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| ISSUE DATE April 18, 2024 | EFFECTIVE DATE January 1, 2024 | NUMBER 26-24-01 |
| SUBJECT Ambulance Services | | BY  Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs |

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>.

PURPOSE:

The purpose of this bulletin is to advise providers that the Department of Human Services (Department) will begin paying for ground ambulance mileage for each loaded mile in addition to increasing the fees for certain ambulance services on the Medical Assistance (MA) Program Fee Schedule, effective with dates of service on or after January 1, 2024.

SCOPE:

This bulletin applies to all ambulance providers enrolled in the MA Program. Ambulance providers rendering services to MA beneficiaries in the managed care delivery system should contact the appropriate managed care organization with any billing and payment questions.

BACKGROUND / DISCUSSION:

Act 15 of 2023 (P.L. 63, No. 15) (Act 15) provides for the payment of ground mileage for each loaded mile, in addition to increasing the fees for certain ambulance services in both the fee-for-service and managed care delivery systems (<https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2023&sessInd=0&act=15>). Specifically, Act 15 authorizes a fee increase that is the greater of Medicare rates published in the ambulance fee schedule public use file for calendar year 2023 or the current Medicaid ambulance fees as updated by MA Bulletin 26-22-07, titled "2023 Ambulance Fee Increases," issued November 10, 2022 (<https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP>

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-service provider service center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:

<https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx>.

[/MAB2022111001.pdf](#)). Act 15 provided that the payment for each loaded mile and the increased fees are subject to Federal approval as may be necessary and contingent on the availability of Federal financial participation.

The Department submitted a State Plan Amendment to the Centers for Medicare & Medicaid Services, which was recently approved.

PROCEDURE:

Effective with dates of service on and after January 1, 2024, the Department will pay for ground mileage for each loaded mile and increase the fees for certain ambulance services on the MA Program Fee Schedule as follows.

| Procedure Code | Procedure Code Definition | Pricing Modifier | Current MA Fee | MA Fee Effective January 1, 2024 |
|-----------------------|--|-------------------------|---|---|
| A0425 | Ground mileage, per statute mile | U8 | \$4.00 per mile for each loaded mile beyond 20 loaded miles of a trip | \$13.20 per mile for each loaded mile of a trip |
| A0426 | Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1) | | \$400.00 | \$421.54 |
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency) | | \$400 | \$667.43 |
| A0428 | Ambulance service, basic life support, nonemergency transport, (BLS) | | \$325.00 | \$351.29 |
| A0429 | Ambulance service, basic life support, emergency transport, (BLS, emergency) | | \$325 | \$562.05 |
| A0430 | Ambulance service, conventional air services, transport, one way (fixed wing) | | \$3,325.53 | \$5,589.00 |

| | | | | |
|-------|---|--|--|--|
| A0431 | Ambulance service, conventional air services, transport, one way (rotary wing) | | \$3,325.53 | \$6,498.05 |
| A0432 | Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers | | \$80.00 | \$501.42 |
| A0433 | Advanced life support, level 2 (ALS 2) | | \$400 | \$966.01 |
| A0434 | Specialty care transport (SCT) | | \$400 | \$1,141.66 |
| A0436 | Rotary wing air mileage, per statute mile | | \$22.45 per mile for each loaded mile beyond 20 loaded miles of a trip | \$40.92 per mile for each loaded mile beyond 20 loaded miles of a trip |

The HealthChoices managed care organizations (MCOs) are required to pay fees for ambulance services that are at least the amount on the MA Program Fee Schedule.

Claims for dates of service on or after January 1, 2024, that were processed prior to the issuance of this bulletin will be reprocessed.

RESOURCES:

Providers should refer to this bulletin, as well as the PROMISe™ Provider Handbook and Billing Guides that can be found on the Department’s website at: https://www.dhs.pa.gov/providers/PROMISe_Guides/Pages/PROMISe-Handbooks.aspx.

The MA Program Outpatient Fee Schedule has been updated to reflect these changes. Providers may view the MA Program Outpatient Fee Schedule on the Department’s website at the following link: <https://www.humanservices.state.pa.us/outpatientfeeschedule>.

ATTACHMENTS:

- 1) Ambulance Services Medical Assistance Program Fee Schedule, Effective January 1, 2024
- 2) CMS-1500 Billing Guide for PROMISe™ Ambulance Providers

Ambulance Services
Medical Assistance Program Fee Schedule

Attachment
January 1, 2024

| Procedure Code | Description | Provider Type | Provider Specialty | Place of Service | Informational Modifier | Pricing Modifier | Limits | MA Fee |
|----------------|---|---------------|--------------------|------------------|--------------------------------|------------------|----------------------------------|---|
| A0425 | Ground mileage, per statute mile | 26 | 260, 261 | 12, 21, 23, 24, | | U8 | Unlimited | \$13.20 per mile for each loaded mile of a trip |
| | | " | " | 32, 49, 50, 54, | | | | |
| | | " | " | 55, 65, 72, 99 | | | | |
| A0426 | Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1) | 26 | 261 | 12 | HR | | 2 trips per day per beneficiary* | \$421.54 |
| | | " | " | 21, 23 | RH, HH, JH, NH | | | |
| | | " | " | 32 | RE, HE, RN, HN | | | |
| | | " | " | 54 | HE, RE | | | |
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency) | 26 | 261 | 21, 23 | SH, IH, HH, JH, RH, NH, PH, EH | | 2 trips per day per beneficiary* | \$667.43 |
| | | " | " | 50 | SD, RD | | | |
| | | " | " | 72 | SD, RD | | | |
| | | " | " | 99 | SI, HI | | | |
| A0428 | Ambulance service, basic life support, nonemergency transport, (BLS) | 26 | 260, 261 | 12 | HR, GR, JR | | 2 trips per day per beneficiary* | \$351.29 |
| | | " | " | 21, 23 | JH, PH, RH, HH | | | |
| | | " | " | 32 | RE, HE, RN, HN | | | |
| | | " | " | 54 | RE, HE | | | |
| | | " | " | 55 | HE | | | |
| A0429 | Ambulance service, basic life support, emergency transport (BLS, emergency) | 26 | 260, 261 | 21, 23 | SH, IH, HH, JH, RH, NH, PH, EH | | 2 trips per day per beneficiary* | \$562.05 |
| | | " | " | 49 | SD, RD | | | |
| | | " | " | 50 | SD, RD | | | |
| | | " | " | 72 | SD, RD | | | |
| | | " | " | 99 | SI, HI | | | |
| A0430 | Ambulance service, conventional air services, transport, one way (fixed wing) | 26 | 262 | 99 | II | U8 | 2 trips per day per beneficiary* | \$5,589.00 |
| A0431 | Ambulance service, conventional air services, transport, one way (rotary wing) | 26 | 262 | 21, 23 | HH, IH, SH | | 2 trips per day per beneficiary* | \$6,498.05 |
| | | " | " | 99 | II, SI, HI | | | |
| A0432 | Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers | 26 | 261 | 21, 23 | SH, IH, RH, NH, PH, EH | | 2 trips per day per beneficiary* | \$501.42 |
| | | " | " | 49 | SD, RD | | | |
| | | " | " | 50 | SD, RD | | | |
| | | " | " | 72 | SD, RD | | | |
| A0433 | Advanced life support, level 2 (ALS 2) | 26 | 261 | 21, 23 | SH, IH, HH, JH, RH, NH, PH, EH | | 2 trips per day per beneficiary* | \$966.01 |
| | | " | " | 49 | SD, RD | | | |
| | | " | " | 50 | SD, RD | | | |
| | | " | " | 72 | SD, RD | | | |
| | | " | " | 99 | SI, HI | | | |

* A trip is from point of beneficiary pick up to point of beneficiary destination

Ambulance Services
Medical Assistance Program Fee Schedule

Attachment
January 1, 2024

| Procedure Code | Description | Provider Type | Provider Specialty | Place of Service | Informational Modifier | Pricing Modifier | Limits | MA Fee |
|----------------|--|---------------|--------------------|------------------|------------------------|------------------|----------------------------------|--|
| A0434 | Specialty care transport (SCT) | 26 | 261 | 21, 23 | HH, IH | | 2 trips per day per beneficiary* | \$1,141.66 |
| | | " | " | 99 | HI | | | |
| A0435 | Fixed wing air mileage, per statute mile | 26 | 262 | 99 | | | Unlimited | \$22.45 per mile for each loaded mile beyond 20 loaded miles of a trip |

* A trip is from point of beneficiary pick up to point of beneficiary destination

CMS-1500 Billing Guide for PROMISe™ Ambulance Providers

| | |
|--------------------------------|--|
| Purpose of the document | <p>The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:</p> <ul style="list-style-type: none">• Ambulance – Provider Type 26 |
| Document format | <p>This document contains a table with four columns. Each column provides a specific piece of information as explained below:</p> <ul style="list-style-type: none">• Block Number – Provides the block number as it appears on the claim.• Block Name – Provides the block name as it appears on the claim.• Block Code – Lists a code that denotes how the claim block should be treated. They are:<ul style="list-style-type: none">• M – Indicates that the claim block must be completed.• A – Indicates that the claim block must be completed, if applicable.• O – Indicates that the claim block is optional.• LB – Indicates that the claim block should be left blank.* – Indicates special instruction for block completion.• Notes – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions. |

November 1, 2004 – Effective November 1, 2004, the Department of Human Services (Department) implemented the use of the National Ambulance Procedure Codes, Ambulance Modifiers, and Place of Service Codes.

February 20, 2007 – Effective February 20, 2007, the Department issued Medical Assistance Bulletin (MAB) 26-07-01 (Clarification of Procedure Codes and Modifiers to be used when billing Ambulance Services), that provides clarification for the use of the Ambulance Procedure Codes and Ambulance Informational/Pricing Modifiers for specific Places of Service.

Please refer to MAB 26-07-01 to insure for proper billing procedures for Ambulance Service Claims.

The MA Bulletin can also be found on the Office of Medical Assistance Programs (OMAP) website at www.dhs.state.pa.us.

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents:**

1. Block 24F (\$Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24F, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is two hundred and fifty dollars, enter:

| | |
|-----------|----|
| 24F | |
| \$CHARGES | |
| 250 | 00 |

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

| | |
|-------------|----|
| 29 | |
| Amount Paid | |
| 50 | 00 |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

You must follow these instructions to complete the CMS-1500 claim when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

| BlockNo. | Block Name | Block Code | Notes |
|----------|-----------------------------|------------|--|
| 1 | Type of Claim | M | Place an X in the Medicaid box. |
| 1a | Insured's ID Number | M | Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block. |
| 2 | Patient's Name | A | It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim. *This field is required when billing for newborns using the mother's beneficiary number. Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl. |
| 3 | Patient's Birthdate and Sex | A | Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an X in the appropriate box. *Same as the special instruction for Block 2. Enter the newborn's date of birth in an eight-digit format. |
| 4 | Insured's Name | A | If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word SAME may be entered. If there is no other insurance other than MA, leave this block blank. |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|--|
| 5 | Patient's Address | O | Enter the patient's address. |
| 6 | Patient's Relationship to Insured | A | Check the appropriate box for the patient's relationship to the insured listed in Block 4. |
| 7 | Insured's Address | A | Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word SAME . Complete this block only when Block 4 is completed. |
| 8 | Reserved for NUCC Use | LB | Do not complete this block. |
| 9 | Other Insured's Name | A | If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word SAME . If the patient has MA coverage only, leave the block blank. |
| 9a | Other Insured's Policy or Group Number | A | This block identifies a secondary insurance other than MA, and the primary insurance listed in 11a–d. Enter the policy number <u>and</u> the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.) |
| 9b | Reserved for NUCC Use | LB | Do not complete this block. |
| 9c | Reserved for NUCC Use | LB | Do not complete this block. |
| 9d | Insurance Plan Name or Program Name | A | Enter the other insured's insurance plan name or program name. |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|---------------------------------------|------------|--|
| 10a-10c | Is Patient's Condition Related To: | A | Complete the block by placing an X in the appropriate YES or NO box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's 2-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for Pennsylvania). |
| 10d | Claim Codes (Designated for NUCC) | O | It is optional to enter the 9-digit social security number of the policyholder if the policyholder is not the beneficiary. |
| 11 | Insured's Policy Group or FECA Number | A/A | Enter the policy number and group number of the primary insurance other than MA. |
| 11a | Insured's Date of Birth and Sex | A/A | Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3. |
| 11b | Other Claim ID (Designated by NUCC) | LB | Do not complete this block. |
| 11c | Insurance Plan Name or Program Name | A | List the name and address of the primary insurance listed in Block 11. |
| 11d | Is There Another Health Benefit Plan? | A | If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the YES box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource. |
| 12 | Patient's or Authorized Person's | M/M | The beneficiary's signature or the words Signature Exception must appear in this field. Also, enter the date of claim submission in an 8- |

CMS-1500 Claim Form Completion for PROMISe™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|--|
| | Signature and Date | | digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) |
| | | | Note: Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures. |
| 13 | Insured's or Authorized Person's Signature | O | If completed, this block should contain the signature of the insured, if the insured is not the patient. |
| 14 | Date of Current Illness, Injury or Pregnancy (LMP) | O | If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004). |
| 15 | Other Date | O | If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002). |
| 16 | Dates Patient Unable to Work in Current Occupation | O | If completed, enter the FROM and TO dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations. |
| 17 | Name of Referring Provider or Other Source | M | Enter the name and the degree of the attending practitioner. |

| | | | |
|-----|-----------------------------------|---|--|
| 17a | I.D. Number of Referring Provider | A | <p>In the first portion of this block, enter a two-digit qualifier that indicates the type of ID:</p> <p>0B = License Number</p> <p>G2 = 13-digit Provider ID number (Legacy</p> |
|-----|-----------------------------------|---|--|

CMS-1500 Claim Form Completion for PROMISe™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|---|------------|--|
| | | | Number) In the second portion, enter the license number of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, |
| | | | enter the number in the new format (e.g., MD123456). If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X. |
| 17b | NPI # | A | Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source. |
| 18 | Hospitalization Dates Related to Current Services | LB | Do not complete this block. |

| | | | |
|----|---|-----|---|
| 19 | Additional Claim Information (Designated by NUCC) | A/A | <p>This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters “AT”, followed by a two-digit number (i.e., AT05).</p> <p>Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,).</p> <p>When using “AT05”, indicating a Medicare payment, please remember to properly complete and attach the "Supplemental Medicare Attachment for Providers" form MA 539.</p> <p>When using “AT10”, indicating a payment from a Commercial Insurance, please remember to properly complete and attach the "Supplemental Attachment for Commercial Insurance for</p> |
|----|---|-----|---|

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|------------|------------|---|
| | | | <p>Providers" form MA 538.</p> <p>Attachment Type Code “AT99” indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary’s number on the top left-hand corner of the page (i.e., Enter AT26, AT99 if billing for newborns that have temporary eligibility under the mother’s beneficiary number. On the</p> |
| | | | <p>remarks sheet, include the mother’s full name, date of birth, and social security number.).</p> <p>If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment.</p> <p><i>For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</i></p> |

| | | | |
|---|--|---|---|
| | | A | <p>Qualified Small Businesses</p> <p>Qualified small businesses must <u>always</u> enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes:</p> <p>“(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.”</p> |
| <p>*Note: If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter AT05 in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.</p> | | | |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|---|
| 20 | Outside Lab? | LB | Do not complete this block. |
| 21 | Diagnosis or Nature of Illness or Injury | M/A | <p>The ICD indicator (ICD Ind) is required. If a valid “9” or “0” indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete.</p> <p>For dates of service prior to October 1, 2015, enter the most specific ICD-9-CM code (indicator “9”); OR for dates of service on or after October 1, 2015, enter the ICD-10-CM code (indicator “0”) that describes the diagnosis.</p> <p>The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.</p> |
| 22 | Resubmission Code | A/A | <p>This block has two uses:</p> <ol style="list-style-type: none"> 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the ORIGINAL rejected claim in the right portion of this block (e.g., 1103123523123). 2) When submitting a claim adjustment for a previously approved claim. If submitting a claim adjustment, enter ADJ in the left portion of the block and the LAST APPROVED 13-digit ICN, a space and the two-digit line number from the RA Statement in the right portion of the block (e.g., ADJ 1103123523123 01). |
| 23 | Prior Authorization Number | LB | Do not complete this block. |
| 24a | Date(s) of Service | M/M | <p>Enter the applicable date(s) of service.</p> <p>If billing for a service that was provided on one day</p> |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|---|
| | | | <p>only, complete either the From or the To column (but not both.).</p> <p>If the same service was provided on consecutive days, enter the first day of the service in the From column and the last day of service in the To column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.</p> |
| 24b | Place of Service | M | <p>Enter the 2-digit place of service code that indicates where the beneficiary was transported (i.e., destination).</p> <p>12 – Patient’s Home 21 – Inpatient Hospital 22 – Outpatient Hospital 23 – Emergency Room 24 – Ambulatory Surgical Center (ASC)/ Hospital Short Procedure Unit (SPU) 32 – Nursing Facility 49 – Independent Clinic 50 – Federally Qualified Health Center 54 – Intermediate Care Facility/Mentally Retarded 55 – Residential Substance Abuse Treatment Facility 65 – End Stage Renal Disease Treatment Facility 72 – Rural Health Clinic 99 – Other Unlisted Facility</p> |
| 24c | EMG | A | <p>Enter 1 if the service provided was in response to an emergency, 2 if urgent. Otherwise, leave this item blank.</p> |
| 24d | Procedures, Services, or Supplies (CPT/HCPCS & Modifier) | M/M/A | <p>List the procedure code(s) for the service(s) being rendered and any applicable modifier(s).</p> <p>In the first section of the block, enter the procedure code that describes the service provided.</p> <p>In the second and third sections of the block, enter</p> |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|------------|------------|--|
| | | | <p>up to four applicable modifiers.</p> <p>Note: There must be at least one modifier enter in the second section of this block for the service(s) provided.</p> <p><i>Ambulance procedure codes A0425 (Ground mileage, per statute mile) and A0430 (Ambulance service, conventional air services, transport, fixed wing) must have modifier U8 in the second section of this block.</i></p> <p>The modifiers applicable to ambulance services are:</p> <p>RH – Residence to Hospital</p> <p>HR – Hospital to Residence</p> <p>HE – Hospital to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)</p> |
| | | | |

RE – Residence to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)

HN – Hospital to Skilled Nursing Facility (SNF)

PH – Physician’s Office (includes HMO non-hospital facility, clinic, etc) to Hospital

RJ – Residence to Non-Hospital based dialysis facility

JH – Non-Hospital based dialysis facility to Hospital

JR – Non-Hospital based dialysis facility to Residence

RG – Residence to Hospital based dialysis facility (hospital or hospital-related)

GR – Hospital based dialysis facility (hospital or hospital-related to Residence)

SD – Scene of accident or acute event to

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|------------|------------|--|
| | | | <p>Diagnostic or therapeutic site other than “P” (physician) or “H” (hospital)</p> <p>SH – Scene of accident or acute event to Hospital</p> <p>SI – Scene of accident or acute event to Site of transfer (for example, airport or helicopter) between types of ambulance</p> <p>IH – Site of transfer (for example, airport or helicopter) between types of ambulance to Hospital</p> <p>HH – Hospital to Hospital</p> <p>HI – Hospital to Site of transfer (for example, airport or helicopter) between types of ambulance</p> |
| | | | |

NH – Skilled Nursing Facility to Hospital

EH – Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility) to Hospital

RD – Residence to Diagnostic or therapeutic site other than “P” (physician) or “H” (hospital)

II – Site of transfer (for example, airport or helicopter) between types of ambulance to Site of transfer (for example, airport or helicopter) between types of ambulance

RN – Residence to Skilled Nursing Facility (SNF)

HD – Hospital to Diagnostic or therapeutic site other than “P” (physician) or “H” (hospital)

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|-------------------|------------|--|
| 24e | Diagnosis Pointer | M | <p>This block may contain up to four letters.</p> <p>Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21.</p> <p>If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis.</p> <p>Note: The primary diagnosis pointer must be entered first.</p> |
| 24f | \$Charges | M | <p>Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter 6500.</p> |
| 24g | Days or Units | M | <p>Enter the number of units, services, or items provided.</p> <p>Note: Providers submitting claims for ambulance transport mileage reimbursement for more than one episode of transportation for a single beneficiary on the same date of service, and the same ambulance transport Procedure Code / Modifier combination applies to more than one episode of transportation, the episodes requiring the same Procedure Code / Modifier combination must be billed on the same claim line indicating the total number of episodes provided in the Block 24G (Units).</p> <p>In instances of this nature it is important to document in the beneficiary's file associated with these services the reason why it was necessary to bill the Procedure Code/Modifier combination for more than 1 unit.</p> <p>For ground mileage, billable mileage is paid for all</p> |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|--------------------------|------------|--|
| | | | miles of the loaded trip. Enter the number of loaded |
| | | | miles minus the first twenty miles of the loaded trip (e.g., If the round trip was 100 miles, then enter 80 (miles) in block 24g). |
| 24h | EPSDT/Family Planning | A | <p>Enter the 2-digit visit code, if applicable. Visit codes are especially important if providing services that do not require copay (i.e., for a pregnant beneficiary or long term care resident.)</p> <p><i>For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</i></p> <p>Note: When billing for mileage, it is not necessary to enter a visit code, as the Department does not assess a copayment on mileage charges.</p> |
| 24i | ID Qualifier | A | <p>Enter the two-digit ID Qualifier:</p> <p>G2 = 13-digit Provider ID Number (legacy #)</p> |
| 24j (a) | Rendering Provider ID # | A | <p>Complete with the Rendering Provider's Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total).</p> <p>Note: Only one rendering provider per claim form.</p> |
| 24j (b) | NPI | A | Enter the 10-digit NPI number of the rendering provider. |
| 25 | Federal Tax I.D. Number | M | Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an X in the appropriate block. |
| 26 | Patient's Account Number | O | Use of this block is strongly recommended. It can contain up to 10 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help |

CMS-1500 Claim Form Completion for PROMISE™ Ambulance Providers

| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|---|
| | | | |
| | | | identify claims if an incorrect beneficiary number is listed. |
| 27 | Accept Assignment? | LB | Do not complete this block. |
| 28 | Total Charge | LB | Do not complete this block. |
| 29 | Amount Paid | A | If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. Do not enter copay in this block. |
| 30 | Reserved for NUCC Use | LB | Do not complete this block. |
| 31 | Signature of Physician or Supplier Including Degree or Credentials | M/M | This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, except for abortions, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004). |
| 32 | Service Facility Location Information | LB | Do not complete this block. |
| 32a | | LB | Do not complete this block. |
| 32b | | LB | Do not complete this block. |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|------------------------------|------------|--|
| 33 | Billing Provider Info & Ph.# | A/A& M/M | Enter the billing provider's name, address, and telephone number Do not use slashes, hyphens, or spaces. Note: If services are rendered in the patient's home or facility, enter the service location of the provider's main office. |
| 33a | | A | Enter the 10-digit NPI number of the billing provider. |
| 33b | | M/A | Enter the 13-digit Group/Billing Provider ID number (Legacy #) |