

Medicare Ambulance Fee Schedule

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INTRODUCTION

Health Care Financing Administration (HCFA) has commissioned Blue Cross and Blue Shield Association (Association) to develop this Medicare Ambulance Fee Schedule training session. The training session has been prepared to assist providers, suppliers, Medicare fiscal intermediaries (FIs) and carriers with the information they will need to know to successfully implement the new fee schedule payment system.

This session and the training publication are designed for training individuals who will in turn, train providers, suppliers, FI and carrier staff on the fee schedule. We have provided training text, overhead slides, and reference documents to facilitate that process.

This training publication was initially produced prior to the publication of the final rule implementing Medicare's ambulance fee schedule. We have revised the training material to incorporate the best information available at the time of publication. Please refer to the final rule as published in the *Federal Register* for authoritative guidance in the new system.

This publication should not be considered an authoritative source in making Medicare program policy determinations.

COURSE OBJECTIVES

At the end of this session participants will be able to:

- Explain the basic components of the Ambulance Fee Schedule
- Explain how the components of ambulance fee schedule interact from claim submission to finalization, using Program materials developed for provider/supplier training
- Understand the impact of the ambulance fee schedule on FI and carrier workload and work flow, as well as the impact on audit and reimbursement
- Understand the FI and carrier responsibilities related to ambulance fee schedule provider education and anticipated provider concerns
- Use the training tools developed for this course to help address provider/supplier ambulance fee schedule education

CERTIFICATION

This training course meets the Continuing Education and Training (CET) requirements of the Government Auditing Standards and should qualify for CET credit by your state Board of Accountancy, since Blue Cross and Blue Shield Association is a corporate sponsor in the state of Illinois and an approved sponsor in the National Association of State Boards of Accountancy, National Registry of CPE Sponsors (91-00149-99).



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GLOSSARY OF TERMS

ALS Assessment	Advanced Life Support (ALS) Assessment: An assessment performed by an ALS crew that results in the determination that the patient's condition requires an ALS level of care, even if no other ALS intervention is performed.
ALS1	Advanced Life Support, Level 1 (ALS1): Where medically necessary, the provision of an assessment by an advanced life support (ALS) provider or supplier and/or the provision of one or more ALS interventions. An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.
ALS2	Advanced Life Support, Level 2 (ALS2): Where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following ALS procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line.
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BLS	Basic Life Support (BLS): Where medically necessary, the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous line.
CAH	Critical Access Hospital
CF	Conversion Factor
CFR	Code of Federal Regulations
CPT	Current Procedural Terminology

CY	Calendar Year
DME	Durable Medical Equipment
DOA	Dead on Arrival
DOS	Date of Service
EMS	Emergency Medical Services
EOMB	Explanation of Medicare Benefits
FI	Fiscal Intermediary
FL	Form Locator
FR	Federal Register
FW	Fixed Wing Air Ambulance (FW): Fixed wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, fixed wing air ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.
GAF	Geographic Adjustment Factor
Goldsmith Modification	Establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)
GPCI	Geographic Practice Cost Index
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HHA	Home Health Agency
HMO	Health Maintenance Organization

IIC	Inflation Index Charge
Loaded Miles	A patient on board the ambulance
MAR	Mileage Air Rate
MCM	Medicare Carriers Manual
MGR	Mileage Ground Rate
MIM	Medicare Intermediary Manual
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
NECMA	New England County Metropolitan Area
OPPS	Outpatient Payment Perspective System
PE	Practice Expense
PI	Paramedic Intercept (PI): Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. For a description of these services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.
PPS	Payment Perspective System
RA	Rural Air Adjustment Factor
RG	Rural Ground Adjustment Factor
RPCH	Rural Primary Care Hospital
RVU	Relative Value Unit
RW	Rotary Wing Air Ambulance (RW): Rotary wing air ambulance is provided when the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. In addition, rotary wing air

ambulance may be necessary because the point of pick-up is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities.

SCT

Specialty Carrier Transport (SCT): When medically necessary, for a critically injured or ill beneficiary, a level of inter-facility service provided beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training.

SNF

Skilled Nursing Facility

SSA

Social Security Act

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OBJECTIVE

This chapter provides an overview of the Ambulance Fee Schedule. It also introduces terminology and concepts that will facilitate understanding of the detailed discussion in later chapters.

Background

Current Payment System

Medicare program pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier

- **The term "provider" means all Medicare-participating institutional providers that submit claims for Medicare ambulance services: hospitals (including CAHs), SNFs, and HHAs**
- **The term "supplier" means an entity that is independent of any provider**

The Medicare program pays for ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier. For purposes of this discussion, the term "provider" means all Medicare-participating institutional providers that submit claims for Medicare ambulance services, such as hospitals (including critical access hospitals), skilled nursing facilities (SNFs), and home health agencies (HHAs). The term "supplier" means an entity that is independent of any provider. The reasonable charge methodology which is the basis of payment for ambulance services furnished by ambulance suppliers is determined by the lowest of the customary, prevailing, actual, or inflation indexed charge.

Following are the current billing methods for ambulance services:

- Method 1 is an all-inclusive charge reflecting all services, supplies, and mileage.
- Method 2 is one charge reflecting all services and supplies (base rate) with a separate charge for mileage.
- Method 3 is one charge for all services and mileage, with a separate charge for supplies.
- Method 4 is separate charges for services, mileage, and supplies.

All providers are currently billing Method 2.

Over the past 20 years, Congress has been moving toward fee schedules and prospective payment systems for Medicare payment. In the case of ambulance services, the reasonable charge methodology has resulted in a wide variation of payment rates for the same service depending on location. In addition, this payment methodology is administratively burdensome, requiring substantial recordkeeping for historical charge data. The Balanced Budget Act of 1997 (BBA) mandated the establishment of a fee schedule for payment of ambulance services.

BBA

Section 4531 (b) (2) of the BBA added a new section 1834 (l) to the Social Security Act, which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. This section requires that in establishing the fee schedule, HCFA will:

- Establish mechanisms to control increases in expenditures for ambulance services under Part B of the Medicare program;
- Establish definitions for ambulance services that link payments to the type of services furnished;
- Consider appropriate regional and operational differences;
- Consider adjustments to payment rates to account for inflation and other relevant factors;
- Limit payment for ambulance covered services to the lower of actual billed charges or the Ambulance Fee Schedule amount;
- Phase in the fee schedule in an efficient and fair manner; and,
- Required mandatory assignment for all supplier ambulance services.

BBA-97 requires fee schedule for all ambulance services

Mandatory assignment required for all ambulance services

BBA required that total payments under the Ambulance Fee Schedule be budget neutral.

Negotiated Rulemaking Process

BBA provided that the Ambulance Fee Schedule be established through the negotiated rulemaking process described in the Negotiated Rulemaking Act of 1990

BBA provided that the Ambulance Fee Schedule be established through the negotiated rulemaking process described in the Negotiated Rulemaking Act of 1990.

A committee chartered under the Federal Advisory Committee Act conducted negotiations. HCFA used the services of an impartial convener to help identify interests that would be significantly affected by the proposed rule and the names of persons who were willing and qualified to represent those interests. The Negotiated Rulemaking Committee on the Medicare Ambulance Services Fee Schedule consisted of national representatives of interests that were likely to be significantly affected by the fee schedule. The committee recommendations have been included in the proposed rule.

Proposed Rule

- **Published On 9/12/00**
- **60-Day Comment Period**

Proposed Rule

HCFA published a proposed rule in the *Federal Register* on September 12, 2000. The proposed rule set forth requirements for the new Ambulance Fee Schedule as required by BBA-97. HCFA plans to implement the fee schedule effective for ambulance services provided on or after January 1, 2001. However, the number and content of comments as well as proposed legislation could cause a delay.

Note: In the event the Ambulance Fee Schedule is delayed, HCFA will announce a new effective date. All other provisions in the proposed rule except for the fee schedule and mandatory assignment will be implemented on January 1, 2001.

Negotiated Rulemaking Committee's Recommendations

- The definitions and RVUs for each category of service.
- An emergency response adjustment factor.
- Application of Ambulance Fee Schedule to all entities.
- Payment adjustments to reflect geographical variations.
- Separate payment for mileage and base rate.
- Establishment of an overall structure of the fee schedule.
- Ambulance inflation factor.
- A four-year payment transition period.

Other Items Included in Proposed Rule

- Updated coverage of ambulance services.

- Revised Physician Certification Requirements.
- Development of a conversion factor.
- The base rate will include the transportation cost and all items and services furnished with the ambulance service.
- Regardless of local or state ordinances, payment rates are based on actual service required for condition of beneficiary.
- Mandatory assignment.

Program Memorandum AB-00-88

Program Memorandum AB-00-88

- **Published on
September 18, 2000**
- **Includes instructions
implementing the
Ambulance Fee
Schedule**

Program Memorandum (PM) AB-00-88, dated September 18, 2000 instructs intermediaries and carriers about the Ambulance Fee Schedule. The PM includes an effective date of January 1, 2001 with a disclaimer that, the final rule implementing the fee schedule had not been published. If the fee schedule is not implemented on January 1, 2001, HCFA plans to implement all the provisions included in the PM except for the fee schedule, mandatory assignment for claims paid by suppliers and payment based on beneficiary's condition.

The fee schedule is effective for claims with dates of service on or after the implementation of the fee schedule. Payment based on lower of the actual billed amount or the fee schedule amount.

The fee schedule is effective for claims with dates of service on or after implementation of the fee schedule. Ambulance services covered under Medicare will then be paid based on the lower of the actual billed amount or the Ambulance Fee Schedule amount. The fee schedule will be phased in over a four-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers. The carrier reimbursement rate will be based on the supplier's current billing methodology during the transition period.

This manual provides payment and billing concepts to implement the fee schedule that applies to all

ambulance services. This includes volunteer, municipal, private, independent, and institutional providers, e.g., hospitals, critical access hospitals, skilled nursing facilities and home health agencies.

New Categories of Ambulance Services

Ground Ambulance Services

There are seven categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note: “ground” refers to both land and water transportation.)

a. **Basic Life Support (BLS)** - When medically necessary, the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT- Basic, including the establishment of a peripheral intravenous line.

b. **Basic Life Support (BLS) - Emergency** - When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary’s health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

An emergency response does guarantee that Medicare will pay as emergency service. Medicare pays for the appropriate services rendered for the beneficiary’s condition.

c. **Advanced Life Support, Level 1 (ALS1)** - When medically necessary, the provision of an assessment by an advanced life support (ALS) provider or supplier or the provision of one or more ALS interventions. An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS

intervention is defined as procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

d. **Advanced Life Support, Level 1 (ALS1) - Emergency** - When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

An emergency response does guarantee that Medicare will pay as emergency service. Medicare pays for the appropriate services rendered for the beneficiary's condition.

e. **Advanced Life Support, Level 2 (ALS2)** - When medically necessary, the administration of three or more different medications and the provision of at least one of the following ALS procedures:

Manual defibrillation/cardioversion
Endotracheal intubation
Central venous line
Cardiac pacing
Chest decompression
Surgical airway
Intraosseous line

f. **Specialty Care Transport (SCT)** - When medically necessary, for a critically injured or ill beneficiary, a level of inter-facility service provided beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training.

g. **Paramedic Intercept (PI)** - Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. No mileage is paid for this benefit. For a description of these services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.

Air Ambulance Services

There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

a. **Fixed Wing Air Ambulance (FW)** - Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

b. **Rotary Wing Air Ambulance (RW)** - Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other

obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Changes Related to the Fee Schedule

- A base rate payment plus a separate payment for mileage.
- Eventual elimination of a separate payment for items and services furnished under the ambulance benefit.
- Payment for items and services is included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing -- but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit. An exception to this preclusion exists during the transition period for those billing under Methods 3 and 4 for carriers.
- Medicare pays only for the category of service provided and then only when the service is medically necessary and relevant to beneficiary's condition.

Overview of the Transition to a Fee Schedule

Transition Schedule

Payment under the fee schedule will be phased in over a four-year period. In the first year, the fee schedule amount will comprise only 20% of the amount allowed from Medicare. The remaining 80% of the allowed amount will be based on the provider's reasonable cost or the supplier's reasonable charge. The fee schedule amount will increase each calendar year as a percentage of the total allowed amount from Medicare until it reaches 100% in year 4. During the transition, the amount allowed for an ambulance service will be the lower of the submitted charge or a blended rate that includes both a fee schedule component and a provider's reasonable cost or a supplier's reasonable charge. Payment amount is subject to any remaining deductible and coinsurance.

The phase-in schedule is as follows:

	<u>Fee Schedule Percentage</u>	<u>Cost/Charge Percentage</u>
Year 1	20%	80%
Year 2	50	50
Year 3	80	20
Year 4	100	0

Calculating the Blended Rate During the Transition

Payment of ambulance services currently follows one of two methodologies.

Suppliers are paid based on a reasonable charge methodology.

Providers are paid based on the provider's interim rate (which is a percentage based on the provider's historical cost-to-charge ratio multiplied by the

For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of a percentage of both a fee schedule and a provider or supplier's current payment methodology

submitted charge) and then cost-settled at the end of the provider's fiscal year.

For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of a percentage of both a fee schedule and a provider or supplier's current payment methodology.

For suppliers, the blended rate includes both a portion of the reasonable charge and the fee schedule amount. To implement the transition to the fee schedule, the reasonable charge for each supplier is the reasonable charge for 2000 adjusted for each year of the transition period by the ambulance inflation factor as published by HCFA.

Intermediaries must determine both the reasonable cost for a service furnished by a provider and the fee schedule amount for the service, then apply the appropriate percentage to each such amount to derive a blended-rate payment amount applicable to the service.

The following sections explain the items that are used to arrive at a fee schedule amount. The contractors' systems will do this automatically. These sections are presented to further your understanding of how the fee schedule amount is derived.

Components of the Ambulance Fee Schedule

<p>Components of the Ground Ambulance Fee Schedule</p>

- **Conversion Factor**
- **RVU**
- **GAF**
- **Loaded Mileage Rate**
- **Rural Mileage Adjustment**

Ground Ambulance Services

The fee schedule amount comprises:

- A money amount that serves as a nationally uniform base rate, called a "conversion factor" (CF), for all ground ambulance services.
- A relative value unit (RVU) assigned to each category of ground ambulance service.
- A geographic adjustment factor (GAF) for each Ambulance Fee Schedule area (geographic practice cost index (GPCI)).

- A nationally uniform loaded mileage rate.
- A rural adjustment on loaded mileage for services furnished in a rural area.

Air Ambulance Services

For air ambulance services, the fee schedule amount includes:

- A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing.
- A geographic adjustment factor (GAF) for each Ambulance Fee Schedule area (GPCI).
- A nationally uniform loaded mileage rate for each type of air service.
- A rural adjustment to the base rate and mileage for services furnished in a rural area.

Components of the Air Ambulance Fee Schedule

- **Uniform Base Rate for fixed wing and rotary wing**
- **GAF**
- **Uniform loaded mileage rate for each type of air service**
- **Rural Mileage Adjustment**

Description of FEE SCHEDULE Components

Ground Ambulance Services

(1) Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF will be updated as necessary. The CF included in the proposed rule is \$157.52.

Conversion Factor in Proposed Rule is \$157.52

(2) Relative Value Units (RVU)

The RVUs are as follows:

<u>Service Level</u>	<u>RVU</u>
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service. Higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

(3) Geographic Adjustment Factor (GAF)

The GAF for the Ambulance Fee Schedule uses the non-facility practice expense of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services. The GAF for the Ambulance Fee Schedule uses the non-facility practice expense of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the Ambulance Fee Schedule are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance (“point of pickup”) establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the point of pickup establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the mileage factor.

(4) Mileage

The mileage rate for all categories of ground ambulance services is \$5 per loaded statute mile. Paramedic Intercept has no mileage payment.

The Ambulance Fee Schedule provides a separate payment amount for mileage. The mileage rate for all categories of ground ambulance services is \$5 per loaded statute mile. Paramedic Intercept has no mileage payment.

(5) Adjustment for Mileage for Services Furnished in Rural Areas

Payment is adjusted upward for ambulance services that are furnished in rural areas to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period. For ground ambulance services, the rural adjustment is a 50% increase in the mileage rate to \$7.50 per loaded statute mile for the first 17 miles.

The point of pickup is identified by the zip code and establishes whether a rural adjustment applies. The point of pickup for each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the zip code of the point of pickup establishes whether a rural adjustment applies to such second (or subsequent) transport.

For all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service zip code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith Modification."

The paramedic intercept benefit is based on certain services provided in a rural area. Though no mileage is paid the zip code is required. See PM B-00-01 for details.

HCFA will furnish contractors electronic files that identify a zip code as rural or urban.

There is no conversion factor or RVU applicable to air ambulance services

Air Ambulance Services

(1) Base Rates

Each type of air ambulance service has a base rate. The base rate for a fixed wing ambulance service is \$2,213.00. The base rate for a rotary wing ambulance service is \$2,573.00. There is no conversion factor applicable to air ambulance services. Also, air ambulance services have no RVUs.

(2) Geographic Adjustment Factor

The GAF, as described above for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50% of each of the base rates (fixed and rotary wing).

The mileage rate for fixed wing ambulance services is \$6 per loaded statute mile flown. The mileage rate for rotary wing ambulance services is \$16 per loaded statute mile flown.

(3) Mileage

The fee schedule for air ambulance services provides a separate payment for mileage. The mileage rate for fixed wing ambulance services is \$6 per loaded statute mile flown. The mileage rate for rotary wing ambulance services is \$16 per loaded statute mile flown.

(4) Adjustment for Services Furnished in Rural Areas

Payment is increased for air ambulance services that are furnished in rural areas. For air ambulance services, the rural adjustment is an increase of 50% of the base rate and mileage. A rural adjustment is determined by the point of pickup.

Zip Code Determines Applicable Fee Schedule Amount

The zip code of the point of pickup determines both the appropriate payment and any rural adjustment

The zip code of the point of pickup determines both the appropriate payment and any rural adjustment. If the ambulance transport required a second or subsequent leg, then the zip code of the point of pickup of each leg will determine both the applicable payment for such leg and whether a rural adjustment applies to such leg. Accordingly, the zip code of the point of pickup must be reported on every claim to determine both the correct payment and any rural adjustment.

HCFA will furnish contractors electronic files that identify a zip code as rural or urban

HCFA will furnish contractors electronic files that identify a zip code as rural or urban.

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CHAPTER II - CARRIER COVERAGE AND Related Issues FOR THE AMBULANCE FEE SCHEDULE

OBJECTIVE

The objective of the Coverage chapter is to provide the medical necessity requirements and coding guidelines for submitting ground and air ambulance services to Medicare.

Participants will learn about the following in the course of this chapter:

1. Medicare coverage requirements for ambulance services.
2. New aspects of coverage related to the Ambulance Fee Schedule.

COVERAGE Requirements

Medicare covers ambulance service, when furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated. While physician certification allows the ambulance supplier to assert that transportation was reasonable and necessary, the beneficiary's medical record must support the coverage of the transportation.

Beginning with the implementation of the fee schedule, all ambulance suppliers must accept assignment. This means that providers cannot bill or collect from the beneficiary any amount other than any unmet Part B deductible and/or Part B coinsurance amounts.

Although HCFA required contractors to make changes for mandatory assignment based on the Program Memorandum AB-00-88, "Implementation of the Ambulance Fee Schedule" (CR 1281), released September 18, 2000, HCFA has revised its instructions with regard to mandatory assignment. Mandatory assignment will begin with the implementation of the Ambulance Fee Schedule.

Ground Ambulance Categories of Service

- 1. Basic Life Support (BLS)**
- 2. BLS-Emergency**
- 3. Advanced Life Support 1 (ALS1)**
- 4. ALS1-Emergency**
- 5. ALS2**
- 6. Specialty Care Transport (SCT)**
- 7. Paramedic Intercept (PI)**

Categories of Service

The new Ambulance Fee Schedule has seven categories of ground (land or water) ambulance services and two categories of air ambulance services.

Basic Life Support (BLS)

The Basic Life Support category is the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT- Basic, including the establishment of a peripheral intravenous line.

Basic Life Support – Emergency

The Basic Life Support – Emergency category is the provision of BLS services, as specified above, in the context of an emergency response.

An emergency response is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the beneficiary's health in serious jeopardy;
2. impairment to bodily functions; or
3. serious dysfunction to any bodily organ or part.

Advanced Life Support Level 1 (ALS1)

The Advanced Life Support, Level 1 category is the provision of an assessment by an advanced life support (ALS) provider or supplier or the provision of one or more ALS interventions.

An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint.

An ALS intervention is defined as procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

Advanced Life Support, Level 1 – (ALS1) Emergency

The Advanced Life Support, Level 1 – Emergency Response category is defined as the provision of ALS1 services, as specified above, in the context of an emergency response.

An emergency response is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the beneficiary's health in serious jeopardy;
2. impairment to bodily functions; or
3. serious dysfunction to any bodily organ or part.

Advanced Life Support, Level 2 (ALS2)

The Advanced Life Support, Level 2 category is:

1. The administration of three or more different medications,
or
2. The provision of at least one of the following ALS procedures:
 - Manual defibrillation/cardioversion
 - Endotracheal intubation
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway
 - Intraosseous line

Specialty Care Transport (SCT)

The specialty care transport category is a level of inter-facility service provided for a critically injured or ill beneficiary beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training.

Paramedic Intercept (Carrier only)

Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. For a description of these services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.

**Air Ambulance
Categories of Service**

- 1. Fixed Wing Air Ambulance (FW)**
- 2. Rotary Wing Air Ambulance (RW)**

Fixed Wing Air Ambulance (FW)

The fixed wing air ambulance (airplane) category is services furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility.

Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Rotary Wing Air Ambulance (RW)

The rotary wing air ambulance (helicopter) is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility.

Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Physician Certification Statement

Neither the presence nor the absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary.

When a non-emergency transport is scheduled/unscheduled, the ambulance supplier must obtain a written order from the patient's attending physician certifying that the medical necessity requirements are met (as stated above).

Before submitting a claim the ambulance supplier must:

1. Obtain a signed physician certification statement from the attending physician, or
2. If the ambulance supplier is unable to obtain a signed physician certification statement from the attending physician, a signed physician certification must be obtained from either the physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the hospital or facility where the beneficiary is being treated and who has personal knowledge of the beneficiary's condition at the time the transport is ordered or the service was furnished (the term physician certification statement will also be applicable to statements signed by the other authorized individuals); or
3. If the supplier is unable to obtain the required statement as described in 1 and 2 above, within 21 calendar days following the date of service, the ambulance supplier must document its attempts to obtain the physician certification statement and may then submit the claim.

The supplier must keep the appropriate documentation on file and, upon request, present it to the carrier. It is important to note that neither the presence nor the absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary.

Non-Emergency Response

Ambulance transportation is covered when it meets medical necessity requirements. One of the primary, but not the sole, determining factors of medical necessity for non-emergency transport is the status of whether the patient is

“bed confined.” For bed confinement, the following criteria must be met:

Bed confinement criteria is met when the beneficiary is:

1. Unable to get up from bed without assistance
2. Unable to ambulate
3. Unable to sit in a chair or wheelchair

1. The beneficiary is unable to get up from bed without assistance;
2. The beneficiary is unable to ambulate; and
3. The beneficiary is unable to sit in a chair or wheelchair.

All three of the above-listed components must be met in order for the patient to meet the requirements of the definition of “bed confined.” The term applies to individuals who are unable to tolerate any activity out of bed. This term is not synonymous with “bed rest,” “non-ambulatory,” or “stretcher-bound.”

Non-emergency services may be:

1. Scheduled, or
2. Unscheduled

Some non-emergency response services are actually scheduled. **Scheduled** services are generally regularly scheduled transportation for the diagnosis or treatment of a patient’s medical condition (e.g., transportation for dialysis.)

Unscheduled services generally pertain to non-emergency transportation for medically necessary services, e.g., from one facility to another.

Special circumstances

Multiple Patients

An ambulance may transport more than one patient at a time. This may happen at the scene of a traffic accident. In this case, the fee should be prorated by the number of patients in the ambulance. For example, if two patients were transported at one time, one was a Medicare beneficiary and the other was not, the payment would be based on one-half of the ambulance fee schedule amount for the level of medically appropriate services furnished to the Medicare patient. The Medicare B coinsurance and/or deductible, and mandatory assignment apply to the prorated allowed amount.

Similarly, if both patients were Medicare beneficiaries, payment for each beneficiary would be based on half of the ambulance fee schedule amount for the level of medically appropriate services furnished to each patient. The

Medicare Part B coinsurance, deductible, and assignment rules would apply to these prorated amounts.

Multiple Arrivals

When multiple units respond to a call for services, the entity that provides the transport for the beneficiary should bill Medicare for all services furnished.

For example, a BLS and ALS entity respond to a call and the BLS entity furnishes the transport after an ALS assessment is furnished. The BLS entity will bill using the ALS1 rate. Medicare will pay the BLS entity at the ALS1 rate. The BLS entity and the ALS entity should settle payment for the ALS assessment.

Pronouncement of Death

Pronouncement of Death

The following information explains Medicare policy related to the death of a patient and the resultant effect on payment for ambulance services under the Ambulance Fee Schedule.

The death of a patient is recognized when the pronouncement of death is made by an individual legally authorized to do so by the state where the pronouncement is made. The following three scenarios apply to payment for ambulance services when the beneficiary dies.

1. If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment may be made; however, neither mileage nor a rural adjustment would be paid.

If a ground vehicle is dispatched, payment is made for a BLS service.

If an air ambulance is dispatched, payment is made at the fixed wing or rotary wing base rate, as applicable.

2. Payment is made following the usual rules of payment (as if the beneficiary had not died) when:

The beneficiary is pronounced dead after being loaded into the ambulance, regardless of whether the

pronouncement is made during or subsequent to the transport. A determination of "dead on arrival" (DOA) is made at the facility to which the beneficiary is transported.

3. No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called.

HCPCS CODES

The HCPCS code reflects the service rendered and relates to the condition of the patient but not the type of vehicle used

The following codes must be used to reflect the condition of the patient, not the type of vehicle used. (PM AB-00-88)

The following HCPCS codes are effective for dates of service on or after January 1, 2001:

A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1(ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air service, transport, one way (rotary wing)
A0432	Paramedic Intercept, rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers (PI-volunteer ambulance co)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty Care Transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile

A POSSIBLE DELAY IN SOME CODING CHANGES

If the fee schedule is delayed beyond January 1, 2001, the following requirements will be changed.

1. Mandatory assignment will be delayed.
2. Medicare will continue to pay for an ALS vehicle used, but no ALS service furnished. Suppliers and providers using an ALS vehicle to furnish a BLS service currently bill one of the following HCPCS codes, A0304, A0308, A0324, A0328, A0344, A0348, A0364, or A0368. They may continue to bill for these services but should bill the new HCPCS codes, A0426 (ALS1) or A0427 (ALS1 emergency) as appropriate until the fee schedule is implemented. Once the fee schedule is implemented these services should be billed as A0428 (BLS) and A0429 (BLS Emergency).
3. Suppliers should continue to bill BLS mileage as A0380 and ALS mileage as A0390. After the fee schedule has been implemented all mileage should be billed as A0425.

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Chapter III – carrier Billing

OBJECTIVE

This chapter provides participants with an overview of the carrier claims billing changes and processing system under the Ambulance Fee Schedule.

New Coding Requirements

The implementation of the Ambulance Fee Schedule has generated new coding requirements for carrier claims. The following are the concepts from the Ambulance Fee Schedule that require changes in coding claims:

1. Seven categories of ground ambulance services;
2. Two categories of air ambulance services;
3. Payment based on the condition of the beneficiary and the service provided not on the type of vehicle used;
4. Payment is determined by the point of pickup which is reported by the five-digit zip code;
5. Increased payment for rural services;
6. New HCPCS codes effective for dates of service beginning January 1, 2001;
7. No grace period for dates of service after January 1, 2001. There is an exception for suppliers using Methods 3 and 4 who may continue to use the HCPCS codes for items and services, including J codes and CPT codes for EKG testing, during the transition period. There is also exceptions for mileage codes A0380 and A0390 from January 1, 2001, until the fee schedule is implemented;
8. Services and supplies included in base rate; and
9. With the implementation of the fee schedule, assignment is mandatory for all ambulance suppliers. This means that suppliers may not bill or collect from the beneficiary any amount other than any unmet Part B deductible and Part B coinsurance amounts.

CLAIM CODING GUIDELINES

Coding Instructions For The HCFA-1500 Claim Form

Beginning with dates of service January 1, 2001, the following coding instructions must be used:

1. The new HCPCS codes must be used to reflect the type of service the beneficiary received and not the type of vehicle used.
2. There will be no grace period to transition the use of the new HCPCS codes. Claims that are submitted with the old HCPCS codes for dates of service January 1, 2001, or later will be returned as unprocessable. There is an exception for suppliers using Methods 3 and 4 who may continue to use the HCPCS codes for items and services. There is also an exception for mileage codes A0380 and A0390 from January 1, 2001, until the fee schedule is implemented
3. Suppliers using Methods 3 and 4 may use supply codes A0382, A0384, and A0392-A0999, as well as J codes and CPT codes for EKG testing, during the transition period.
4. Claims must contain the five-digit zip code of the point of pickup.
 - On the HCFA 1500, use box 23.
 - Electronic billers using **X-12N 837** (4010) are to report the origin information in loop 2310D(Service Facility Location). NM1 is required. MN101 will have the value "77" (Service Location) and NM102 will have the value "2" (Non-Person Entity). The remaining fields are not required. N2 is not required. N3 (Service Facility Location Address) is used to report address information. N4 (Service Facility Location City/State/ZIP) is required. N401 is used to report city name, N402 is used to report the State Code and N403 is used to report the zip code.
 - Electronic billers using **National Standard Format** (NSF) are to report the origin information in record EA1. EA1-06 is address information (optional), EA1-

08 is city name (optional), EA1-09 is state code (optional), EA1-10 is zip code (**required**).

5. Since the zip code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup are located in the same zip code. However, suppliers must prepare a separate claim form for each trip if the points of pickup are located in different zip codes.
6. A claim without a zip code or with multiple zip codes will be returned as unprocessable.
7. Generally, each ambulance trip will require two lines of coding: one line for the service and one line for the mileage. Suppliers who do not bill mileage, e.g., paramedic intercept suppliers, would have one line of coding for the service. (Note: Until the fee schedule is implemented, BLS mileage code A0380 and ALS mileage code A0390 will be used. After the implementation of the fee schedule only A0425 will be acceptable for dates of service on or after the implementation date).
8. When mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. If it is less than one mile, code one mile.
9. The following values **must be used** in combinations of two in order to form a two-position modifier. The modifier must indicate both origin and destination. For example, if the origin is the patient's home, and the destination is a hospital, the modifier would be RH; if the origin is a hospital, and the destination is a nursing home, the modifier would be HE, etc.
 - The first position alphabetic value is used to report the origin of service.
 - The second position alphabetic value is used for the destination of service.
 - The origin/destination codes are defined below.

D	Diagnostic or therapeutic site other than P or H
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)

G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
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)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

Coding Guidelines for the HCFA-1491

Form HCFA-1491 has not been revised for the new fee schedule. The following coding instructions should be followed until the form is revised.

1. Box 22 should contain the service HCPCS code, as well as any information necessary to describe the illness or injury.
2. The new HCPCS code must be used to reflect the type of service the beneficiary received and not the type of vehicle used.
3. There will be no grace period to transition the use of the new HCPCS codes. Claims submitted with old HCPCS codes for dates of service January 1, 2001 and later will be returned as unprocessable. The exception are those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill through years 1, 2, and 3, and for mileage codes A0380 and A0390 which are billable until the fee schedule has been implemented.
4. Generally, a claim for ambulance service will require two entries: one HCPCS code for the service and one HCPCS code for the mileage. Suppliers who do not bill mileage would have an entry only for the service.
5. Box 14 should contain the HCPCS mileage code, as well as the number of loaded miles.
6. If mileage is billed, the miles must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest

whole number. If the trip is less than a mile, code one mile.

7. Suppliers using Method 3 or 4 may use supply codes A0382, A0384, and A0392-A0999, as well as J codes, and CPT codes for EKG testing, during the transition period. These supply codes should be entered in box 22. Method 1 and Method 2 claims should be denied.
8. The zip code of the point of pickup must be entered in box 12. If a zip code is not entered in box 12 or there are multiple zip codes entered, the claim will be returned as unprocessable.
9. The following values **must be used** in combinations of two in order to form a two-position modifier. The modifier must indicate both origin and destination. For example, if the origin is the patient's home, and the destination is a hospital, the modifier would be RH; if the origin is a hospital, and the destination is a nursing home, the modifier would be HE, etc.

- The first position alphabetic value is used to report the origin of service.
- The second position alphabetic value is used for the destination of service.
- The origin/destination codes are defined below.

D	Diagnostic or therapeutic site other than P or H
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
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)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office enroute to the hospital

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CHAPTER IV - CARRIER PAYMENT AND REIMBURSEMENT FOR THE AMBULANCE FEE SCHEDULE

OBJECTIVE

The objective of this chapter is to provide participants with an understanding of the new Ambulance Fee Schedule payment provisions. At the end of this session, participants will obtain an understanding of:

- The reimbursement components of the Ambulance Fee Schedule
- The transition schedule and its impact on payment
- How to calculate payment using the new Ambulance Fee Schedule

Reimbursement under THE AMBULANCE FEE SCHEDULE

Upon implementation of the Ambulance Fee Schedule, ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the Ambulance Fee Schedule amount.

The fee schedule will be phased in over a four-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers. During the transition period, the supplier's reimbursement will be based on its current billing methodology. (PM AB-00-88)

The payment amount under the fee schedule is determined as described in the next sections.

Ground Ambulance

For ground ambulance services, the fee schedule amount is calculated using:

1. A money amount that serves as a nationally uniform base rate called a "conversion factor" (CF) for all ground ambulance services;
2. A relative value unit (RVU) assigned to each type of ground ambulance service;
3. A geographic adjustment factor (GAF) for each Ambulance Fee Schedule area (geographic practice cost index (GPCI)),
4. A nationally uniform loaded mileage rate; and
5. For services furnished in a rural area, an additional amount for mileage.

Air Ambulance

For air ambulance services, the fee schedule payment is calculated using:

1. A nationally uniform base rate for fixed wing and a nationally uniform rate for rotary wing;
2. A geographic adjustment factor (GAF) for each Ambulance Fee Schedule area (GPCI);
3. A nationally uniform loaded mileage rate for each type of air service; and
4. A rural adjustment to the base rate and mileage for services furnished in a rural area.

COMPONENTS OF THE FEE SCHEDULE

Ground Ambulance Fee Components
--

- | |
|--|
| <ol style="list-style-type: none">1. Conversion Factor2. Relative Value Unit3. Geographic Practice Cost Index4. National uniform mileage rate5. Additional amount for mileage in a rural area |
|--|

Ground Ambulance Services

Conversion Factor

The conversion factor (CF) is a dollar amount used to develop a base rate for each category of ground ambulance service. The CF will be updated as necessary. The CF included in the proposed rule is \$157.52.

Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service.

The different payment amounts are based on levels of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, i.e., BLS has an RVU of 1; higher

RVU values are assigned to the other types of ground ambulance services, which require more services than BLS.

The Service Levels and their associated RVUs are listed below.

Service Levels	<u>RVU</u>
BLS	1.00
BLS- Emergency	1.60
ALS1	1.20
ALS-Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

Geographic Adjustment Factor (GAF)

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services.

The GAF for the ambulance schedule uses the non-facility practice expense of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the Ambulance Fee Schedule are the same as those used for the physician fee schedule.

The location where the beneficiary was put in the ambulance (“point of pickup”) establishes which GPCI applies.

The location where the beneficiary was put in the ambulance (“point of pickup”) establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for second (or any subsequent) leg of a transport, the point of pickup establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70% of the base rate. The base rate for each level of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the mileage factor.

**Adjustment for
Mileage for Services
in Rural Areas**

**Ground ambulance
services is \$7.50 for
the first 17 miles**

Mileage

The Ambulance Fee Schedule provides a separate payment amount for mileage. The mileage rate for all types of ground ambulance services, except Paramedic Intercept, is \$5.00 per loaded statute mile. Paramedic Intercept has no mileage payment.

Payment is adjusted upward for ambulance services that are furnished in rural areas. To account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period. For ground ambulance services, the rural adjustment is a 50% increase in the mileage rate to \$7.50 per loaded statute mile for the first 17 miles.

The point of pickup, as identified by zip code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the zip code of the point of pickup establishes whether a rural adjustment applies to such second (or subsequent) transport.

**Air Ambulance Fee
Components**

- 1. National base rate for fixed and rotary wing**
- 2. Geographic Practice Cost Index**
- 3. National mileage rate for each type of air service**
- 4. Rural adjustment for base rates and mileage**

Air Ambulance Services

Base Rates

Each type of air ambulance service has a base rate. The base rate for a fixed wing ambulance service is \$2,213.00. The base rate for a rotary wing ambulance service is \$2,573.00. There is no conversion factor applicable to air ambulance services. Also, air ambulance services have no RVUs. The rural adjustment is a 50% increase in the base rate.

Geographic Adjustment Factor (GAF)

The GAF, as described above for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50% of each base rate (fixed and rotary wing).

Mileage

The fee schedule for air ambulance services provides a separate payment for mileage. The mileage rate for fixed wing ambulance services is \$6.00 per loaded statute mile flown. The mileage rate for rotary wing ambulance services is \$16.00 per loaded statute mile flown. The rural adjustment is a 50% increase of the urban mileage rate.

**Adjustment for
Mileage for Services
in Rural Areas**

**Fixed wing services is
\$9.00
Rotary wing service is
\$24.00**

OVERVIEW OF THE TRANSITION TO THE FEE SCHEDULE

Payment under the fee schedule will be phased-in over a four-year period. In the first year the fee schedule amount will comprise only 20% of the amount allowed from Medicare. The remaining 80% allowed by Medicare will be based on the supplier's reasonable charge. Thereafter, the fee schedule amount will increase each calendar year as a percentage of the allowed amount until it reaches 100% in year 4. Thus in year 1, 2, and year 3, the amount allowed for an ambulance service will be the lower of the submitted charge or a blended rate that comprises both a fee schedule component and a suppliers reasonable charge. The phase-in schedule is as follows:

	Fee Schedule Percentage	Cost/Charge Percentage
Year 1	20%	80%
Year 2	50%	50%
Year 3	80%	20%
Year 4	100%	0%

New Suppliers

New suppliers that have not billed Medicare in the past would be subject to the transition period rules. Carriers would determine a reasonable charge under the current rules.

Calculating the Blended Rate During the Transition

Suppliers are paid based on a reasonable charge methodology.

For services furnished during the transition period, payment of ambulance services will be a blended rate that consists of both a fee schedule component and a supplier's current payment methodology as follows:

1. The blended rate includes both a portion of the reasonable charge and the fee schedule amount. For the purpose of implementing the transition to the fee schedule, the reasonable charge for each supplier is the charge for 2000 adjusted for each year of the transition period by the ambulance inflation factor as published by HCFA.
2. Methods 3 and 4 may use supply codes A0382, A0384 and A0392-A0999, as well as J codes and codes for EKG testing, for dates of service during the transition period.

Transition and Payment for Suppliers

With the implementation of the fee schedule, the amount paid will be the lower of the submitted charge or the blended amount determined under the fee schedule. For services furnished in the first year, the blended amount is based on 80% of the reasonable charge plus 20% of the Ambulance Fee Schedule amount. For services furnished during the second year, the blended payment amount is based on 50% of the reasonable charge plus 50% of the Ambulance Fee Schedule amount. For services furnished during the third year the blended payment amount is based on 20% of the reasonable charge plus 80% of the Ambulance Fee Schedule amount.

Suppliers using Method 3 or 4 may bill codes:

(Subject to phase in)

1. **A0382, A0384 and A0392-A0999**
2. **J codes**
3. **EKG testing**

For methods 3 and 4, HCPCS, items and supplies, as well as J codes and codes for EKG testing will be valid until the transition is completed. Payment for such Method 3 and 4 HCPCS (which is available only to a current Method 3 or 4 biller) is based on the reasonable charge for such items and services (80% the first year, 50% second year, and 20% in third year).

USING THE FEE SCHEDULE

HCFA will provide each carrier with two files: a national Zip Code File and a national Ambulance Fee Schedule file. Each carrier will program a link between the Zip Code File to determine the locality and the Ambulance Fee Schedule file to obtain the fee schedule amount.

The fee schedule locality is based on the point of pickup as identified by the zip code that is coded on the claim form. The carrier will use the zip code point of pickup to crosswalk to the appropriate fee schedule amount.

Determining Fee Schedule Amounts

When an **urban zip code** is reported with a ground or air ambulance code, the amount for the service is determined by using the fee schedule amount for the urban base rate for that HCPCS. The mileage amount will be determined by

multiplying the number of reported miles by the urban mileage rate.

When a **rural zip code** is reported with a ground HCPCS code the amount for the service will be determined by using the fee schedule amount for the appropriate base rate. The mileage amount will be determined by multiplying the first 17 loaded miles by the rural mileage rate. NOTE: For Air Ambulance, there is no limit to the number of rural miles.

If a rural zip code is reported with an air HCPCS code, determine the amount for the service by using the fee schedule amount for rural base rate. To determine the amount allowable for the mileage, multiply the number of loaded miles by the rural mileage rate.

For claims with dates of service in the first year of transition, the carrier will use 20% of the fee schedule amount as determined above and calculate a blended amount by adding 80% of the reasonable charge amount. Deductible and coinsurance will be applied.

Example 1

Reasonable charge *IIC	Reasonable new charge x 80%	Fee schedule	Fee schedule x 20%	Total allowed charge
\$315.62	\$252.50	\$317.46	\$63.49	\$315.99

Ground ambulance, urban

A Medicare beneficiary residing in Baltimore, Maryland, was transported via ground ambulance from his/her home to the nearest appropriate hospital two miles away. An emergency service was required and an ALS assessment was performed. The level of service would be ALS1-Emergency.

Assuming that the beneficiary was placed on board the ambulance in Baltimore, it would be an urban trip. Therefore, no rural payment would apply. In Baltimore, the GPCI is 1.039.

The payment rate is \$315.99 (subject to Part B deductible and coinsurance requirements).

In the 1st year of a four-year transition period, the Ambulance Fee Schedule payment rate would be multiplied by 20% and added to 80% of the payment calculated by the current payment system. The payment rate for year 2 would be calculated by multiplying the Ambulance Fee Schedule payment by 50% and adding the result to 50% of the current payment system amount. The payment rate for year 3 would be calculated by multiplying the Ambulance Fee Schedule payment rate by 80% and adding the result to 20% of the current payment system amount. The payment rate for year 4 is the full fee schedule

CODING

New HCPCS Coding:

A0427 (ALS1 Emergency) + A0425 (Mileage)

Old HCPCS Coding:

A0310 (ALS Emergency) + A0390 (Mileage)

Example 2

Reasonable charge *IIC	Reasonable new charge x 80%	Fee schedule	Fee schedule x 20%	Total allowed charge
\$1982.26	\$1585.81	\$2825.30	\$565.06	\$2150.87

AIR AMBULANCE, URBAN

A Medicare beneficiary in Detroit, Michigan was transported from an accident site by air ambulance to the nearest facility 14 miles away.

An emergency service was required.

Urban zip code was reported on the claim.

The payment rate is \$2150.87 (subject to Part B deductible and coinsurance requirements).

In the 1st year of a four-year transition period, the Ambulance Fee Schedule payment rate would be multiplied by 20% and added to 80% of the payment calculated by the current payment system. The payment rate for the year 2 would be calculated by multiplying the Ambulance Fee Schedule payment by 50% and adding the result to 50% of the current payment system amount. The payment rate for year 3 would be calculated by multiplying the Ambulance Fee Schedule payment rate by 80% and adding the result to 20% of the current payment system amount. The payment rate for year 4 is based solely on the full fee schedule

CODING

New HCPCS Coding:

A0431 (Rotary Wing, Conventional) + A0436 (Mileage)

Old HCPCS Coding:

A0040 (BLS Non-Emergency) + Local Code/Range Code (Mileage)

A POSSIBLE DELAY IN SOME CODING CHANGES

If the fee schedule is delayed beyond January 1, 2001, the following requirements will be changed.

1. Mandatory assignment for carriers will be delayed.

2. Medicare will continue to pay for an ALS vehicle used, but no ALS service furnished. Suppliers and providers using an ALS vehicle to furnish a BLS service currently bill one of the following HCPCS codes, A0304, A0308, A0324, A0328, A0344, A0348, A0364, or A0368. They may continue to bill for these services but should bill the new HCPCS codes, A0426 (ALS1) or A0427 (ALS1 emergency) as appropriate until the fee schedule is implemented. Once the fee schedule is implemented these services should be billed as A0428 (BLS) and A0429 (BLS Emergency).

3. Suppliers should continue to bill BLS mileage as A0380 and ALS mileage as A0390. After the fee schedule has been implemented all mileage should be billed as A0425.