered in the diagnosis field EAO-30.0 - 33.0 and the applicable condition code/s from below should be the first entry in the explanation record (GAO-20.0 or 21.0).

<u>Code</u>	<u>Description</u>
X01	Accidents: <ol style="list-style-type: none"> 1. amputation 2. assault 3. fall 4. head injury 5. internal injury
X05	Splinting or strapping was used
X06	Cardioversion was administered

F. Diagnosis List #2

Do not submit the decimal or leave a space on electronic claims.

Code	Description
1991, 2349	Cancer, terminal, debilitating
780	Coma, semi-conscious, semi-comatose
995	Condition to be specified by "X" code
436, 438	CVA (recent, acute or with paralysis)
707	Decubitus ulcers
820	Fractured hip
805	Fractured neck
808	Fractured pelvis
806	Fractured spine
410	Myocardial infarction
436, 438	Stroke (recent, acute or with paralysis)
780	Unconscious

The following codes indicate conditions. These codes are not ICD-9-CM codes. They are special codes set up to be used by ambulance providers only. If one of the following conditions is applicable, the "995" ICD9-CM diagnosis code should be entered in the diagnosis field EAO-30.0 - 33.0 and the applicable condition code/s from below should be the first entry in the explanation record (GAO-20.0 or 21.0).

Code	Description
X02	Restraints were used
X03	Back injury
X04	Oxygen was administered
X08	Bed confined/bedfast/bedridden
X09	Stretcher (patient could only be moved by stretcher)

IV. ORIGIN AND DESTINATION

Although origin and destination are indicated by modifiers (see Modifiers on pages A.9 - A.13), additional information must also be supplied.

- Name and Address of Origin
- Name and Address of Destination
- Explanation for Transfer/Additional Information

This information is to be supplied in the following record:

GAO-18.0	Origin Name and Address
GAO-19.0	Destination Name and Address
GAO-20.0	Explanation/Additional information
GAO-21.0	Explanation/Additional information

A. Origin/Destination Abbreviations

See Attachment 1 for origin/destination abbreviations and other acceptable abbreviations that may be used in the GAO records if there is insufficient room to enter full words.

B. Multiple Trips on Same Day or Round Trips

When billing for multiple trips on the same day or for round trips, use 1 GAO record per base/transport code. Reminder: All ambulance services rendered to a patient on a day must be submitted all on a single claim.

C. Address of Origin/Destination

- Street Address - Required
- City - Required
- State - Conditional - It is not necessary to enter the state if the origin and destination are within the same state.
- Zip Code - Not required.
- Special Characters - # . , /
- It is not necessary to use special characters unless the address of the origin/destination is not distinguishable without their use.
- If the origin is a "scene of accident or acute event" the description should identify the location and provide an appropriate address (i.e., mall, intersection, department store - 123 Main St. - Dallas).

V. AMBULANCE PROCEDURE CODES

The Health Care Financing Administration (HCFA) implemented a comprehensive revision to the HCPCS coding system for ground basic life support (BLS) and advanced life support (ALS) ambulance services on January 1, 1995. These changes were needed to standardize coding for ambulance services and permit ambulance payment and utilization analysis across carriers.

There are four methods of billing indicated by HCFA for ambulance services. Each method reflects a specific billing pattern. After careful examination of each provider's billing pattern, a method was assigned to each provider. Ensure you know which method you are assigned prior to billing any ambulance services.

Note: The ALS codes can be used only by ambulance companies that have Advanced Life Support (ALS) equipment and personnel in their vehicles. An ALS company can also bill any of the basic life support codes.

A. Ambulance Transfer Codes

Method #1

Method #1 is an all inclusive method. All inclusive service bundles into one code all the services and supplies associated with a patient's transport. This code reflects all services rendered (including specialized services such as oxygen administration, defibrillation, intubation and IV drug administration, but excludes the injectable drug), all supplies consumed and mileage.

A0300 Ambulance service, basic life support (BLS), non-emergency transport, all inclusive (mileage and supplies)

A0302 Ambulance service, BLS, emergency transport, all inclusive (mileage and supplies)

A0304 Ambulance service, advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)

A0306 Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)

A0308 Ambulance service, ALS, emergency transport, no specialized services rendered, all inclusive (mileage and supplies)

A0310 Ambulance services ALS, emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)

These are the only transport and mileage codes that may be billed by method #1 providers. A separate charge may not be billed for supplies. The "J" codes may be billed for drugs administered in the ambulance.

Method #2

Method #2 bundles into one code all the services and supplies associated with a patient's transport. The code reflects all services rendered (including specialized services such as oxygen administration, defibrillation, intubation and IV drug administration, but excludes the injectable drug) and all supplies consumed. Mileage may be billed separately.

A0320 Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed

A0322 Ambulance service, BLS, emergency transport, supplies included, mileage separately billed

A0324 Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed

A0326 Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed

A0328 Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed

A0330 Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed

A0380 BLS mileage (per mile)

A0390 ALS mileage (per mile)

These are the only transport and mileage codes that may be billed by method #2 providers. A separate charge may not be billed for supplies. The "J" codes may be billed for drugs administered in the ambulance.

Method #3

Method #3 is one charge for all services and mileage, with a separate charge for supplies. This code reflects all services rendered (including specialized services such as oxygen administration, defibrillation, intubation and IV drug administration, but excludes the injectable drug) and mileage. Disposable supplies may be billed separately.

A0340 Ambulance service, BLS, non-emergency transport, mileage included, disposable supplies separately billed

A0342 Ambulance service, BLS, emergency transport, mileage included, disposable supplies separately billed

A0344 Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed

A0346 Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed

A0348 Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed

A0350 Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed

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)

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

A0422 Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining

These are the only transport and mileage codes that may be billed by method #3 providers. A separate charge may not be billed for supplies. The "J" codes may be billed for drugs administered in the ambulance.

Method #4

Method #4 is a separate charge for services, mileage and supplies.

A0360 Ambulance service, 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, 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

A0422 Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining

These are the only transport and mileage codes that may be billed by method #4 providers. A separate charge may not be billed for supplies. The "J" codes may be billed for drugs administered in the ambulance.

B. Ambulance Supply Codes - **Valid for Method 3 and 4 Providers Only**

It is not necessary to provide a description/list of the items included when billing the following procedure codes. These codes may only be reported once per transport. Add the supplies together and submit as one charge.

A0382 BLS Routine Disposable Supplies; includes supplies such as gauze, tape, bandages, blood tubes, cold packs, burn sheets, dextrostix, EKG pads, yankauer suction tip.

A0384 BLS Specialized Service Disposable Supplies, Defibrillation; includes supplies such as defibrillation pads, conductor gel.

A0392 ALS Specialized Service Disposable Supplies, Defibrillation; includes the same supplies as A0384.

A0394 ALS Specialized Service Disposable Supplies, IV Drug Therapy; includes supplies such as mini-drip set, IV tubing, extension tubing, needles, butterfly needles, veniguard, IV prep kit, syringes, IV administration set, angiocath, stop cock.

A0396 ALS Specialized Service Disposable Supplies, Esophageal Intubation; includes supplies such as EOA, ET tubes, ET holder, tube tamer, endo lock, combitube, disposable BVM respirator, airway/nasal intubation tube.

A0398 ALS Routine Disposable Supplies; includes supplies such as gauze, sponges, tape, bandages, blood tubes, cold packs, burn sheets, dextrostix, EKG pads, yankauer suction tip.

A0422 Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation includes supplies such as nasal canula, face mask, tubing, nebulizers (disposable).

Definition of Specialized Services:

Specialized services include EKG, intubation, oxygen administration, defibrillation, IV administration.

NOTE: These codes may not be multiple serviced greater than one. If the supplies were provided on both legs of a round trip transport, each service must be billed on an individual line with the appropriate origin/destination modifier. Medicare will only reimburse these codes for one unit of service per leg of the transport.

Charges for the following services are to be combined with the appropriate transport code and are not to be billed separately.

- Defibrillation
- Decompression
- Intubation
- Resuscitation
- IV Administration
- Administration of CPR

C. Miscellaneous Supplies

Use code A0999 to report any unusual/disposable supplies that present an unusually high cost to the ambulance supplier.

If you use procedure code A0999, you must identify the supply in a HA0-05.0 field, including a description of the item and the charge.

If there is insufficient room to provide a description and charge for each unclassified drug/supply, you may utilize the "FAX or MAIL Documentation" option to provide a complete itemization of the services/supplies. Refer to Appendix F for instructions on this option.

D. Ambulance Drug Codes

Use the following codes when submitting charges for these drugs when administered in the ambulance.

Enter dosage in the multiple service field (FAO-18.0) as follows:

- If the dosage administered is less than the dosage listed with the code, use the appropriate code with the lowest dosage and a unit of one.
- If the dosage is higher than the listed code, use appropriate dosage code and multiple service to reach the amount administered.

<u>Code</u>	<u>Description</u>
J0150	Injection, adenosine, 6 mg
J0170	Injection, adrenalin, Epinephrine, up to 1 ml ampule
J0280	Aminophyllin, up to 250 mg
J0380	Injection, Metaraminol, up to 10 mg
J0460	Atropine Sulfate, up to 0.3 mg
J0610	Calcium Gluconate, up to 10 ml
J1100	Dexamethasone sodium phosphate, up to 4 mg/ml
J1160	Digoxin, up to 0.5 mg
J1200	Diphenhydramine HCL, up to 50 mg
J1240	Dimenhydrinate, up to 50 mg

J1700 Injection, Hydrocortisone Acetate, up to 25 mg
 J1710 Injection, Hydrocortisone Sodium Phosphate, up to 50 mg
 J1720 Injection, Hydrocortisone Sodium Succinate, up to 100 mg
 J1800 Propranolol HCL, up to 1 mg
 J1940 Furosemide, up to 20 mg
 J2000 Lidocaine HCL, 50 cc
 J2150 Mannitol, 25 percent in 50 ml
 J2175 Meperidine
 J2270 Morphine sulfate, up to 10 mg
 J2550 Promethazine HCL, up to 50 mg
 J2560 Phenobarbital sodium, up to 120 mg
 J2590 Oxytocin, up to 10 units
 J2690 Procainamide HCL, up to 1 gm
 J2720 Injection, Protamine Sulfate, up to 5 ml
 J2912 Injection, Sodium Chloride
 J2930 Methylprednisolone sodium succinate, up to 125 mg
 J3070 Injection, Pentazocine HCL, up to 30 mg
 J3105 Terbutaline Sulfate, up to 1 mg
 J3360 Diazepam, up to 5 mg
 J3490 Unclassified drugs
 J7030 Infusion, normal saline solution, 1,000 cc
 J7040 Infusion, normal saline solution, sterile (500 ml = 1 unit)
 J7042 5 percent Dextrose/normal saline (500 ml = 1 unit)
 J7050 Infusion, normal saline solution, 250 cc
 J7051 Sterile saline or water, up to 5 cc
 J7060 Infusion, Dextrose/water (500 ml = 1 unit)
 J7070 Infusion, D5W, 1,000 cc
 J7080 Infusion, Albumisol 5%, 500 ml vial
 J7090 Infusion, Albumisol 25%, 50 ml vial
 J7100 Infusion, Dextran 40, 500 ml
 J7110 Infusion, Dextran 75, 500 ml
 J7120 Ringers lactate infusion, up to 1,000 cc
 J7130 Hypertonic saline solution, 50 or 100 meq, 20 cc vial
 J7660 Isoproterenol Hydrochloride, 0.5% per ml
 J7665 Isoproterenol Hydrochloride, 1.0% per ml

Note: All unlisted drugs should be billed on a single detail line with procedure code J3490 and a unit of one. The drug name, strength, amount, route of administration and individual charge must be submitted in the GA0-20.0 or 21.0 fields. If additional space is required, you should continue onto a HA0 record.

E. Drug Crosswalk

<u>Generic Name</u>	<u>Brand Name</u>
Adenosine	Adenocard
Adrenalin	Epinephrine
Aminophyllin	Phyllocontin
Atropine Sulfate	Atropine Sulfate
Calcium Gluconate	Calcium Gluconate
Dexamethasone sodium phosphate	Dalalonge, Decadron Phosphate, Decajet, Dexasone, Dexone, Hexadrol Phosphate, Solurex
Diazepam	Valium
Digoxin	Lanoxicaps, Lanoxin
Dimenhydrinate	Dinate, Dommanate, Dramamine, Dramilin Hydrate, Marmine, Wehamine
Diphenhydramine HCL	Benadryl, Benahist, Benojet, Nordryl, Dihydrex, Hyrexin, Wehdryl
Furosemide	Lasix
Isoproterenol Hydrochloride	Isuprel
Lidocaine	Xylocaine HCL, Caine-1, Dilocaine, L-Caine, Lidojet
Mannitol	Osmitrol
Meperidine	Demerol HCL
Methylprednisolone Sodium Succinate	Solu-Medrol
Morphine Sulfate	Astramorph
Oxytocin	Pitocin
Phenobarbital	Solfoton, Luminal Sodium
Procainamide HCL	Pronestyl
Promethazine HCL	Duramorph, Phenergan, Phenameth, Anergan
Propranolol HCL	Inderal

F. Other Services

- A0420 Ambulance waiting time, (ALS or BLS), one half (1/2) hour increments (Valid for all Methods)
- A0422 Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation (Valid for Method 3 and 4 only)
- A0424 Extra ambulance attendant, ALS or BLS (Valid for all Methods)
- A0888 Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility) (Valid for all Methods)

G. Air/Special Ambulance Codes

- A0030 Ambulance Service, Conventional Air Service Transport, One Way
- A0040 Ambulance Service, Air Helicopter Service, Transport
- A0050 Ambulance Service, Emergency, Water, Special Transportation Services
- A0225* Ambulance Service, neonatal transport
- A0050 Ambulance Service, Emergency, Water, Special Transportation Services -
Must be submitted on paper
- A0100* Non-Emergency Transportation: Taxi-Intra City
- A0110* Non-Emergency Transportation and Bus, Intra or Inter State Carrier
- A0130* Non-Emergency Transportation: wheelchair van
- A0140* Non-Emergency Transportation and Air Travel (Private or Commercial) Intra
or Inter State
- A0160* Non-Emergency Transportation: per mile - case worker or social worker
- A0170* Non-Emergency Transportation: Ancillary; Parking Fee, Tolls, Other
- A0180* Non-Emergency Transportation: Ancillary; Lodging - Recipient
- A0190* Non-Emergency Transportation: Ancillary; Meals - Recipient
- A0200* Non-Emergency Transportation: Ancillary; Lodging - Escort
- A0210* Non-Emergency Transportation: Ancillary; Meals - Escort

* Non-covered service

VI. SPECIAL BILLING REQUIREMENTS - AMBULANCE

A. Air Ambulance Billing Requirements

Due to the circumstances surrounding air ambulance transports and the severity of the patient's condition, the ambulance run sheet often provides pertinent information to support the coverage of these transports. Attached is an "Air Ambulance Fax Sheet" by which you may submit this or any pertinent documentation relating to AIR AMBULANCE transport claims. You must submit one of these fax cover sheets and the documentation for each air ambulance claim submitted electronically. The GAO-20.0 or 21.0 record should include the statement "FAX SENT" to ensure proper processing. The documentation should be faxed on the same day you transmit the claim. These records will be retained and attached to the electronic claims for processing. If this information is not received within 2 days of the transmission of your claim, it may be subject to processing delay due to development for additional information or denial. The faxed documents will be retained for a 30 day period. If the electronic claim is not received within that time, the documents will be disposed of and you must fax the documents again upon successful transmission of the claim. The AIR AMBULANCE FAX sheet, (Appendix F, page F.8) may be xeroxed for additional copies. Please do not phone Medicare to confirm receipt of these documents. The telephone units will not have access to this information. If there is a problem with the fax transmission, we will telephone the contact person listed on the fax cover sheet.

B. Fax/Mail Documentation Option

Electronic Ambulance claims that include numerous non-itemized supplies may utilize the Fax/Mail Documentation option to provide a complete description and charge. (The only information that can be faxed are the explanations for codes A0999 or J3490. Diagnosis information and origin and destination information must be included on the claim. **Do not submit claims for review by fax.**)

If you wish to take advantage of this feature, refer to Appendix F for instructions.

Note: NSF users may submit a HA0 record for each FA0 (detail) record, therefore, it should rarely be necessary for a NSF user to fax any information.

If you have any questions, please contact the Provider Automation EDI Helpline at (972) 766-5480 or (410)527-5654 in Baltimore.

C. Two or More Ambulances Involved in the Same Transfer

In some unusual cases, one ambulance may not be able to transport the patient (i.e., the ambulance breaks down), and a second ambulance is dispatched. Medicare will reimburse each ambulance for the services and supplies rendered. The mileage billed must only be the loaded mileage actually involved in the transport by each ambulance. Each ambulance must document the circumstances that required the use of two different ambulances in the narrative fields, GA0-20.0, 21.0 or HA0-05.0.

D. Two or More Patients in the Same Ambulance

In some situations, it may be necessary to transport more than one patient in the same ambulance at the same time. The full charge for the ambulance service to both patients is not considered reasonable under existing Medicare regulations. If more than one beneficiary is transported per ambulance, the reimbursement rate will be prorated equally.

To be reimbursed for the full charge for more than one patient transported in an emergency situation, the claim must indicate a complete detailed description of the emergency needs of the patient in the narrative fields, GA0-20.0, 21.0 or HA0-05.0

ATTACHMENT 1

<u>ABBREVIATION</u>	<u>DEFINITION</u>
abd	abdomen, abdominal
ABG	atrial blood gases
ADM	admission
A-fib	atrial fibrillation
ALS	advanced life support
ASA	aspirin
ASHD	arteriosclerotic heart disease
BBB	bundle branch block
bilat.	bilateral
BLS	basic life support
BP,B/P	blood pressure
c/c	chief complaint
CHF	congestive heart failure
CNS	central nervous system
COPD	chronic obstructive pulmonary disease
CPR	cardiopulmonary resuscitation
C-Spine	cervical spine
CTR	center
CVA	cerebrovascular accident
disch.	discharged (from hospital)
DM	diabetes mellitis
DOA	dead on arrival
EKG	electrocardiogram
EOA	esophageal obturator airway
ER	Emergency Room
ETOH	ethanol alcohol
FUO	fever of unknown origin
fx	fracture
GEN	general
HM	home
HOS	hospital
HTN	hypertension
Hx	history
IM	intramuscular
inj, inj	injuries
IV	intravenous
LOC	loss of consciousness
MAST	military anti-shock trouser
MVA	motor vehicle accident
n/c	non-covered
NH	Nursing Home
NTG	Nitroglycerin
O ₂	Oxygen
OBS	organic brain syndrome

ABBREVIATION DEFINITION

po	oral administration
PVS,PVCs	premature ventricular contractions
RBBB	right bundle branch block
RSCH	research
resp., resp	respiration
SNF	Skilled Nursing Facility
SOB	shortness of breath
ST	street
THPY	therapy
TIA	transient ischemic attack
TKO	to keep open
Tx	treatment
Vfib, V-fib	ventricular fibrillation
VS, V/S	vital signs
Vtach/V-tach	ventricular tachycardia

