

Billing and Payment Fact Sheet for Ambulance Suppliers and Providers (Participants)



Welcome to the Centers for Medicare & Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) Model. This factsheet provides billing and payment instructions for ambulance suppliers and providers with whom CMS has executed an ET3 Model Participation Agreement (Participants).

The ET3 Model is a voluntary five-year CMS payment model under which CMS will test two new payments available to Participants. Participants are eligible to receive payment from CMS for 1) transporting ET3 Model beneficiaries to an alternative destination (AD), such as a primary care office, urgent care clinic, or a community mental health center; and 2) initiating and facilitating treatment in place (TIP) by a qualified health care partner (QHCP) or the QHCP's downstream practitioner (DSP) to an ET3 Model beneficiary either at the scene of a 9-1-1 emergency response or via telehealth. During the model performance period, CMS will continue to pay Participants to transport a Medicare Fee-For-Service (FFS) beneficiary to a hospital emergency department or other covered destination.

Participants are eligible to receive payment for transport to an alternative destination (TAD) and the initiation and facilitation of TIP only when such services are furnished to Medicare FFS beneficiaries, meaning beneficiaries who are entitled to benefits under Medicare Part A and enrolled under Medicare Part B. Payment is not available from CMS if these services are furnished to beneficiaries who receive their Medicare coverage from a Medicare Advantage plan (Part C), which is a type of Medicare health plan offered by a private company that contracts with Medicare to provide, at a minimum, Part A and Part B benefits.

Billing for TAD and facilitation of TIP under the ET3 Model is similar to how ambulance suppliers and providers currently bill Medicare Part B, with modifications in order to identify claims for ET3 Model interventions. The sections below provide ET3 Participants information about submitting claims to CMS for ET3 interventions including associated reimbursement rates, destination modifiers, how to code for a beneficiary refusal of ET3 intervention, and other helpful tips.

Payment to Participant for Transport to Alternative Destination

Participants may receive payment for TAD at the appropriate emergency Basic Life Support (BLS-E) (A0429) or emergency Advanced Life Support, Level 1, (ALS1-E) (A0427) rate, plus adjustments (mileage and applicable rural/urban geographic factors, or add-ons or multiple-patient rule), and are subject to medical necessity criteria for emergency ambulance transport.

PLEASE NOTE: Billing practices for Transport to an Alternative Destination under the ET3 Model are different from billing practices for transports furnished under 42 C.F.R. 410.40(f)(5) during the Public Health Emergency (PHE) declaration. Failure to accurately bill either for TAD transports as part of ET3 or for transports as allowed under 42 C.F.R. 410.40(f)(5) could result either in denied claims or CMS recoupment of payment.

Payment to Participant for Initiation and Facilitation of TIP (No Transport)

Participants may receive payment for the initiation and facilitation of TIP furnished in-person or via telehealth by QHCPs or their DSPs at either the BLS-E (A0429) or ALS1-E (A0427) level, plus adjustments (applicable rural/urban geographic factors or add-ons, or multiple-patient rule), even though there is no transport. Do not submit mileage (A0425) on a claim for the initiation and facilitation of a TIP intervention.

QHCPs who partner with Participants to provide covered services to ET3 model beneficiaries as part of a TIP intervention are paid for their services similar to standard Medicare reimbursement.

- Any covered services provided as part of a TIP intervention, either in person or through telehealth, must be medically necessary for the ET3 Model Beneficiary.
- Please reference the Billing and Payment Factsheet for covered services furnished during a TIP intervention for additional information.

Destination Modifiers

New alpha character modifiers will be used in the "destination" position of the origin/destination modifier combination on a claim submitted by the Participant for ET3 TAD or the initiation and facilitation of covered services furnished during a TIP intervention. (Note: These modifiers are **not** to be used for transports allowed under 42 C.F.R. 410.40(f)(5) that are not part of an ET3 intervention.)

Participants should select the most closely related ET3 Model destination code, as appropriate (e.g., the modifier for community mental health center, "C," may be appropriate for a TAD intervention where a beneficiary is transported to a residential substance abuse treatment facility).

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| Service Provided | Modifiers |
|---------------------|--|
| Transport to an ADP | C: Community Mental Health Center |
| | F: Federally Qualified Health Center |
| | O: Physician Office |
| | U: Urgent Care |
| Treatment in Place | W: Treatment in Place (in-person or via telehealth) |

Note: These new destination modifiers may NOT be used in the origin code position of an ambulance service line Healthcare Common Procedural Coding System (HCPCS) origin/destination modifier combination.

ET3 Model G-Code for Beneficiary Refusal of Model Interventions

A new non-payable G-code **MUST** be used to track ET3 Model Beneficiary refusal of ET3 Model interventions. The claim submission process is the same as usual, with the following addition:

| HCPCS Code | Short Description | When to Use It | Where to Use It | Claim Line Submitted Charge Amount |
|--------------|--|--|----------------------|------------------------------------|
| G2022 | Beneficiary refuses ET3 Model services | If an ET3 Model Beneficiary refuses both TIP (in-person or telehealth) services and TAD, and is transported to an otherwise Medicare-covered destination | CPT/HCPCS code field | \$0.01 |

Important notes about the Participant G-code:

- G2022 should be appended to a claim only when an ET3 model beneficiary declines an offer to receive an ET3 model intervention, but consents to an otherwise Medicare-covered transport (including a transport allowed under 42 C.F.R. 410.40(f)(5)). Do not include G2022 if an ET3 Model beneficiary is never offered an ET3 model intervention.
- The G2022 code will be denied by your Medicare Administrative Contractor (MAC) and identified as being part of required reporting. This is by design, and Participants will not be held financially responsible for the denied \$0.01 charge.

TIPS FOR SUCCESS

To ensure success of your ET3 Model claim, use the following guidance:

- Do **not** combine ET3 Model services and non-ET3 Model services on a single claim. This will result in a claims denial.
- Do **not** submit a mileage claim (HCPCS Code A0425) and a Destination modifier "W" (treatment in place) on the same claim.
- Do **not** submit a G2022 beneficiary refusal of services G-code on a claim with any of the ET3 Model destination modifiers (C, F, O, U, or W) on the same claim.
- Submit revenue code 540 on Institutional Part A ET3 Model claims.
- Contact your respective MAC with additional ET3 Model billing and payment questions.



If you have any questions about your participation in the ET3 Model, please email ET3Model@cms.hhs.gov and include your Application ID in the format "ET3-0XXX" in the subject line. Please visit the ET3 Model website <https://innovation.cms.gov/initiatives/et3/> for other Model news or information.