CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 942	**Date: August 5, 2011**
	Change Request 7489

SUBJECT: Instructions to Accept and Process All Ambulance Transportation Healthcare Common Procedure Coding System (HCPCS) Codes

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors to revise their claims processing systems in order to allow HCPCS codes identifying Medicare statutorily excluded (or otherwise not payable by Medicare) ambulance transportation and transportation related services into their systems for adjudication and to deny claims for such services as "non-covered" services.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 942	Date: August 5, 2011	Change Request: 7489

SUBJECT: Instructions to Accept and Process All Ambulance Transportation Healthcare Common Procedure Coding System (HCPCS) Codes

Effective Date: **January 1, 2012**

Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: Certain HCPCS codes identify various transportation and transportation related services that are statutorily excluded from Medicare coverage and, therefore, are not payable when billed to Medicare. All HCPCS codes contained in the Medicare Physician Fee Schedule Database (MPFSDB) have status indicator codes associated with them which indicate to Medicare claims processing contractors such things as which HCPCS codes are "Active," "Contractor Priced," "Local Codes," "Bundled/Excluded," etc. These HCPCS codes identifying various transportation and transportation related services that are statutorily excluded from Medicare coverage have a status indicator of "I" or "X" associated with them. In the Centers for Medicare and Medicaid Services' (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 23 – Fee Schedule Administration and Coding Requirements, § 30.2.2 – MPFSDB Status Indicators, the "I" status indicator code is defined as "Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services" while the "X" status indicator code is defined as "Statutory Exclusion."

Because HCPCS codes are valid codes under the Health Insurance Portability and Accountability Act (HIPAA), claims for ambulance transportation and transportation related services (HCPCS codes A0021 through A0424 and A0998) which are statutorily excluded or otherwise not payable by Medicare should be allowed into the Medicare claims processing system for adjudication and, since these services are statutorily excluded from, or otherwise not payable by, Medicare, then denied as such. Doing so affords providers and suppliers submitting the claims on behalf of Medicare beneficiaries the opportunity to submit "no-pay claims" to Medicare for statutorily excluded or otherwise not payable by Medicare services with the HCPCS code that accurately identifies the service that was furnished to the Medicare beneficiary. Doing so will allow providers/suppliers to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

B. Policy: Contractors shall revise their claims processing systems in order to allow HCPCS codes identifying Medicare statutorily excluded ambulance transportation and transportation related services into their systems for adjudication. Claims containing these statutorily excluded ambulance transportation and transportation related service codes shall be denied as statutorily excluded. Those providers/suppliers wishing to bill for statutorily excluded ambulance transportation and transportation related services in order to obtain a "Medicare denial" shall bill for such services by attaching the "GY" modifier to the HCPCS code identifying the service according to long-standing CMS policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7489.1	Contractors shall accept into their systems the range of HCPCS codes A0021 through A0424 and A0998 (while continuing to accept those HCPCS codes included in the CMS Ambulance Fee Schedule).	X		X	X		X				
7489.2	Contractors shall deny claims for services (individual claim lines) containing the HCPCS codes A0021 through A0424 and A0998.	X		X	X		X				
7489.2.1	Contractors shall use the following remittance advice language when denying these statutorily excluded services: Claim Adjustment Reason Code -96 – "Non-covered charge(s)." Remittance Advice Remark Code -N425 – "Statutorily excluded service(s)." Group Code -PR – "Patient Responsibility."	X		X	X		X				
7489.2.2	Contractors shall use the following MSN message when denying these statutorily excluded services: 16.10 - "Medicare does not pay for this item or service." OR "Medicare no paga por este artículo o servicio."	X		X	X		X				
7489.3	Contractors shall apply the instructions above to claims received on or after January 1, 2012 as long as the claims are received within the proper timely filing deadline.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7489.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Contact Eric Coulson at eric.coulson@cms.hhs.gov or (410) 786-3352.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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Section B: *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.