DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® — Information for Medicare Fee-for-Service Health Care Professionals

News Flash – A new publication titled "Medicare Ambulance Services" (May 2011), which is designed to provide education on Medicare ambulance services, is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/Medicare_Ambulance_Services_ICN903194.pdf on the Centers for Medicare & Medicaid Services (CMS) website. This booklet includes information about the ambulance service benefit, ambulance transports, ground and air ambulance providers and suppliers, ground and air ambulance vehicles and personnel requirements, covered destinations, ambulance transport coverage requirements, and ambulance services payments.

MLN Matters® Number: MM7489

Related Change Request (CR) #: CR 7489

Related CR Release Date: August 5, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R942OTN

Implementation Date: January 3, 2012

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

Provider Types Affected

This article is for ambulance providers and suppliers who bill Medicare Carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MACs) for ambulance transportation services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2012, you will be able to submit "no-pay claims" to Medicare for statutorily excluded ambulance transportation services, in order to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

 CAUTION – What You Need to Know

Change Request (CR) 7489, from which this article is taken, announces that (effective January 1, 2012,) Medicare FIs, carriers, and A/B MACs will revise their claims processing systems to begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily excluded ambulance transportation services. Medicare will then deny claims containing these codes as "non-covered," which will allow you to submit the denied claim to a beneficiary's secondary insurance for coordination of benefits purposes.

 GO – What You Need to Do

You should ensure that your billing staffs are aware of this change, and the need to include the "GY" modifier to the HCPCS code identifying the excluded ambulance transportation service.

Background

Certain HCPCS codes identify various transportation services that are statutorily excluded from Medicare coverage and, therefore, not payable when billed to Medicare. In the Medicare Physician Fee Schedule Database (MPFSDB), a status indicator of "I" or "X" is associated with these codes. The "I" shows the HCPCS code is "Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services." The "X" indicates a (Statutory Exclusion" of the code. (See the "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 30.2.2 (MPFSDB Status Indicators), which you can find at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

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..

If you wish to bill for statutorily excluded ambulance transportation services in order to obtain a "Medicare denial," you should bill for such services by attaching the "GY" modifier to the HCPCS code identifying the service according to long-standing CMS policy.

When denying these claims for statutorily excluded services, your carrier, FI, or A/B MAC will use the following remittance advice language:

- Claim Adjustment Reason Code - 96 – "Non-covered charge(s);"
- Remittance Advice Remark Code - N425 – "Statutorily excluded service(s);" and
- Group Code - PR – "Patient Responsibility."

Note: Make sure that you include the HCPCS code that accurately identifies the excluded ambulance transportation service that the beneficiary was furnished.

Additional Information

You can find more information about instructions given to your carrier, FI, or A/B MAC to accept and process all ambulance transportation HCPCS Codes by going to CR7489, located at http://www.cms.gov/Transmittals/downloads/R942OTN.pdf on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.