DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410 and 414

[HCFA–1002–P]

RIN 0938–AK07

Medicare Program; Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a fee schedule for the payment of ambulance services under the Medicare program, implementing section 1834(l) of the Social Security Act. As required by that section, this proposed fee schedule for ambulance services was the product of a negotiated rulemaking process that was carried out consistent with the Federal Advisory Committee Act. The fee schedule described in this proposed rule would replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for suppliers of ambulance services. In addition, this proposed rule would require that payment for ambulance services would be made only on an assignment related basis; establish new codes to be reported on claims for ambulance services; establish increased payment for ambulance services furnished in rural areas based on the location of the beneficiary at the time the patient is placed on board the ambulance; and revise the physician certification requirements for coverage of nonemergency ambulance services.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 13, 2000.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attn: HCFA–1002–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Since comments must be *received* by the date specified above, please allow sufficient time for mailed comments to be received timely in the event of delivery delays. If you prefer, you may deliver your written comments (one original and three copies) by courier to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

C5–15–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the two above addresses may be delayed and received too late to be considered.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1002–P.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC 20201, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Margot Blige, (410) 786–4642, for coverage issues. Glenn McGuirk, (410) 786–5723, for payment issues.

SUPPLEMENTARY INFORMATION:

I. Background

A. Current Payment System

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 (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 (IIC).

The following describes the current billing methods for ambulance services:

- Method 1 is a single, 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.

Over the past 20 years, the Congress has been moving towards 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 Congress, under the Balanced Budget Act of 1997 (BBA), (Pub. L. 105–33), mandated the establishment of a fee schedule for payment of ambulance services.

B. Recent Legislation

1. Balanced Budget Act of 1997

Section 4531(b)(2) of the BBA added a new section 1834(l) to the Social Security Act (the Act). Section 1834(l) of the Act requires that we establish a national fee schedule for payment of ambulance services furnished under Medicare Part B. This section also requires that in establishing the ambulance fee schedule, we 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;
- Phase in the fee schedule in an efficient and fair manner; and,
- Require payment for ambulance services be made only on an assignment related basis.

In addition, the BBA requires that ambulance services covered under Medicare be paid based on the lower of the actual billed charge or the ambulance fee schedule amount. The BBA also requires that total payments under the ambulance fee schedule may be no more than what would have been paid if the ambulance fee schedule were not in effect. As discussed below, we intended to incorporate $65 million in program savings in the 1998 base year data upon which the ambulance fee schedule is calculated consistent with the statutory requirement that, in the aggregate, we pay no more than would have been paid in the absence of the fee schedule for CY 2001. This amount correlates to $67.3 million when updated for the effects of inflation.

2. Balanced Budget Refinement Act of 1999

Section 412 of the Medicare, Medicaid, and the State Child Health

Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) provided a new definition for the term ''rural'' in the context of the Medicare coverage provision for paramedic advanced life support (ALS) intercept services. The BBRA states that, effective for services furnished on or after January 1, 2000:

> An area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith modification, originally published in the **Federal Register** on February 27, 1992 (57 Fed. Reg. 6725)).

This definition applies only to the Medicare paramedic ALS intercept benefit implemented at 42 CFR 410.40(c). This is a very limited benefit and to date we know of only one State (New York) with areas that meet the statutory requirements. (See the March 15, 2000 final rule (65 FR 13911).) For all other ambulance services, the definition of ''rural'' specified in this proposed rule would apply.

C. Components of Ambulance Fee Schedule Payment Amounts

In general, the payment amount for each air ambulance service paid under the ambulance fee schedule would be the product of two primary factors: (1) A nationally uniform unadjusted base rate; and (2) a geographic adjustment factor for an ambulance fee schedule area. A detailed description of these factors is discussed in this proposed rule.

In general, the payment amount for each ground ambulance service paid under the ambulance fee schedule would be the product of three primary factors: (1) A nationally uniform relative value for the service; (2) a geographic adjustment factor for an ambulance fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. A detailed description of these factors is discussed in this proposed rule.

Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service. Thus, if the value of the resources necessary to furnish service B are twice the value of the resources needed to furnish service A, service B will have RVUs that are twice the value of the RVUs for service A. RVUs are multiplied by a CF expressed as a dollar value to produce a payment amount. The RVUs represent, on average, the relative resources associated with the various levels of ambulance services.

Because the fee schedule is based on the relative values of different levels of ground ambulance services relative to a basic life support ground ambulance service, a factor is needed in order to convert the relative value to a dollar amount equal to the national base payment rate. In order to determine the conversion factor (CF), the general approach is first to determine the total amount of money available and divide that total by the total number of relative value units. As we describe in more detail below, we used 1998 Medicare ambulance claims data to determine the total RVUs in this calculation. The total dollars is equal to the total allowed charges for all ambulance services billed to Medicare in 1998, less the $65 million adjustment for those basic life support (BLS) services that had been paid at the advanced life support (ALS) services payment rate, as described in Section 1834(l)(3) of the Act. This section states that, in establishing the ambulance fee schedule, the Secretary must ensure that the aggregate amount of payment made for ambulance services in calendar year (CY) 2000 does not exceed the aggregate amount of payment that would have been made absent the fee schedule. In the January 22, 1999 notice concerning the negotiated rule meetings, we stated that, although we were postponing final agency action on the proposal to define BLS and ALS services because of the BBA requirement that this issue be subject to negotiated rulemaking, we believe that the savings that would have been realized through implementation of that policy should not be lost to the Medicare program. We determined that $65 million in program savings would have been realized in the base year 1998 data if the final rule had been in effect. The total RVUs are equal to the sum of the total number of allowed services that were billed in 1998 for each of the categories (levels) of ambulance services established by the negotiated rulemaking committee multiplied by the respective relative value of each of the new levels of service.

Section 4531(b)(3) of the BBA provides that the fee schedule was to be effective for ambulance services furnished on or after January 1, 2000. However, because of other statutory obligations and the scope of systems changes required to implement the ambulance fee schedule, we could not meet this statutory deadline while assuming that our respective systems were compliant with the Year 2000 requirements. Therefore, because we were unable to implement the ambulance fee schedule on January 1, 2000, we delayed implementation of the fee schedule for ambulance services until January 1, 2001. This action is in keeping with our objective to have the ambulance fee schedule become effective as soon as possible after the January 1, 2000 statutory date, given our Year 2000 activities and our other statutory obligations to implement various revised payment systems in calendar year 2000.

D. Negotiated Rulemaking Process

Section 1834(l)(1) of the Act provided that the ambulance fee schedule be established through the negotiated rulemaking process described in the Negotiated Rulemaking Act of 1990 (Pub. L. 101–648, 5 U.S.C. 561–570). Prior to using negotiated rulemaking under the Negotiated Rulemaking Act, the head of an agency must generally consider whether the following conditions exist:

- There is a need for a rule.
- There are a number of identifiable interests that will be significantly affected by the rule.
- There is a reasonable likelihood that a committee can be convened with a balanced representation of persons who—
  + Can adequately represent the interests identified; and,
  + Are willing to negotiate in good faith to reach a consensus on the proposed rule.
- There is a reasonable likelihood that a committee will reach a consensus on the proposed rule within a fixed time frame.
- The negotiated rulemaking procedure will not unreasonably delay the notice of proposed rulemaking and the issuance of a final rule.
- The agency has adequate resources and is willing to commit its resources, including technical assistance, to the committee.
- The agency, to the maximum extent possible consistent with the legal obligations of the agency, will use the consensus of the committee as the basis for the rule proposed by the agency for notice and comment.

Negotiations were conducted by a committee chartered under the Federal Advisory Committee Act (FACA) (5 U.S.C. App. 2). We used the services of an impartial convener to help identify interests that would be significantly affected by the proposed rule (including residents of rural areas) 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 (that is, ''the Committee'') consisted of national representatives of interests that were likely to be

significantly affected by the fee schedule. (Additional information about the negotiations can be found in the January 22, 1999 notice or may be accessed at our Internet website at http://www.hcfa.gov/medicare/ambmain.htm.)

To the extent that this proposed rule accurately reflects the Committee Statement as signed on February 14, 2000, each member to the Committee has agreed not to comment on those issues on which consensus was reached.

E. Interaction With the Proposed Rule Published on June 17, 1997

On June 17, 1997, we published a proposed rule (62 FR 32715) in the **Federal Register** to revise and update the Medicare ambulance services regulations at 42 CFR 410.40. Specifically, we proposed: to base Medicare payment on the level of ambulance service required to treat the beneficiary's condition; to clarify and revise the policy on coverage of nonemergency ambulance services; and to set national vehicle, staff, billing, and reporting requirements. As noted above, section 1834(l)(2) of the Act provides, in part, that in establishing the ambulance fee schedule, the Secretary will establish definitions for ambulance services that link payments to the types of services furnished. One of the provisions of the June 17, 1997 proposed rule would have defined ambulance services as either BLS or ALS and linked Medicare payment to the type of service required by the beneficiary's condition. We received a large number of comments on this issue, and, in general, commenters were very concerned about our proposal. In light of that concern and because defining ambulance services is a required element of this negotiated rulemaking (under section 1834(l) of the Act), we decided not to proceed with a final rule on the definition of BLS and ALS services. Instead, we included this issue as a matter for the Committee. We did, however, proceed with a final rule on all other issues of the June 17, 1997 proposed rule. That rule was published on January 25, 1999 (64 FR 3637).

Section 1834(l)(3) of the Act provides that, in establishing the ambulance fee schedule, the Secretary must ensure that the aggregate amount of payment made for ambulance services in calendar year (CY) 2000 does not exceed the aggregate amount of payment that would have been made absent the fee schedule. In the January 22, 1999 notice concerning the negotiated rule meetings, we stated that, although we were postponing final agency action on the proposal to define BLS and ALS services because of the BBA requirement that this issue be subject to negotiated rulemaking, we believe that the Medicare program should not lose the savings that would have been realized through implementation of that policy. We determined that $65 million in program savings would have been realized in the base year 1998 data if the final rule had been in effect. After adjusting for inflation, program savings for CY 2001 have been estimated at $67.6 million. Therefore, in the January 22, 1999 notice (64 FR 3474), we stated that we intended to incorporate these savings in the base amount upon which the fee schedule is calculated consistent with the statutory requirement that in the aggregate we pay no more than would have been paid in the absence of the fee schedule.

II. Provisions of the Proposed Rule

A. Proposed Changes Based on Negotiated Rulemaking

In accordance with the negotiated rulemaking procedures described above, we propose the following additions to Part 414 based on the recommendations of the Committee.

1. Definitions and levels of services. In Part 414, we propose to add Subpart H, § 414.605 that would define several levels of ground ambulance services ranging from BLS to specialty care transport. (Note that the term ''ground'' refers to both land and water transportation. The definitions and RVUs for each of the levels of service are described in § 414.605, ''Definitions.'') Also, the rate per ground mile for all ground ambulance services would be the same for each level of service.

During 1990, the development of a training blueprint and the evaluation of current levels of prehospital provider training and certification were identified as priority needs for national emergency medical services (EMS). As a result, the National EMS Training Blueprint Project was formed.

In May 1993, representatives of EMS organizations adopted the National EMS Education and Practice Blueprint (Blueprint) consensus document. This consensus document is used as the basis for defining the levels of service. As stated in the National EMS Education and Practice Blueprint, Executive Summary, printed September 1993, ''The Blueprint divides the major areas of prehospital instruction and/or core performance into 16 'core elements'.'' For each core element, the Blueprint recommends that there be four levels of prehospital EMS providers ''corresponding to various knowledge and skills in each of the core elements.'' At the First Responder level, personnel use a limited amount of equipment to perform initial assessments and interventions. The EMT—Basic has the knowledge and skill of the First Responder, but is also qualified to function as the minimum staff for an ambulance. EMT—Intermediate personnel has the knowledge and skills identified at the First Responder and EMT—Basic levels, but is also qualified to perform essential advanced techniques and to administer a limited number of medications. The EMT—Paramedic, in addition to having the competencies of an EMT—Intermediate, has enhanced skills and can administer additional interventions and medications.

Since the release of the Blueprint, a consensus panel of EMS educators has recommended that the Department of Transportation, National Highway Traffic and Safety Administration (DOT/NHTSA) revise the document. DOT/NHTSA has accepted the recommendation of the panel and expects to release a revised Blueprint or an equivalent document in the near future.

To request a copy of the National Emergency Medical Services Education and Practice Blueprint, please fax your request to: NHTSA/EMS Division, (202) 366–7721. Please include your name and address. Because of staffing and resource limitations NHTSA will forward the requested document via regular mail.

There would be two levels of air ambulance services to distinguish fixed wing from rotary wing (helicopter) aircraft. In addition, to recognize the operational cost differences of the two types of aircraft, there would be two distinct payment amounts for air ambulance mileage. The air ambulance services mileage rate would be calculated per actual loaded (patient onboard) miles flown, expressed in statute miles (that is, ground, not nautical, miles.)

We are proposing the following seven levels of ambulance services.

a. Basic Life Support (BLS)—When medically necessary, the provision of basic life support (BLS) services as defined in the National Emergency Medicine Services (EMS) Education and Practice Blueprint for the Emergency Medical Technician-Basic (EMT-Basic) including the establishment of a peripheral intravenous (IV) line.

b. Advanced Life Support, Level 1 (ALS1)—When medically necessary, this is the provision of an assessment by an advanced life support (ALS) ambulance provider or supplier and the

furnishing of one or more ALS interventions. An ALS assessment is performed by an ALS crew and results in the determination that the patient's condition requires an ALS level of care, even if no other ALS intervention is performed. An ALS provider or 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.

c. Advanced Life Support, Level 2 (ALS2)—When medically necessary, the administration of at least three different medications 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.

d. Specialty Care Transport (SCT)—When medically necessary, for a critically injured or ill beneficiary, a level of interhospital service furnished 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 furnished by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

e. Paramedic ALS Intercept (PI)—These services are defined in § 410.40(c) ''Paramedic ALS Intercept Services''. These are ALS services furnished by an entity that does not provide the ambulance transport. Under limited circumstances, Medicare payment may be made for these services. (To obtain additional information about paramedic ALS intercept services, please refer to the March 15, 2000 final rule (65 FR 13911)).

f. Fixed Wing Air Ambulance (FW)—Fixed wing air ambulance services are covered when the point from which the beneficiary is transported to the nearest hospital with appropriate facilities is inaccessible by land vehicle, or great distances or other obstacles (for example, heavy traffic) and the beneficiary's medical condition is not appropriate for transport by either BLS or ALS ground ambulance.

g. Rotary Wing Air Ambulance (RW)—Rotary wing (helicopter) air ambulance services are covered when the point from which the beneficiary is transported to the nearest hospital with appropriate facilities is inaccessible by ground vehicle, or great distances or other obstacles (for example, heavy traffic) and the beneficiary's medical condition is not appropriate for transport by either BLS or ALS ground ambulance.

2. Emergency Response Adjustment Factor

We are proposing to add § 414.610, ''Basis of Payment,'' paragraph (c)(1), to state that for the BLS and ALS1 levels of service, an ambulance service that qualifies as an emergency response service would be assigned higher RVUs to recognize the additional costs incurred in responding immediately to an emergency medical condition. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call. No emergency response adjustment factor applies to PI, ALS2, SCT, FW, or RW.

3. Operational Variations

We are proposing to add § 414.610(a) which would state that the ambulance fee schedule applies to all entities that furnish ambulance services, regardless of type. For example, all public or private, for profit or not-for-profit, volunteer, government-affiliated, institutionally-affiliated or owned, or wholly independent supplier ambulance companies, however organized, would be paid according to this ambulance fee schedule.

4. Regional Variations

a. Cost of living differences:

The payment for ambulance services would be adjusted to reflect the varying costs of conducting business in different regions of the country. We would adjust the payment by the geographic adjustment factor (GAF), equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) for the Medicare physician fee schedule. (For purposes of this document, we use the abbreviation ''GPCI'' to mean the PE portion of the GPCI.) The GPCI is an index that reflects the relative costs of certain components of a physician's costs of doing business (for example, employee salaries, rent, and miscellaneous expenses) in one area of the country versus another. The geographic areas would be the same as those used for the physician fee schedule. (A detailed discussion of the physician fee schedule areas can be found in the July 2, 1996 proposed rule (61 FR 34615) and the November 22, 1996 final rule (61 FR 59494).)

The GPCI would be applied to 70 percent of the base payment rate for ground ambulance services; this percentage approximates the portion of ground ambulance service costs that are represented by salaries. Similarly, the GPCI would be applied to 50 percent of the base payment rate for air ambulance services. The GPCI would not be applied to the mileage payment rate. In addition, the applicable GPCI would be based on the geographic location at which the beneficiary is placed on board the ambulance.

We would use the most recent GPCI; the physician fee schedule law requires that the GPCI be updated every 3 years. The next revision will be effective January 1, 2001. We anticipate using the updated data, which was proposed in the July 17, 2000 proposed rule on the physician fee schedule (65 FR 44176).

b. Services furnished in rural areas:

We are proposing to add § 414.610(c)(1)(v) which would state that an adjustment would be made to increase the base payment rate for ambulance services furnished in rural areas. This adjustment would be made because of the additional cost per ambulance trip of isolated, essential ambulance suppliers (that is, when there is only one ambulance service in a given geographic area) for which there are not many trips furnished over the course of a typical month because of a small rural population. While we recognize the inadequacy of the methodology to completely compensate for these costs (that is, not every rural ambulance supplier is isolated, essential, low-volume, and the definition of rural we are proposing is not as precise as other alternatives), we propose an additional adjustment to increase the mileage rate if the location at which the beneficiary is placed on board the ambulance is located in a rural area. The definition of a rural area would be an area outside a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area, or an area within an MSA identified as rural, using the Goldsmith modification.

The Goldsmith modification evolved from an outreach grant program sponsored by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. This program was created to establish an operational definition of rural populations lacking easy geographic access to health services in large counties with metropolitan cities. Using 1980 census data, Dr. Harold F. Goldsmith and his associates created a methodology for identifying rural census tracts located within a large

metropolitan county of at least 1,225 square miles. However, these census tracts are so isolated by distance or physical features that they are more rural than urban in character. Additional information regarding the Goldsmith modification can be found on the Internet at http://www.nal.usda.gov/orhp/Goldsmith.htm.

We could not easily adopt and implement, within the timeframe necessary to implement the fee schedule by January 1, 2001, a methodology for recognizing geographic population density disparities other than MSA/non-MSA. However, we will consider alternative methodologies that may more appropriately address payment to isolated, low-volume rural ambulance suppliers. Thus, the rural adjustment in this rule is a temporary proxy to recognize the higher costs of certain low-volume rural supplies.

In the process of evaluating the operation of the regulations developed through the negotiated rulemaking process, there are several difficult issues that will need to be resolved. Examples of such issues include: (1) Appropriately identifying an ambulance supplier as rural; (2) identifying the supplier's total ambulance volume (since Medicare only has a record of its Medicare services); and (3) identifying whether the supplier is isolated, given that some suppliers might not furnish services for Medicare (that is, Medicare would have no record of their existence) and one of these suppliers may be located near an otherwise ''isolated'' supplier. Addressing these issues in some cases will require the collection of data that is currently unavailable. We intend to work with the industry to identify and collect all pertinent data as soon as possible, and we encourage comments regarding the type and source of data that could be used for this purpose.

The application of the rural adjustment would be determined by the geographic location at which the beneficiary is placed on board the ambulance. The rural adjustment would be made using the following methodology:

- Ground—A 50 percent add-on applied to only the mileage payment rate for the first 17 loaded miles.
- Air—A 50 percent add-on applied to the base rate and to all of the loaded mileage.

5. Mileage

We are proposing to add § 414.610(c)(1) that would state that mileage would be paid separately from the base rate. The payment for mileage reflects the costs attributable to the use of the ambulance vehicle (for example, maintenance and depreciation), which increase as the vehicle's mileage increases. Based on the Committee's agreement, the mileage rate for 2001 is as follows: $5 for ground ambulance, $6 for fixed wing ambulance, and $16 for rotary wing ambulance. Payment for some mileage in rural areas is made at a higher rate and is discussed in detail later in this proposed rule.

6. Structure of the Fee Schedule for Ambulance Services

We are proposing in § 414.610(a) that the fee schedule payment for ambulance services would equal a base rate payment plus payments for mileage and applicable adjustment factors. (See Table 1 for a description of the structure of the ambulance fee schedule.)

7. Ambulance Inflation Factor

We are proposing to add § 414.615, ''Transition methodology for implementing the ambulance fee schedule,'' which would state that the ambulance fee schedule would include the ambulance inflation factor specified in section 1834(l)(3) of the Act and discussed below.

8. Phase-in Methodology

We are proposing to add § 414.615 that would provide for a 4-year transition period. (The phase-in schedule is described in section IV.)

B. Proposed Changes Not Based on Negotiated Rulemaking

We are proposing changes to certain policies that were not within the scope of the negotiated rulemaking process. These proposed changes are as follows:

1. Coverage of Ambulance Services

In § 410.40(b), we are proposing to revise the introductory language to provide a cross reference to § 414.605 for a description of the specific levels of services. We are proposing to revise paragraph § 410.40(d)(1) to state that transportation includes fixed wing and rotary wing ambulances. Also, we are proposing to revise § 410.40(d)(3) by adding two options to document medical necessity.

2. Physician Certification Requirements

On January 25, 1999, we published a final rule (64 FR 3637) that updated Medicare coverage policy concerning ambulance services. That final rule provided the documentation requirements for coverage of nonemergency ambulance services for Medicare beneficiaries. The rule requires ambulance suppliers to obtain, from the beneficiary's attending physician, a written order certifying the medical necessity of nonemergency scheduled and unscheduled ambulance transports. The final rule became effective February 24, 1999.

Our present regulations (at §§ 410.40(d)(2) and 410.40(d)(3)) set forth the requirements for scheduled and unscheduled nonemergency ambulance transports. The regulations require ambulance suppliers to obtain, from the beneficiary's attending physician, a written physician statement certifying the medical necessity of requested ambulance transports.

Section 410.40(d)(3)(i) specifies that, in cases when a beneficiary living in a facility and under the direct care of a physician requires nonemergency, unscheduled transport, the physician's certification can be obtained up to 48 hours after transport. After publication of this rule, we were made aware of instances in which ambulance suppliers, despite having provided ambulance transports, were experiencing difficulty in obtaining the necessary physician certification statements within the required 48-hour timeframe.

While we still believe that the 48-hour timeframe is the appropriate standard, we recognize that there may be instances when, not through fault of their own, it may not be possible for the ambulance suppliers to meet the requirement. Therefore, we have determined that there is a need to revise and clarify this requirement (as described in § 410.40, ''Coverage of ambulance services,'' paragraph (d)(3)).

Before submitting a claim, the ambulance supplier must obtain: (1) A signed physician certification statement from the attending physician; (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 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.

Acceptable documentation must include a signed return receipt from the U.S. Postal Service or similar delivery service. A signed return receipt will serve as proof that the ambulance supplier attempted to obtain the required physician certification statement from the beneficiary's attending physician.

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier or intermediary. It is important to note that neither the presence nor absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary. The ambulance supplier must meet all coverage criteria in order for payment to be made.

3. Payment During the First Year

As explained below in more detail, we would use the universe of claims paid in 1998 (reduced by the $65 million savings that would have been realized through implementation of the BLS and ALS definitions proposed in the June 17, 1997 proposed rule (62 FR 32718)) to establish the CF and would index the 1998 dollars to 2001 dollars using the compounded inflation factors provided by section 1834(l)(3) of the Act. (The transition and the inflation factors are described in proposed § 414.615.)

4. Billing Method

In § 414.610, we would state that after the transition period, we would bundle into the base rate payment all items and services furnished within the ambulance service benefit. This would eliminate billing on an itemized basis for any items and services related to the ambulance service (for example, oxygen, drugs, extra attendants, and EKG testing). In addition, only the base rate code and the mileage code would be used to bill Medicare. (This decision was made, in accordance with section 1834(l)(7) of the Act, which gives us the authority to specify a uniform coding system.) During the transition period, suppliers who currently use billing methods 3 or 4 may continue to bill for supplies separately.

5. Local or State Ordinances

In § 414.610, we would state that, regardless of any local or State ordinances that contain provisions on ambulance staffing or furnishing of all ambulance services by ALS suppliers, we would pay the appropriate ambulance fee schedule rate for the services that are actually required by the condition of the beneficiary. This policy derives from the Medicare statutory requirement (see section 1834 (1)(2)(C) of the Act) to link payments to the types of services furnished.

6. Mandatory Assignment

In § 414.610, we would state that effective January 1, 2001, all payments for ambulance services must be made on an assignment-related basis. Ambulance suppliers must accept the Medicare allowed charge as payment in full and not bill the beneficiary any amount other than unmet Part B deductible or coinsurance amounts. There is no transitional period for mandatory assignment.

7. Miscellaneous Payment Policies

Although not included in the proposed regulations, we are clarifying the following payment policies.

a. Multiple patients—Occasionally, an ambulance will transport more than one patient at a time. (For example, this may happen at the scene of a traffic accident.) In this case, we propose to prorate the payment as determined by the ambulance fee schedule among all of the patients in the ambulance. For example, if two patients were transported at one time, and one was a Medicare beneficiary and the other was not, we would make payment based on one-half of the ambulance fee schedule amount for the level of medically appropriate service furnished to the Medicare patient. The Medicare Part B coinsurance, deductible, and assignment rules would apply to this prorated payment.

Similarly, if both patients were Medicare beneficiaries, payment for each beneficiary would be made 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.

b. Pronouncement of death—There are three rules that apply to ambulance services and the pronouncement of death. First, if the beneficiary was pronounced dead by an individual who is licensed to pronounce death in that State prior to the time that the ambulance is called, no payment would be made. Second, if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment for an ambulance trip would be made at the BLS rate, but no mileage would be paid. Third, if the beneficiary is pronounced dead after being loaded into the ambulance, payment would be made following the usual rules (that is, the same level of payment would be made as if the beneficiary had not died).

c. Multiple Arrivals—When multiple units respond to a call for services, we would pay the entity that provides the transportation for the beneficiary. The transporting entity would bill for all services furnished, as stated in current policy. For example, if BLS and ALS entities respond to a call and the BLS entity furnishes the transportation after an ALS assessment is furnished, the BLS entity would bill using the ALS1 rate. We would pay the BLS entity at the ALS1 rate. The BLS entity and the ALS entity would have to negotiate payment for the ALS assessment.

d. BLS Services in an ALS Vehicle—Effective January 1, 2001, claims will be paid at the BLS level where an ALS vehicle was used but no ALS level of service was furnished. Claims must be filed using the appropriate BLS code. There is no transitional period for claims paid at the BLS level for non-ALS services rendered in an ALS vehicle.

III. Methodology for Determining the Conversion Factor

Our approach to determining the CF would be to: (1) Use the most recent complete year of ambulance claims; (2) translate those claims into the format that would have been used under the fee schedule; and (3) calculate the CF to be applied to the RVUs of the different levels of service that would result in the same total program payment for those claims less $65 million. We would then inflate this CF in accordance with the inflation factor prescribed in the statute. (See section 1834(1)(3) of the Act.) We used 1998 as the base year because this was the most recent complete year for which claims data were available. For claims processed by carriers (that is, claims from independent ambulance suppliers), we used allowed charges. For claims processed by fiscal intermediaries (FIs) from provider-based ambulance services, we used the submitted charges on the Medicare claims multiplied by the cost-to-charge ratio applicable to the ambulance costs for that provider.

We decided that choosing the most common number of miles on existing claims would be the best estimate as to those claims that did not report mileage. The research indicated that the mode for urban claims was 1, and the mode for rural claims was also 1.

We modified the claims data in several ways to calculate the proposed fee schedule and its impact. First, we separated all claims into two groups:

- Carrier processed claims for ambulance services (8 million in 1998).

• FI processed claims for ambulance services (900,000 in 1998).

A. Carrier Processed Claims

Not all of the 1998 claims were directly usable for purposes of the proposed ambulance fee schedule. Some of the claims did not show mileage and, because mileage would be required for each ambulance service under the fee schedule, an adjustment had to be made for the missing miles. In other cases, the billing codes under the old system did not translate directly into services that would be paid under the proposed fee schedule. Below is a more detailed explanation of the adjustments that were made to the 1998 base year data in order to accommodate missing data.

1. Mileage

Approximately 1.1 million claims for ground ambulance services did not show any mileage. The proposed fee schedule for ambulance services would provide a payment for the trip and a payment per statute mile for the loaded mileage traveled. Therefore, in calculating the proposed CF, we added mileage to those claims that did not report mileage. We did so by assigning the mode value (that is, the number of miles billed most often) per trip in urban areas (1.0 miles) and the mode value or mileage per trip in rural areas (1.0 miles).

Current billing instructions provide that only one ambulance trip may be billed per line on a claim. Therefore, we did not count multiple trips billed on the same line of a claim. This reduced the total trip count processed by carriers by approximately 1 percent. Billing rules prohibit more than one trip to be reported on a line; therefore, we assumed any number greater than one was an error. Because the allowed charges on these claims represented the amounts paid, there was a corresponding increase by the same percentage of the average charge per trip.

2. Billing Codes

We determined that the billing codes that represent items and services included under the ambulance fee schedule are all billing codes submitted by ambulance suppliers in the range of HCFA Common Procedure Coding System (HCPCS) A0030 through A0999 (excluding HCPCS code A0888, which is not covered by Medicare) and Common Procedural Terminology–4 (CPT–4) [1] codes 93005 and 93041. HCPCS billing codes A0030 through A0999 represent ambulance services, supplies, and equipment that are covered by the ambulance fee schedule, and CPT codes 93005 and 93041 represent electrocardiogram (EKG) services that may be billed by ambulance suppliers. In addition, we included all HCPCS billing codes in the range of A4000 through Z9999; these services may only be paid by a carrier to an ambulance supplier if they represent items and services covered under the Medicare ambulance benefit. We excluded all other CPT billing codes in the range of 00001 through 99999 (except the two EKG codes listed above) because they represent services not covered by the ambulance fee schedule.

Next, we adjusted all billing codes that represented an ALS vehicle when no ALS service was furnished. We removed the actual allowed charges on these claims and replaced them with the charges that would have been allowed by the carrier for the corresponding BLS level of service (that is, emergency for emergency and nonemergency for nonemergency). As described in this preamble, this adjustment reduced the Medicare portion of the total allowed charges for ambulance services by $65 million.

3. Crosswalking the Old Billing Codes to the New Billing Codes

We converted the old billing codes in the base year data to the new billing codes as they would be under the proposed fee schedule. The old BLS codes convert directly to the proposed BLS codes. The old air ambulance codes (fixed wing and helicopter) convert to the proposed air ambulance codes. The old water ambulance code converts to the proposed BLS–Emergency code. The old mileage codes distinguished ALS miles from BLS miles; both of these old codes would convert to the single proposed mileage code. Codes used to report air mileage would convert to the proposed codes for fixed and rotary wing mileage respectively. All air miles would be reported in statute miles. As mentioned earlier, we converted the codes for an ALS vehicle when no ALS services were furnished to the corresponding BLS codes. The conversion of the remaining old ALS codes (for example, when ALS services were furnished) to proposed ALS codes is less straightforward because there are more levels of ALS service under the proposed fee schedule than currently exist. All nonemergency ALS codes convert to the proposed ALS1 (nonemergency) code. Based on advice from various negotiating committee members, we propose converting the old emergency ALS codes according to the following formulas:

• For claims on which both the origin and destination was a hospital: 33 percent would convert to specialty care transport (SCT), 5 percent to advanced life support, level two (ALS2), and the remainder to ALS1—Emergency.

• For all other claims: 8.3 percent would convert to ALS2, and the remainder to ALS1—Emergency.

B. FI Processed Claims

Since all FI claims contained mileage, we did not make any adjustment for mileage. We determined the codes that represented items and services included under the ambulance fee schedule. In the case of hospital-based claims, the same claim is used to report services furnished in the emergency room and other outpatient departments of the hospital as is used to report the ambulance service. Therefore, it is impossible to know exactly where any of the nonambulance services were furnished. Because most of these nonambulance services were of the kind that would likely have been furnished in the hospital's emergency room, we did not include them in data for the proposed ambulance fee schedule. Therefore, we determined the billing codes that would be covered by the ambulance fee schedule were all billing codes representing ambulance services (for example, in the range of HCPCS codes A0030 through A0999 (excluding HCPCS code A0888, which is not covered by Medicare)) submitted by hospitals.

Codes that represented the use of an ALS vehicle, but when no ALS level of service was furnished, were converted to the corresponding BLS BILLING CODE. However, in this case, no adjustment was made for payment because payment for these claims would have been corrected to the proper amount at cost settlement.

C. Air Ambulance

To establish a consistent system of RVUs that could be applied to ground and air ambulance services, we would have been required to know the cost per service in each setting. Unfortunately, these data do not exist. The air ambulance representative to the Committee presented data and stated that the data, when combined with an analysis by an economist, demonstrated that the total costs in 1998 for air ambulance services were between a minimum of $134.8 million and a maximum of $168 million. This amount exceeded the billed charges for air ambulance services. The representative also stated that RVUs should be based

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on cost and that there were no verifiable cost data on the ground ambulance services side against which to compare the cost of air ambulance services. In addition, other Committee members were unsure of the accuracy of the air ambulance services cost data, stating that the air ambulance services costs were not based on an audited statistical sample and that the data had not been subject to independent scrutiny. Based on recommendations from the Committee, we would set the amount of the base year expenditures to be used in determining the payment levels for air ambulance services between $134.8 million and $158 million.

We considered several approaches in an attempt to accurately estimate the appropriate amount for air ambulance services within the range prescribed by the Committee.

We considered using cost data from a ground ambulance services survey acquired by an independent source that was hired by a member of the Committee. We tried to compare the results of this survey to cost data from our estimate. Because the study was only a self-reporting survey and did not report audited costs and because the results varied widely and were substantially different from our estimate, we could not establish a consistent relationship between the survey that resulted in any estimates within the range prescribed by the Committee.

We converted old billing codes to the proposed billing codes in the same way as discussed above for the carrier-rocessed claims. Using the billed charge adjusted by the supplier's cost-to-charge ratio, we are able to estimate the supplier's Medicare–allowable cost for all ambulance services. However, we are unable to estimate with any certainty the split of air ambulance services costs and ground ambulance services costs from the same supplier. This is because the Medicare cost–apportioning rules do not furnish data in this detail. Originally, we assumed that the same cost-to-charge ratio applies to both air and ground ambulance services charges. However, because this assumption may not be correct and because it results in an amount below the range specified by the Committee, we did not pursue this methodology.

Next, we considered using the billed charges for ambulance services. Over 80 percent of ground ambulance services are furnished by independent (not provider-based) ambulance services suppliers. However, the average adjusted charge (that is, the charge adjusted by the provider's cost-to-charge ratio) for ALS and basic life support (BLS) ground ambulance services, excluding mileage, furnished by provider-based ambulance services is more than 60 percent greater than the average charge for independent ambulance services suppliers ($342 vs. $206 per trip). Assuming the appropriate payment for ground ambulance services is the average allowed charge for the independent suppliers, the amount of money misallocated to provider-based ground ambulance services substantially exceeds the amount that would result in a total payment for air ambulance services at the maximum authorized by the Committee ($158 million). Considering this large discrepancy between the payment rates for provider-based and independent supplier ground ambulance services and the fact that suppliers are able to furnish services at the lower rate, we believe that the appropriate payment for ground ambulance services is closer to the independent supplier charge. Consequently, we have chosen the maximum air ambulance total amount designated by the Committee, that is, $158 million.

D. Calculation of the CF

Following this process, we determined the total number of ambulance trips and loaded miles and the total amount of charges allowed by Medicare for ambulance services in the base year of 1998 (less the adjustment for those cases where an ALS vehicle was used, but no ALS services were furnished, described above). To calculate the CF for ground ambulance services, we followed these steps—

- Multiplied the volume of services for each level of ground ambulance service by the respective RVUs recommended by the Committee (including application of the practice expense of the GPCI and rural payment rate as described above);
- Summed those products to arrive at the total number of RVUs;
- Subtracted the total allowed amount for air ambulance services ($158 million as discussed above) from the total charges allowed by Medicare for ambulance services, which results in the total amount of charges allowed by Medicare for ground ambulance services;
- Subtracted the total amount of RVUs for ground mileage from this total charge amount;
- Divided the remaining charge amount by the total number of RVUs for ground services and applied the ambulance inflation factor for 2001, which results in a CF for ground ambulance trips of $157.52.

We would follow a similar procedure to determine the fee schedule amount for air ambulance services. Because there are only two kinds of air ambulance—fixed wing and rotary—we would not calculate RVUs and a CF, but would calculate the actual fee schedule amounts directly. Namely, we divided the total number of billed air ambulance services into the total amount of payment available for these services ($158 million). The amounts in the base year (1998) are $2,115.00 and $2,459.00 for fixed wing and rotary trips, respectively. Then these numbers would also be inflated by the inflation factor provided in section 1834(l) of the Act. (Additional information regarding the inflation factor is discussed below.)

We would monitor payment data and evaluate whether projections used to establish the original CF (for example, the ratio of the volume of BLS services to ALS services) is accurate. If the actual proportions among the different levels of service are different from the projected amounts, we would adjust the conversion factor accordingly and apply this adjusted conversion factor prospectively.

IV. Implementation Methodology

Currently, payment of ambulance services follows one of two methodologies, depending on the type of ambulance biller. Claims from ambulance service suppliers are paid based on a reasonable charge methodology, whereas claims from 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 submitted charge) and then cost-settled at the end of the provider's fiscal year.

The proposed ambulance fee schedule would be phased in over a 4-year period. The transition would begin on January 1, 2001 and the fee schedule would be phased in on a CY basis. Therefore, for dates of service (DOS) beginning January 1, 2001, suppliers/providers would be paid based on 80 percent of the respective current payment allowance (as described in Program Memorandum AB–99–73) applicable to 2001 plus 20 percent of the ambulance fee schedule amount. (See § 414.615 for additional information.)

Based on the Committee's consensus recommendation, we would implement the ambulance fee schedule as follows:

	Former payment percentage	Fee schedule percentage
Year One (CY 2001)	80	20
Year Two (CY 2002)	50	50
Year Three (CY 2003)	20	80
Year Four (CY 2004)	0	100

A. Revisions and Additions to HCPCS Codes

Claims would be processed using the proposed billing codes created for the ambulance fee schedule. From these proposed codes, the amount for the portion of the payment based on the current system (80 percent in 2001) would be derived using the HCPCS crosswalks as shown below.

We would change current ambulance HCPCS codes in order to implement the ambulance fee schedule. The proposed HCPCS codes would have to be effective January 1, 2001. The existing HCPCS codes are not billable effective January 1, 2001, except for those HCPCS codes related to items and services for which a Method 3 or Method 4 biller may bill for supplies separately during the transition period.

National HCPCS codes and descriptions of services created for ambulance services were presented to the HCFA Alpha-Numeric group. The following chart shows how the existing codes would crosswalk to the proposed new codes under the ambulance fee schedule. We would establish the codes before implementation of the ambulance fee schedule on January 1, 2001. Additionally, the chart shows current HCPCS codes that would not have a corresponding code under the proposed ambulance fee schedule. The items and services represented by these codes would be bundled into the base rate services.

Codes Not Valid Under the New Fee Schedule (Codes Terminate Effective 01/01/04):

A0382, A0384, A0392, A0396, A0398, A0420, A0422, A0424, A0999

HCPCS CODE CHANGES

Current HCPCS Code(s)	New HCPCS Code	Descriptions of proposed new codes
A0380, A0390	A0425	Ground mileage (per statute mile).
A0306, A0326, A0346, A0366.	A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1).
A0310, A0330, A0350, A0370.	A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency).
A0300, A0304, A0320, A0324, A0340, A0344, A0360, A0364.	A0428	Ambulance service, basic life support, non-emergency transport (BLS).
A0050, A0302, A0308, A0322, A0328, A0342, A0348, A0362, A0368.	A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency).
A0030	A0430	Ambulance service, conventional air services, transport, one way (fixed wing).
A0040	A0431	Ambulance service, conventional air services, transport, one way (rotary nwing).
Q0186	A0432	Paramedic ALS intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.
	A0433	Advanced life support, Level 2 (ALS2). 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.
	A0435	Air mileage; fixed wing (per statute mile).
	A0436	Air mileage; rotary wing (per statute mile).
	A0434	Specialty Care Transport (SCT). In a critically injured or ill patient, a level of interfacility service provided beyond the scope of the Paramedic. This service is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

New suppliers that have not billed Medicare in the past would be subject to the transition period rules. They would be assigned an allowed charge under the current reasonable charge rules (50th percentile charges) and would follow the same blended transition payments as other ambulance suppliers. In all cases, the resulting transitional payment would be subject to the Part B coinsurance and deductible requirements.

Currently, provider claims are paid based on the provider's interim rate (the provider's submitted charge multiplied by the provider's past year's cost to charge ratio) which is cost settled at the end of the provider's fiscal year and limited by the statutory inflation factor applied to the provider's cost per ambulance trip. The fee schedule transition would begin on January 1, 2001 and would phase in the fee schedule on a CY basis. Therefore, for providers that file cost reports on other than a CY basis, for cost reporting periods beginning after January 1, 2001, two different blended rates would apply. Effective for services furnished during CY 2001, the proposed blended amount for provider claims would equal the sum of 80 percent of the current payment system amount and 20 percent of the ambulance fee schedule amount. The intent of our implementing payment under the fee schedule at only 20 percent in the first year is to give ambulance providers a period of time to adjust to the new payment amounts, because some providers may receive substantially lower payments that at present. For DOS in CY 2002, the blended amount would equal the sum of 50 percent of the current payment system amount and 50 percent of the ambulance fee schedule amount. For DOS in CY 2003, the blended amount would equal the sum of 20 percent of the current payment system amount and 80 percent of the ambulance fee schedule amount. For DOS in CY 2004 and beyond, the payment amount would equal the ambulance fee schedule amount. The program's payment in all cases would be subject to the Part B coinsurance and deductible requirements.

To assure that the providers receive the correct payment amount during the transition period, all submitted charges attributable to ambulance services furnished during a cost-reporting period would be aggregated and treated separately from the submitted charges attributable to all other services furnished in the hospital. Also, the necessary statistics would be maintained for the provider's Provider Statistics and Reimbursement report; this would ensure that the ambulance fee schedule portion of the blended transition payment would not be cost settled at cost settlement time.

New providers would not have a cost per trip from the prior year. Therefore, there would be no cost per trip inflation limit applied to new providers in their first year of furnishing ambulance services.

New suppliers would use the customary charge established for new suppliers in accordance with standard program procedures from the year 2000, adjusted for each year of the transition period by the ambulance inflation factor that we published.

Section 1834(1) of the Act also requires that all payments made for ambulance services under the proposed fee schedule be made on an assignment-related basis. As stated in section 1842(b)(18) of the Act, referenced in section 1834(l)(6), ambulance suppliers would have to accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than the unmet Part B deductible and Part B coinsurance amounts. Violations of this requirement may subject the supplier to sanctions. The law provides that mandatory assignment provisions apply as soon as payment is made under the fee schedule; therefore, there would be no transitional period for mandatory assignment of claims. Also, the rule that claims would be paid at the BLS level if an ALS vehicle was used but no ALS level of service was furnished would be effective on January 1, 2001 and would not be subject to transition. These claims would have to be filed using the appropriate BLS code.

V. Mechanisms To Control Expenditures for Ambulance Services

A. Number of Services

We do not anticipate that the number of ambulance services furnished will increase to offset the effects of lower payments per service. Therefore, the Committee has not suggested mechanisms to control expenditures. However, we will monitor payment data and evaluate whether projections used to set the original CF (for example, the ratio of the volume of BLS services to ALS services) are accurate. If the actual proportions of the various levels of service are different (too high or too low) from the projected ones, we will adjust the CF accordingly.

B. Low Billers

A concern was raised about low billers of ambulance services. Low billers are suppliers who currently bill less than the maximum charge allowed by Medicare. There are several reasons low billers exist. For example, low billers may be municipal or volunteer suppliers of services, regulated by local ordinances, limited by an inflation-indexed charge that is part of the Medicare program's current reasonable charge policy, or restricted for other reasons.

Because the total ambulance service payment amount is based on the actual allowed charges from the base year (1998), the CF will reflect the lower than maximum charges. At the same time, if low billers of ambulance services continue to charge less than the ambulance fee schedule amount, we will pay less than if all suppliers charged the ambulance fee schedule amount. Therefore, some members of the ambulance industry have urged us to increase the fee schedule CF anticipating that otherwise savings would result from billers who continue to charge less than the fee schedule amount. We have estimated that in the base year 1998 the difference between actual charges and the maximum charges allowed by Medicare is approximately $150 million. Approximately half of this amount is attributable to charges that are 70 percent of the maximum allowed charges or greater. Assuming that a low biller is someone whose charge is less than 70 percent of the maximum allowed charge, approximately $75 million can be attributed to low billing.

We have neither a means to estimate the extent to which low billing will continue after the fee schedule is implemented and the inflation-indexed charge limit no longer applies, nor a means to estimate the extent to which volunteer and municipal ambulances will choose not to file Medicare claims at the fee schedule amounts to which they could be entitled. The Congress has provided that ''the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule * * *'' (section 1833(a)(1)(R) of the Act). Moreover, the Congress did not require that payment under the ambulance fee schedule be budget neutral to the current reasonable charge system, but rather specified only that the aggregate amount of payments for ambulance services not exceed the amount that would have been paid absent the fee schedule.

Given the law and the uncertainty of suppliers' future behavior, we propose not to attempt to adjust the CF on the assumption that low billing will or will not continue. However, as mentioned above, we will monitor payment and billing data and recalculate the CF as appropriate.

VI. Adjustments to Account for Inflation and Other Factors

In setting the CF for 2001, we would adjust the base year data from 1998 for inflation. Section 4531 of the Balanced Budget Act of 1997 prescribes the inflation factor to be used in determining the payment allowances for ambulance services paid under Medicare under the current payment system. The inflation factor is equal to the projected consumer price index for all urban consumers (U.S. city average) (CPI–U) minus 1 percentage point from March-to-March for claims paid under cost reimbursement (providers) and from June-to-June for claims paid under reasonable charges (carrier processed claims). The base year for our data is 1998. The inflation factors in percent are:

	March-to-March (provider claims)	June-to-June (carrier claims)
1999/1998	0.9	1.1
2000/1999	2.4	2.0
2001/2000	1.3	1.4
Compounded inflation factor (in percent)	4.665	4.566

We would use the most recently available estimate of inflation from 2000 to 2001 at the time of the writing of the final rule.

In addition, the Committee acknowledged that the statutory provisions in section 1834(l)(3)(B) of the Act, regarding annual updates to the fee schedule, would be used to make adjustments to account for inflation. That section of the Act provides for an annual update to the ambulance fee schedule based on the percentage increase in the CPI-U for the 12-month period ending with June of the previous year. For 2001 and 2002, the increase in the CPI-U is reduced by 1.0 percentage point for each year.

We would monitor payment data and evaluate whether projections used to establish the original CF (for example,

the ratio of the volume of BLS services to ALS services) is accurate. If the actual proportions among the different levels of service are different from the projected amounts, we would adjust the CF accordingly.

VII. Medical Conditions Lists

When the Congress mandated that the ambulance fee schedule be developed through the negotiated rulemaking process, we deferred final action on our proposal to base Medicare payment on the level of ambulance service required to treat the beneficiary's condition. That proposal would have used International Classification of Diseases, 9th revision, Clinical Modification (ICD–9–CM) diagnostic codes that would have described the nature of the beneficiary's medical condition. Use of the ICD–9–CM codes would also have assisted ambulance suppliers to bill the medically necessary level of ambulance service.

While we are not establishing a formal proposal in this proposed rule, as a first step, we reopened the discussion of developing a medical condition listing during the negotiated rulemaking process. The goal of the discussion was to develop a list of medical conditions, not diagnoses, that generally require ambulance services and the appropriate level of care. The identified condition(s) would describe the beneficiary's medical condition that would necessitate the ambulance services.

The medical conditions listed in Addendum A of this proposed rule would enable the ambulance supplier to identify the level of service at which a claim may be paid. The list identifies nonemergency conditions; emergency medical conditions—traumatic and nontraumatic; and emergency and nonemergency conditions that warrant interfacility transport services. This listing would also aid Medicare contractors in their efforts to assure that claims for ambulance services are paid appropriately and that providers and suppliers of ambulance services are educated as to the documentation that would best support a claim. Use of an identified condition, however, would not make the claim payable if the beneficiary could have been served by other means. We recognize that unusual circumstances exist that warrant the use of ambulance services. In these circumstances, the publication of the list would not preclude the contractor from accepting other relevant medical information (for example, ICD–10–CM codes or other relevant on-the-scene information) to describe a medical condition that is not included on the list. Therefore, the medical condition list is not all-inclusive.

Since the negotiated rulemaking committee concluded its work, we have received positive feedback on the medical conditions list in Addendum A. While we maintain the final decision-making authority regarding required use of the above referenced medical condition list or a similar type of list, we are soliciting information from interested parties on the need for such a listing and the development of codes used in association with such a list that would best support the processing of claims.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 410.40 Coverage of Ambulance Services.

(d)(3)(iii) If the ambulance supplier is unable to obtain the signed physician certification statement from the beneficiary's attending physician, a signed physician certification statement must be obtained from either the physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), 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 ambulance transport is ordered or the ambulance service was furnished.

The burden associated with this requirement is the time and effort necessary for the required hospital employee to provide the certification. We estimate that, there will be 5,000 certifications on an annual basis at an estimated 5 minutes per certification. Therefore, the annual national burden associated with this requirement is 417 hours.

(d)(3)(iv) If the ambulance supplier is unable to obtain the required physician certification statement within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested physician certification statement and may then submit the claim. Acceptable documentation must include a signed return receipt from a U.S. Postal Service or other similar service. This documentation will serve as proof that the ambulance supplier attempted to obtain the required signature from the attending physician.

The burden associated with this requirement is the time and effort necessary for the ambulance supplier to document its attempts to obtain the requested physician certification statement. We estimate that 5,000 providers will be required to submit a receipt instead of certification for an average of 12 instances on an annual basis, at an estimated 5 minutes per instance. Therefore, the annual national burden associated with this requirement is 5,000 hours.

Section 414.610 Basis of Payment.

(d) The zip code of the point of pick-up must be reported on each claim for ambulance services, so that the correct GAF and RAF may be applied, as appropriate.

The burden associated with this requirement is the time and effort necessary for the ambulance supplier to note the required zip code for each claim of service. We estimate that of the 9,000 (potential) providers, 5000 providers will be required to provide the documentation, for an estimated 550,000 (5% of total claims volume of 11M) instances on an annual basis. Per provider (5,000), we estimate 1 minute per instance to meet this requirement, for a burden of 2 hours per provider on an annual basis. Therefore, the annual national burden associated with this requirement is 10,000 hours.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn: John Burke, Room N2–14–26,7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

IX. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). We have determined that this is not a major rule. It would result in spending for the first year at approximately $67.6 million less than would have been paid if the fee schedule were not implemented. The total impact would be $84.5 million in reduced revenue for ambulance providers and suppliers ($67.6 million plus $16.9 million in reduced Part B coinsurance). In addition, approximately $19 million in total revenue (due to Medicare Part B coinsurance and deductible requirements of approximately 80 percent that would be program expenditures) would be redistributed among entities that furnish ambulance services according to the data presented in this section.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, most ambulance providers and most ambulance suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. In the aggregate, in 2001, $17 million in total revenue would be redistributed from urban to rural entities. It is also true that some rural entities would be paid less than their current rate. While we do not have specific data on the number of small rural hospitals that furnish ambulance services, we recognize that the rural adjustment factor incorporated in this proposal may not completely offset the higher costs of low-volume suppliers. As stated earlier, we recognize that this rural adjustment is a temporary proxy to acknowledge the higher costs of certain low-volume isolated and essential suppliers. We will consider alternative methodologies that would more appropriately address payment to isolated, low-volume rural ambulance suppliers. Therefore, we solicit public comment on the number, location, and characteristics of the rural entities that are affected by this proposal.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. The proposed rule would not have any unfunded mandates.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. The proposed rule would not impose compliance costs on the governments mentioned.

Although we view the anticipated results of this proposed regulation as beneficial to the Medicare program and to Medicare beneficiaries, we recognize that not all of the potential effects of this proposed rule can be anticipated.

The foregoing analysis concludes that this regulation may have a financial impact on a number of small entities. This analysis, in combination with the rest of the preamble, is consistent with the standards for analysis set forth by the RFA.

B. Anticipated Effects

1. Effect on Ambulance Providers and Suppliers

Section 1834(l)(3)(A) of the Act requires that the aggregate amount paid under the ambulance fee schedule not exceed the aggregate amount that would have been paid absent the fee schedule. One of the characteristics of the present payment system is that widely varying amounts are paid for the same type of service depending upon the location of the service. In effect, the proposed ambulance fee schedule would lower payments in areas of high current levels of payment and raise payments in areas of low current levels of payment. When examining the impact of the proposed ambulance fee schedule, a given area could have a large reduction in payment only because such an area had historically been paid at a rate higher than average for the type of service. Also, as previously described, we are taking into account a $67.6 million program savings that would have resulted from a coverage change that was proposed in 1997. Implementation of that proposed rule was delayed until the ambulance fee schedule was established.

Implementation of the proposed ambulance fee schedule would have several general effects. One effect would be that in 2001, $19 million in total revenue would be redistributed from providers to ambulance suppliers because providers have been paid, on average, more for the same service furnished by a supplier.

2. Effects on Urban, Rural, and Air Ambulance Services

Payment could be redistributed from urban ambulance services to rural ambulance services for two reasons: (1) urban ambulance services have been paid, on average, more than for the same services furnished in rural areas; and (2) the proposed ambulance fee schedule would pay more for the same services furnished in a rural area because of the rural adjustment factor (RAF). Payment would also be redistributed from urban air ambulance services to rural air ambulance services because of the RAF for air services. Finally, there would be a redistribution of payment from ground ambulance services to air ambulance services. This effect is explained in greater detail in the discussion of the CF.

Currently, providers are paid on average 66 percent more than independent suppliers for the same type of ambulance service. This is because providers are currently paid based on reasonable cost and suppliers are paid based on reasonable charges capped by the inflation indexed charge (IIC). The IIC has limited the growth of suppliers' payments over the years, whereas, until enactment of the BBA in 1997, there had not been a limit on the growth of providers' reimbursable cost for ambulance services.

There are offsetting factors that affect payment in urban versus rural areas. While payment rates in rural areas would generally be lowered by the proposed GPCI (since the GPCI is generally lower in rural areas than it is in urban areas), rural payment rates would increase because of the rural mileage add-on. As a result, in 2001, $17 million in total revenue would be redistributed from providers and suppliers in urban areas to providers and suppliers in rural areas.

Furthermore, in 2001, $7 million in total revenue would be redistributed from providers and suppliers of ground ambulance services to providers and suppliers of air ambulance services.

The following chart summarizes these findings for 2001:

From	To	Revenue
Providers	Suppliers	$19 million.
Urban	Rural	$17 million.
Ground	Air	$7 million.

These amounts represent total revenue, that is, the 80 percent Medicare portion plus the 20 percent beneficiary coinsurance liability.

3. Effect on the Medicare Program

We estimate that the proposed rule would produce a calendar year net savings to the Medicare program of $67.6 million because of the delayed implementation of the coverage policy proposed in the June 17, 1997 rule. The following chart shows the estimated fiscal year annual savings that the Medicare program would realize over the next 5 years as a result of our proposal to implement the policy proposed in 1997 of paying for an ALS ambulance vehicle at the BLS payment rate when no ALS service is furnished to the beneficiary. This change would be implemented as part of the ambulance fee schedule.

Fiscal year	Savings ($ Million)
2001	40
2002	70
2003	70
2004	70
2005	80

Under this proposed rule, we anticipate savings for beneficiaries in terms of reduced coinsurance and savings due to mandatory assignment of benefits.

The table below represents the proposed fee schedule amounts for CY 2001 under this rule:

TABLE 1.—2001 FEE SCHEDULE FOR PAYMENT OF AMBULANCE SERVICES

Service level	RVUs	CF	Unadjusted base rate (UBR)†	Amount adjusted by GPCI (70% of UBR)	Amount not adjusted (30% of URB)	Loaded mileage	Rural ground mileage*
BLS	1.00	157.52	$157.52	$110.26	$47.26	$5.00	$7.50
BLS—Emergency	1.60	157.52	252.03	176.42	75.61	5.00	7.50
ALS1	1.20	157.52	189.02	132.31	56.71	5.00	7.50
ALS1—Emergency	1.90	157.52	299.29	209.50	89.79	5.00	7.50
ALS2	2.75	157.52	433.18	303.23	129.95	5.00	7.50
SCT	3.25	157.52	511.94	358.36	153.58	5.00	7.50
PI	1.75	157.52	275.66	192.96	82.70	(1) No Mileage Rate	

Service Level	Unadjusted base rate (UBR)†	Amount adjusted by GPCI (50% of UBR)	Amount not adjusted (50% of UBR)	Loaded mileage	Rural Air mileage**	Rural air base rate***
FW	$2,213.00	$1,106.50	$1,106.50	$6.00	$9.00	$3,319.50
RW	2,573.00	1,286.50	1,286.50	16.00	24.00	3,859.50

* A 50 percent add-on to the mileage rate (that is, a rate of $7.50 per mile) for each of the first 17 miles identified as rural. The regular mileage allowance applies for every mile over 17 miles.

** A 50 percent add-on to the air mileage rate is applied to every mile identified as rural.

*** A 50 percent add-on to the air base rate is applied to air trips identified as rural.

The payment rate for rural air ambulance (rural air mileage rate and rural air base rate) is 50 percent more than the corresponding payment rate for urban services (that is, the sum of the base rate adjusted by the geographic adjustment factor and the mileage).

† This column illustrates the payment rates without adjustment by the GPCI. The conversion factor (CF) has been inflated for 2001.

Legend for Table 1

ALS1—Advanced Life Support, Level 1
ALS2—Advanced Life Support, Level 2
BLS—Basic Life Support
CF—Conversion Factor
FW—Fixed Wing
GPCI—Practice Expense Portion of the Geographic Practice Cost x from the Physician Fee Schedule
PI—Paramedic ALS intercept
RVUs—Relative Value Units
RW—Rotary Wing
SCT—Specialty Care Transport
UBR—Unadjusted Base Rate

Formulas—The amounts in the above chart are used in the following formulas to determine the fee schedule payments—

Ground:

Ground—Urban:
Payment Rate=[(RVU* (0.3+(0.7*GPCI)))*CF]+[MGR*#MILES]
Ground—Rural:
Payment Rate=[(RVU* (0.3+(0.7*GPCI)))*CF]+ [(((1+RG)*MGR)*#MILES≤17)+ (MGR*#MILES≤17)]

Air:

Air—Urban:
Payment Rate = [(((RVU* 0.5)+((RVU*0.5)*GPCI))*CF)]+ [MAR*#MILES]
Air-Rural:
Payment Rate = [(1+RA)*(((RVU*0.5)+((RVU* 0.5)*GPCI))*CF)]+ [(1+RA)*(MAR*#MILES)]

Legend for Formulas

Symbol and Meaning
≤ less than or equal to.
> greater than.
* multiply.
CF conversion factor (ground = $157.52; air = 1.0).

GPCI practice expense portion of the geographic practice cost index from the physician fee schedule.
#MILES number of miles the beneficiary was transported.
MGR mileage ground rate (5.0).
MAR mileage air rate (fixed wing rate = 6.0, helicopter rate = 16.0).
RA rural air adjustment factor (0.50 on entire claim).
Rate maximum allowed rate from ambulance fee schedule.
RG rural ground adjustment factor amount (0.50 on first 17 miles).
RVUs relative value units (from chart).

Notes: The GPCI is determined by the address of the point of pickup.

Table 2

EXAMPLES: The following examples demonstrate the use of the proposed ambulance fee schedule amounts and how they would be used during the first year (2001). Examples 1 through 4 relate to independent supplier claims, and Example 5 relates to hospital based supplier claims.

Example 1: Ground Ambulance, Urban (Independent Supplier)

A Medicare beneficiary residing in Baltimore, Maryland, was transported via ground ambulance from his or her home to the nearest appropriate hospital 2 miles away. An emergency response was required, and an ALS assessment was performed. The level of service furnished 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 rate would apply. In Baltimore, the GPCI = 1.039. The fee schedule amount would be calculated as follows—

Payment Rate = [(RVU* (0.3+ (0.7*GPCI)))*CF]+ [MGR*#MILES]
Payment Rate = [(1.9*(0.3+(0.7*1.039)))*157.52]+[5*2]
Payment Rate = [(1.9*(0.3+(.7273)))*157.52]+[10]
Payment Rate = [(1.9*(1.0273))*157.52]+[10]
Payment Rate = [(1.95187)*157.52]+[10]
Payment Rate = [307.4585624]+[10]
Payment Rate = 317.4585624
Payment Rate = $317.46 (subject to Part B deductible and coinsurance requirements)

Because 2001 would be the first year of a 4-year transition period, the ambulance fee schedule payment rate would be multiplied by 20 percent and added to 80 percent of the payment calculated by the current payment system. The payment rate for Year 2 (2002) would be calculated by multiplying the ambulance fee schedule payment rate by 50 percent and adding the result to 50 percent of the current payment system amount. The payment rate for Year 3 (2003) would be calculated by multiplying the ambulance fee schedule payment rate by 80 percent and adding the result to 20 percent of the current payment system amount. The payment rate for Year 4 (2004) would be based solely on the ambulance fee schedule.

Assuming the inflation indexed charge (IIC) in 2001, the reasonable charge rate for this service in Maryland would be $315.62 ($303.00 for HCPCS A0310, $6.31 × 2 miles for A0390). Therefore, the total allowed charge for this service during 2001 would be:

Old HCPCS Code(s) = A0310 and A0390
New HCPCS Code(s) = A0427 and A0425

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

Assuming that the Part B deductible has been met, the program would pay 80 percent, and beneficiary's liability would be 20 percent, representing the Part B coinsurance amount:

Medicare Payment (80%)	Beneficiary Liability (20%)
$252.79	$63.20

Example 2: Ground Ambulance, Rural (Independent Supplier)

A Medicare beneficiary residing in Cottle County, Texas, was transported via ground ambulance from his or her home to the nearest appropriate facility located in Quanah, Texas. Cottle County, where the beneficiary was placed on board the ambulance, is a non-MSA and, therefore, is rural. A rural payment rate would apply. The total distance from the beneficiary's home to the facility was 36 miles. A BLS nonemergency assessment was performed. Under our proposal, the level of service would be BLS (nonemergency).

For this part of Texas, the GPCI = 0.888. The proposed ambulance fee schedule amount would be calculated as follows—

36 mile trip = 17 miles at the rural payment rate plus 19 miles at the regular rate.

Payment Rate = [(RVU* (0.3+ (0.7*GPCI)))*CF]+ [(((1+RG)*MGR)*#MILES≤17)+ (MGR*#MILES>17)]
Payment Rate = [(1.00*(0.3+ (0.7*0.888)))*157.52]+ [(((1+0.5)*5)*17)+ (5*19)]
Payment Rate = [(1.00* (0.3+0.6216))* 157.52]+ [((1.5*5)*17)+95]
Payment Rate = [(1.00*0.9216)*157.52]+[(7.5*17)+95]
Payment Rate = [0.9216*157.52]+[127.50+95]
Payment Rate = [145.170432]+[222.50]
Payment Rate = 367.670432
Payment Rate = $367.67 (subject to Part B deductible and coinsurance requirements)

Under the proposal, since 2001 would be the first year of a 4-year transition period, the ambulance fee schedule payment rate would be multiplied by 20 percent and added to 80 percent of the payment calculated by the current payment system. The payment rate for Year 2 (2002) would be calculated by multiplying the ambulance fee schedule payment rate by 50 percent and adding the result to 50 percent of the current payment system amount. The payment rate for Year 3 (2003) would be calculated by multiplying the ambulance fee schedule by 80 percent and adding the result to 20 percent of the current payment system amount. The payment rate for Year 4 (2004) would be based solely on the ambulance fee schedule.

Assuming the inflation indexed charge (IIC) in 2001, the reasonable charge rate for this service in Texas would be $292.44 ($152.76 for HCPCS A0300, $3.88 × 36 miles for A0380). Therefore, the total allowed charge for this service during 2001 under our proposal would be:

Old HCPCS Code(s) = A0300 and A0380
New HCPCS Code(s) = A0428 and A0425

Reasonable charge IIC	Reasonable new charge × 80%	Fee schedule	Fee schedule × 20%	Total allowed charge
$292.44	$233.95	$367.67	$73.53	$307.48

Assuming that the Part B deductible was met, the program would pay 80 percent, and the beneficiary's liability would be 20 percent, representing the Part B coinsurance amount:

Medicare Payment (80%)	Beneficiary Liability (20%)
$245.98	$61.50

Example 3: Air Ambulance, Urban (Independent Supplier)

A Medicare beneficiary was involved in an automobile accident along a busy interstate near Detroit, Michigan. A helicopter

transported the beneficiary to the nearest appropriate facility located within the city limits of Detroit. The total distance from the accident to the facility was 14 miles. The level of service was rotary wing.

Assuming that the patient was placed on board the air ambulance within the Detroit MSA, and because this is not a Goldsmith county, the trip would be urban. Therefore, no rural payment rate would apply. In the Detroit metropolitan area, the GPCI = 1.022. The ambulance fee schedule amount would be calculated as follows—

Payment Rate = [((UBR*0.5)+ ((UBR*0.5)* GPCI))]+ [MAR*#MILES]
Payment Rate = [((2573.00*0.5)+ ((2573.00*0.5)*1.022))]+ [16.00*14]
Payment Rate = [(1286.50+ ((1286.50)*1.022))]+ [224]
Payment Rate = [(1286.50+1314.803)]+[224]
Payment Rate = [2601.303]+[224]
Payment Rate = [2825.303]
Payment Rate = $2,825.30 (subject to Part B deductible and coinsurance requirements)

Because 2001 would be the first year of a 4-year transition period, the payment rate from the ambulance fee schedule would be multiplied by 20 percent and added to 80 percent of the payment calculated by the current payment system. The payment rate for Year 2 (2002) would be calculated by multiplying the ambulance fee schedule by 50 percent and adding the result to 50 percent of the current payment system amount. The payment for Year 3 (2003) would be calculated by multiplying the ambulance fee schedule by 80 percent and adding the result to 20 percent of the current payment system amount. The payment for Year 4 (2004) would be based solely on the ambulance fee schedule.

Assuming the inflation indexed charge (IIC) in 2001, the reasonable charge rate for this service in Michigan is $1,982.26. Therefore, the total allowed charge for this service during 2001 would be:

Old HCPCS Code = A0040
New HCPCS Code = A0431 and A0436

Reasonable charge IIC	Reasonable new charge × 80%	Fee schedule	Fee schedule × 20%	Total allowed charge
$1,982.26	$1,585.81	$2,825.30	$565.06	$2,150.87

Assuming that the Part B deductible has been met, the program would pay 80 percent and the beneficiary's liability would be 20 percent, representing the Part B coinsurance amount:

Medicare Payment (80%)	Beneficiary Liability (20%)
$1,720.70	$430.17

Example 4: Air Ambulance, Rural (Independent Supplier)

A Medicare beneficiary was transported via helicopter from a rural county in Arizona to the nearest appropriate facility. The total distance from point of pick-up to the facility was 86 miles. The level of service was rotary wing.

Because the point of pick-up was in a rural, non-MSA area, this transport would be a rural trip under the proposed rule. Therefore, a rural payment rate would apply. In Arizona, the GPCI = 0.971. The ambulance fee schedule amount would be calculated as follows—

Payment Rate = [(1+RA)*((UBR*0.5)+ ((UBR*0.5)*GPCI))] +[(1+RA)*(MAR*#MILES)]
Payment Rate = [(1+0.5)*(((2573.00*0.5)+ ((2573.00*0.5)*0.971))]+ [(1+0.5)*(16*86)]
Payment Rate = [(1.5)*((1286.50)+ (1286.50*0.971))]+ [(1.5)*(1376)]
Payment Rate = [(1.5)*(1286.50+1249.192)]+[2064]
Payment Rate = [(1.5)*2535.692]+[2064]
Payment Rate = 4599.692
Payment Rate = $4,599.69 (subject to Part B deductible and coinsurance requirements)

Because 2001 is the first year of a 4 year transition period, this payment rate from the proposed fee schedule would then be multiplied by 20 percent and added to 80 percent of the payment calculated by the current payment system. Year 2 would be calculated by multiplying the fee schedule by 50 percent and adding the result to 50 percent of the current payment system amount. Year 3 would be calculated by multiplying the fee schedule by 80 percent and adding 20 percent of the current payment system amount. Year 4 (2004) is based solely on the fee schedule amount.

Assuming the inflation indexed charge (IIC) for the example in question, in 2001 the reasonable charge rate for this service in Arizona would be $1,564.80. Therefore, the total allowed charge for this service during 2001 would be:

Old HCPCS Code = A0040
New HCPCS Code = A0431 and A0436

Reasonable charge IIC	Reasonable new charge × 80%	Fee schedule	Fee schedule × 20%	Total allowed charge
$1,564.80	$1,251.84	$4,599.69	$919.94	$2,171.78

Assuming that the Part B deductible has been met, the program would pay 80 percent and 20 percent would be the beneficiary's liability:

Medicare payment (80%)	Beneficiary liability (20%)
$1,737.42	$434.36

Example 5: Ground Ambulance, Rural (Hospital Based Supplier) A Medicare beneficiary residing in a rural area in the state of Iowa was transported via ground ambulance from her home located in a rural area (non-MSA) to the nearest appropriate facility (Hospital A). Because the point of pick-up is in a rural area, under our proposal, a rural payment rate would apply. The total distance from the beneficiary's home to Hospital A is 14 miles. A BLS nonemergency transport was furnished. The level of service would be BLS (nonemergency).

For Iowa, the GPCI = 0.882. The ambulance fee schedule amount would be calculated as follows—

14 mile trip = 14 miles at the rural payment rate plus 0 miles at the regular rate.

The HCPCS codes to be used under the fee schedule are A0428 and A0425.

Payment Rate = [(RVU*(0.3+(0.7*GPCI)))*CF]+ [(((1+RG)*MGR)*#MILES≤17)+ (MGR*#MILES>#7)]
Payment Rate = [(1.00*(0.3+(0.7*0.882)))*157.52]+ [(((1+0.5)*5)*14)+(5*0)]
Payment Rate = [(1.00*(0.3+0.6174))*157.52]+ [((1.5*5)*14)+0]
Payment Rate = [(1.00*0.9174)*157.52]+ [(7.5*14)+0]
Payment Rate = [0.9174*157.52]+[105+0]
Payment Rate = [144.508848]+[105]
Payment Rate = 249.508848
Payment Rate = $249.51 (subject to Part B deductible and coinsurance requirements)

Since 2001 would be the first year of a proposed 4-year transition period, the ambulance fee schedule payment rate would be multiplied by 20 percent. The total payment under the proposed fee schedule for 2001 is:

Payment Rate = Fee Schedule * Transition Percentage
Payment Rate = 249.51*0.2
Payment Rate = 49.902
Payment Rate = $49.90

The remaining 80 percent of the payment rate is determined by the current payment system. For FIs, the current payment calculation is as follows.

Assume that Hospital A's charge (HCB) for a BLS-nonemergency service is $220.00, its charge for mileage (HCM) is $4.00 per mile, and its past year's cost-to-charge ratio (CCR) is 0.9.

Assuming that the beneficiary's Medicare Part B deductible has been met, the beneficiary's coinsurance liability for 2001 would be:

Total Charge = HCB+(HCM*#MILES)
Total Charge = 220+(4*14)
Total Charge = 220+56
Total Charge = $276.00 (Current system)

For 2001, the coinsurance is equal to 20 percent of:
Total rate = (0.80*Current System)+(0.20*FS)
Total rate = (0.80*276)+(49.90)
Total rate = (220.80)+(49.90)
Total rate = $270.70
Coinsurance = 0.20*270.70 = $54.14

For 2001, the transition payment rate is equal to:
Transition payment rate = [0.80*current rate]+[0.20*FS]
Transition Payment Rate = [0.80*((HCB)+(HCM*#MILES))*CCR]+ [0.20*FS]
Transition Payment Rate = [0.80*((220)+(4*14))*0.9]+[49.90]
Transition Payment Rate = [0.80*((220)+(56))*0.9]+[49.90]
Transition Payment Rate = [0.80*(276)*0.9]+[49.90]
Transition Payment Rate = [198.72]+[49.90]
Transition Payment Rate = $248.62

Assuming the part B deductible is met:
Medicare program payment = (transition payment rate) − (coinsurance)
Medicare program payment = 248.62 − 54.14
Medicare program payment = $194.48

Under our proposal, the payment rate for Year 2 (2002) would be calculated by multiplying the ambulance fee schedule payment rate by 50 percent and adding the result to 50 percent of the current payment system amount. The payment rate for Year 3 (2003) would be calculated by multiplying the ambulance fee schedule by 80 percent and adding the result to 20 percent of the current payment system amount. The payment rate for Year 4 (2004) would be based solely on the ambulance fee schedule.

C. Alternatives Considered

While there were many alternatives considered during the course of the negotiated rulemaking process, the statute requires that total program expenditures not exceed what the payments would have been without the fee schedule. All of the alternatives considered did not change total program expenditures. The alternatives varied in the manner in which the total amount of program expenditures might be distributed among the entities that furnish ambulance services to Medicare beneficiaries. For example, the Committee considered other geographical adjustment factors, other relative values for the levels of ambulance service, other definitions for the levels of ambulance service and other definitions for ''rural entities'', but it did not adopt them for various reasons. (A full description of these alternatives may be found at the website: www.hcfa.gov/medicare/ambmain.htm.)

D. Conclusion

We anticipate that the proposed ambulance fee schedule amounts for entities that have received lower than average payment rates historically would be relatively higher and the fee schedule amounts for entities that have received higher than average payment rates historically would be relatively lower. Generally, this would mean higher rates in the future for rural transports, lower rates in the future for urban transports, and higher rates in the future for air ambulance services. The ambulance fee schedule will have a leveling effect on coinsurance liability. While beneficiaries in those areas of historically higher than average payment rates would benefit from lower coinsurance liability, beneficiaries in areas of historically lower than average payment rates would experience an upward adjustment of coinsurance liability. Beneficiaries would also benefit in those cases in which suppliers previously did not accept assignment and billed the beneficiary the difference between the Medicare program allowed amount and their actual charge, because under the fee schedule all suppliers must accept assignment. We anticipate that the integrity of the Medicare Part B Trust Fund will be protected by the continuance of the inflation factors prescribed in the statute.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects Affected

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, 42 CFR chapter IV is proposed to be amended:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

I. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Medical and Other Health Services

2. Section 410.40 is amended by:

A. Revising paragraph (b).

B. Revising paragraph (d)(1).

C. Republishing the introductory paragraph (d)(3).

D. Adding new paragraphs (d)(3)(iii), (d)(3)(iv), and (d)(3)(v).

The revisions and additions read as follows:

§ 410.40 Coverage of ambulance services.

* * * * *

(b) Levels of service. Medicare covers the following levels of ambulance service: basic life support ((BLS) emergency and nonemergency), advanced life support, level 1 ((ALS1) emergency and nonemergency), advanced life support, level 2 (ALS2), paramedic intercept (PI), specialty care transport (SCT), fixed wing transport (FW), and rotary wing transport (RW). See § 414.605 for a definition of each level of services.

* * * * *

(d) *Medical necessity requirements*—(1) *General rule.* Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are 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 the transportation was reasonable and necessary, the beneficiary's medical record must support the coverage of the transportation. For nonemergency ambulance transportation, the following criteria must be met to ensure that ambulance transportation is medically necessary:

(i) The beneficiary is unable to get up from bed without assistance.

(ii) The beneficiary is unable to ambulate.

(iii)The beneficiary is unable to sit in a chair or wheelchair.

These criteria, as defined, are not meant to be the sole criterion in determining medical necessity. They are one factor to be considered when

making medical necessity determinations.

* * * * *

(3) *Special rule for nonemergency, unscheduled ambulance services.* Medicare covers nonemergency, unscheduled ambulance services, provided medical necessity is established under one of the following circumstances:

* * * * *

(iii) If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed physician certification statement must be obtained from either the physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), 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 ambulance transport is ordered or the ambulance service was furnished; and,

(iv) If the ambulance provider or supplier is unable to obtain the required physician certification statement within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested physician certification statement and may then submit the claim. Acceptable documentation must include a signed return receipt from a U.S. Postal Service or other similar service. This documentation will serve as proof that the ambulance supplier attempted to obtain the required signature from the attending physician.

(v) In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence or absence of the signed physician certification statement or signed return receipt does not definitively demonstrate that the ambulance transport was medically necessary. The ambulance provider or supplier must meet all other coverage criteria for payment to be made.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

II. Part 414 is amended as set forth below:

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, 1395rr(b)(1)).

2. Section 414.1 is revised to read as follows:

§ 414.1 Basis and scope.

This part implements the indicated provisions of the following sections of the Act:

1802—Rules for private contracts by Medicare beneficiaries.
1820—Rules for Medicare reimbursement for telehealth services.
1833—Rules for payment for most Part B services.
1834(a) and (h)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.
1834(l)—Establishment of a Fee Schedule for Ambulance Services.
1848—Fee schedule for physician services.
1881(b)—Rules for payment for services to ESRD beneficiaries.
1887—Payment of charges for physician services to patients in providers.

3. A new subpart H, consisting of §§ 414.601 through 414.625, is added to read as follows:

Subpart H—Fee Schedule for Ambulance Services

Sec.
414.601 Purpose.
414.605 Definitions.
414.610 Basis of payment.
414.611 Coding system.
414.615 Transition for implementation of the ambulance fee schedule.
414.620 Publication of the ambulance services fee schedule.
414.625 Limitation on review.

Subpart H—Fee Schedule for Ambulance Services

§ 414.601 Purpose.

This subpart implements section 1834(l) of the Act, by establishing a fee schedule for the payment of ambulance services. Section 1834(l) of the Act requires that payment for all ambulance services otherwise payable on a reasonable charge system or retrospective reasonable cost reimbursement system be made under the ambulance fee schedule effective for services furnished after January 1, 2000.

§ 414.605 Definitions.

As used in this subpart, the following definitions apply to both land and water (hereafter referred to as ''ground'') and to air services:

Advanced Life Support (ALS) assessment is 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.

Advanced Life Support, Level 1 (ALS1) means transportation by ambulance vehicle and medically necessary supplies and ancillary services, plus an ALS assessment by an ALS provider or the provision of at least one ALS intervention.

Advanced Life Support, Level 2 (ALS2) means transportation by ambulance vehicle and medically necessary supplies and ancillary services, plus the administration of at least three different medications and the provision of at least one of the following ALS procedures:

(1) Manual defibrillation/cardioversion.

(2) Endotracheal intubation.

(3) Central venous line.

(4) Cardiac pacing.

(5) Chest decompression.

(6) Surgical airway.

(7) Intraosseous line.

Advanced Life Support (ALS) intervention means a procedure beyond the scope of an emergency medical technician-basic (EMT-Basic).

Advanced Life Support (ALS) provider means an individual trained to the level of the EMT-Intermediate or paramedic. The EMT-Intermediate is defined as having the knowledge and skills identified for the EMT-Basic, but also as qualified to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the competencies of the EMT-Intermediate, but also has enhanced skills that include being able to administer additional interventions and medications.

Basic Life Support (BLS) means transportation by ambulance vehicle and medically necessary supplies and ancillary services, plus the provision of BLS ambulance services. The EMT-Basic, in addition to being able to operate limited equipment on board the vehicle and being able to assist in performing assessments and interventions, is qualified to function as minimum staff for an ambulance and, to establish a peripheral intravenous (IV) line.

Conversion Factor (CF) is a nationally uniform dollar value, multiplied by relative value units for a service to produce a payment amount.

Emergency Response means responding immediately to an emergency medical condition. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

Fixed Wing Air Ambulance (FW) means transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance and such ancillary services as may be medically necessary.

Geographic Adjustment Factor (GAF) means the practice expense (PE) portion of the geographic practice cost index

(GPCI) from the physician fee schedule as applied to a percentage of the base rate. For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the base rate. For air ambulance services, the practice expense (PE) portion of the GPCI is applied to 50 percent of the base rate.

Goldsmith Modification means the methodology for the identification of rural census tracts that are located within large metropolitan counties of at least 1,225 square miles, but are so isolated from the metropolitan core of that county by distance or physical features so as to be more rural than urban in character.

Loaded Mileage means the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.

Paramedic ALS Intercept (PI) means EMT-Paramedic services furnished by an entity that does not furnish the ambulance transport. See § 410.40(c) of this chapter for criteria governing direct payment.

Point of Pick-up means the location of the beneficiary at the time he or she is placed on board the ambulance.

Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.

Rotary Wing Air Ambulance (RW) means transportation by a helicopter that is certified as an ambulance and such ancillary services as may be medically necessary.

Rural adjustment factor (RAF) means an adjustment applied to services at the point of pick-up in a rural area and added to the base payment rate.

Services in a Rural area means services that are furnished in an area outside a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA) or an area within an MSA identified as rural, using the Goldsmith modification.

Specialty Care Transport (SCT) means interfacility transportation by an ambulance vehicle, including medically necessary supplies and ancillary services, of a critically injured or ill patient at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a patient's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

§ 414.610 Basis of payment.

(a) *Method of payment.* Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage and applicable adjustment factors. All ambulance services (regardless of the vehicle (for example, ALS or BLS) furnishing the service or of any local or State ordinances) are paid under the fee schedule specified in this subpart.

(b) *Mandatory assignment.* Effective with implementation of the ambulance fee schedule described in § 414.601, for services furnished on or after January 1, 2001, all payments made for ambulance services are made on an assignment-related basis. Ambulance suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount other than the unmet Part B deductible and Part B coinsurance amounts. Violations of this requirement may subject the provider or supplier to sanctions, as provided by law. There is no transitional period for mandatory assignment of claims.

(c) *Formula for computation of payment amounts.* The fee schedule payment amount for ambulance services is computed according to the following:

(1) *Relative value units.* The relative value unit (RVU) scale for the ambulance fee schedule is as follows:

Service level	Relative value units (RVUs)
BLS	1.00
BLS—Emergency	1.60
ALS1	1.20
ALS1—Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

(i) *Ground ambulance service levels.* RVUs for ground ambulance services are multiplied by a CF and adjusted by the GAF and rural adjustment factor (RAF), as appropriate, in order to determine the respective payment rates.

(ii) *Air ambulance service levels.* The base payment rate for air is adjusted by the GAF and RAF, as appropriate, in order to determine the amount of payment. There are no RVUs for air ambulance services because there are only two types of air ambulance services: fixed wing (FW) and rotary wing (RW).

(iii) *Loaded mileage.* Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates for ground and water, FW, and RW.

(iv) *Geographic adjustment factor (GAF).* For ground ambulance services, the PE portion of the GPCI from the physician fee schedule is applied to 70 percent of the base rate. For air ambulance services, the PE portion of the physician fee schedule GPCI is applied to 50 percent of the base rate.

(v) *Rural adjustment factor (RAF).* For ground ambulance services, a 50 percent increase is applied to the mileage rate for each of the first 17 miles; the regular mileage allowance applies to every mile over 17 miles. For air ambulance services, a 50 percent increase is applied to the total payment for air services; that is, the adjustment applies to the sum of the base rate and the mileage.

(2) *Payment Rates.* Payment, in accordance with this section, represents payment in full (subject to applicable Medicare Part B deductible and coinsurance requirements as described in subpart G of part 409 of this chapter) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to Medicare beneficiaries other than costs associated with operating approved educational activities as described in § 413.85 of this chapter.

(d) *Point of pick-up.* The zip code of the point of pick-up must be reported on each claim for ambulance services, so that the correct GAF and RAF may be applied, as appropriate.

(e) *Updates.* The CF is updated annually for inflation by a factor equal to the payment amounts provided under the fee schedule for services furnished in CY 2001 and each subsequent year at amounts under the fee schedule for services furnished during the previous year. The CF is increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in 2001 and 2002 by 1 percentage point.

(f) *Adjustments.* The CF may be adjusted to take into account factors that, as determined by the Secretary, show data that results in a significantly different aggregate payment of items and services paid under the ambulance fee schedule.

§ 414.611 Coding system.

All claims for services for which the amount of payment is determined under § 414.610 must include a code (or codes) from the uniform coding system specified by the Secretary that identifies the services furnished.

§ 414.615 Transition for implementation of the ambulance fee schedule.

The fee schedule for ambulance services will be phased in over 4 years beginning January 1, 2001. Payment for services furnished during the transition period are made based on a combination of the fee schedule payment for ambulance services and the amount the carrier would have paid absent the fee schedule for ambulance services, as follows:

(a) For services furnished in CY 2001, the payment is based 80 percent on the reasonable charge-based payments for independent suppliers and 80 percent on reasonable cost for providers, plus 20 percent of the ambulance fee schedule amount. The reasonable charge or reasonable cost portion of payment in CY 2001 is equal to the reasonable charge or reasonable cost for CY 2000, multiplied by the statutory inflation factors for ambulance services.

(b) For services furnished in CY 2002, the payment is based 50 percent on the reasonable charge or reasonable cost, as applicable, plus 50 percent of the ambulance fee schedule amount. The reasonable charge and reasonable cost portion in CY 2002 is equal to the supplier or provider's reasonable charge or reasonable cost for CY 2001, multiplied by the statutory inflation factors for ambulance services.

(c) For services furnished in CY 2003, the payment is based 20 percent on the reasonable charge or reasonable cost, plus 80 percent of the ambulance fee schedule amount. The reasonable charge and reasonable cost in CY 2003 for each supplier or provider respectively is equal to the supplier or provider's reasonable charge or reasonable cost for CY 2002, multiplied by the statutory inflation factors for ambulance services.

(d) For services furnished in CY 2004 and thereafter, the payment is based solely on the ambulance fee schedule amount.

(e) *Updates.* The portion of the transition payment that is based on the existing payment methodology (that is, the non fee schedule portion) is updated annually for inflation by a factor equal to the projected consumer price index for all urban consumers (U.S. city average), from March to March for claims paid under cost reimbursement and from June to June for claims paid under reasonable charges, minus 1 percentage point. The portion of the transition payment that is based on the ambulance fee schedule is updated annually for inflation as described in § 414.610(e).

§ 414.620 Publication of the ambulance services fee schedule.

Each year, HCFA will publish updates to the fee schedule for ambulance services.

§ 414.625 Limitation on review.

There shall be no administrative or judicial review under sections 1869 of the Act or otherwise of the amounts established under the fee schedule for ambulance services, including but not limited to matters described in section 1834(l)(2) of the Act.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 15, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: August 31, 2000.

Donna E. Shalala,

Secretary.

Note: The following addendum will not appear in the Code of Federal Regulations.

ADDENDUM A

[** When using this chart, use all codes that apply **]

#	On-scene condition (general)	On-scene condition (specific)	Svc. Lev.	Comments and examples [not all-inclusive]
		Emergency Conditions (non-traumatic)		
1	Abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.
2	Abdominal pain	Without other signs or symptoms	BLS	
3	Abnormal cardiac rhythm/Cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks,non-sinus tachycardias, PVC's >6, bi and trigeminy, vtach,vfib, atrial flutter, PEA, asystole.
4	Abnormal skin signs	.....	ALS	Diaphorhesis, cyanosis, delayed cap refill, poor turgor, mottled.
5	Abnormal vital signs (includes abnormal pulse oximetry).	With symptoms	ALS	Other emergency conditions.
6	Abnormal vital signs (includes abnormal pulse oximetry).	Without symptoms	BLS	
7	Allergic reaction	Potentially life-threatening	DALS	Other emergency conditions, rapid progression of symptoms, prior hx. of anaphylaxis, wheezing, difficulty swallowing.
8	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.
9	Animal bites/sting/envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.
10	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling, special handling considerations and patient monitoring required.
11	Sexual assault	With injuries	ALS	
12	Sexual assault	With no injuries	BLS	
13	Blood glucose	Abnormal – <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration, *etc.*

ADDENDUM A—Continued

[** When using this chart, use all codes that apply **]

#	On-scene condition (general)	On-scene condition (specific)	Svc. Lev.	Comments and examples [not all-inclusive]
14	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.
15	Difficulty breathing		ALS	
16	Cardiac arrest—Resuscitation in progress.		ALS	
17	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.
18	Choking episode		ALS	
19	Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frost bite, other emergency conditions.
20	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions.
21	Altered level of consciousness (non-traumatic).		ALS	Acute condition with Glascow Coma Scale<15.
22	Convulsions/Seizures	Seizing, immediate post-seizure, post-ictal, or at risk of seizure & requires medical monitoring/observation.	ALS	
23	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS	
24	Non traumatic headache	With neurologic distress conditions	ALS	
25	Non traumatic headache	Without neurologic symptoms	BLS	
26	Cardiac Symptoms other than chest pain.	Palpitations, skipped beats	ALS	
27	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.
28	Heat Exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.
29	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.
30	Hemorrhage	Severe (quantity)	ALS	Uncontrolled or significant signs of shock, other emergency conditions.
31	Hemorrhage	Potentially life-threatening	ALS	Active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post-surgical bleeding.
32	Infectious diseases requiring isolation procedures / public health risk.		BLS	
33	Hazmat Exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.
34	Medical Device Failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.
35	Medical Device Failure	Health maintenance device failures	BLS	O2 supply malfunction, orthopedic device failure.
36	Neurologic Distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/balance; slurred speech, unable to speak.	ALS	
37	Pain, acute and severe not otherwise specified in this list.	Patient needs specialized handling to be moved: pain exacerbated by movement.	BLS	
38	Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit	BLS	Pain is the reason for the transport.
39		Pain, severe not otherwise specified in this list.	ALS	Use severity scale (7–10 for severe pain), pt. receiving pre-hospital pharmacologic intervention.

ADDENDUM A—Continued

[** When using this chart, use all codes that apply **]

#	On-scene condition (general)	On-scene condition (specific)	Svc. Lev.	Comments and examples [not all-inclusive]
40	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.
41	Back pain—non-traumatic (T and/or LS).	New neurologic symptoms	ALS	Neurologic distress list.
42	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS	
43	Alcohol intoxication, drug overdose (suspected).	Unable to care for self; unable to ambulate; no risk to airway; no other symptoms.	BLS.	
44	Alcohol intoxication, drug overdose (suspected).	All others, including airway at risk, pharmacological intervention, cardiac monitoring.	ALS.	
45	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Orthopedic appliance; prolapse.
46	Pregnancy complication/ Childbirth/ Labor.	.....	ALS	
47	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Suicidal, homicidal, hallucinations, violent, Disoriented, DT's, withdrawal symptoms, transport required by state law/court order.
48	Psychiatric/Behavioral	Threat to self or others, severe anxiety, acute episode or exacerbation of paranoia, or disruptive behavior.	BLS	
49	Sick Person	Fever with associated symptoms (headache, stiff neck, *etc.*).	ALS	
50	Sick Person	Fever without associated symptoms	BLS	>102 in adults; >104 in children.
51	Sick Person	No other symptoms	BLS	With other emergency conditions
52	Sick Person	Nausea and vomiting, diarrhea, severe and incapacitating.	ALS	
53	Unconscious, Fainting, Syncope	Transient unconscious episode or found unconscious.	ALS	
54	Near syncope, weakness or dizziness	Acute episode or exacerbation	ALS	
55	Medical/Legal	State or local ordinance requires ambulance transport under certain conditions.	BLS	Minor with no guardian; DWI arrest at MVA for evaluation; arrests and medical conditions (psych, drug OD).
		Emergency Conditions—Trauma		
56	Major trauma	As defined by ACS Field Triage Decision Scheme.	ALS	Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.
57	Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.
58	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.
59	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.
60	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.
61	Other trauma	Amputation—digits	BLS	

ADDENDUM A—Continued

[** When using this chart, use all codes that apply **]

#	On-scene condition (general)	On-scene condition (specific)	Svc. Lev.	Comments and examples [not all-inclusive]
62	Other trauma	Amputation—all other	ALS	
63	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.
64	Other trauma	Severe pain requiring pharmacologic pain control.	ALS	See severity scale.
65	Other trauma	Trauma NOS: it is up to the provider to furnish sufficient documentation to support this claim.	BLS	Ambulance required because injury is associated with other emergency conditions or other reasons for transport exist such as special patient handling or patient safety issues.
66	Burns	Major—per ABA	ALS	Partial thickness burns > 10% TBSA; involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma;
67	Burns	Minor—per ABA	BLS	Other burns than listed above.
68	Lightning	.....	ALS	
69	Electrocution	.....	ALS	
70	Near Drowning	.....	ALS	
71	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS	

#	Reason for transport (general)	Reason for transport (specific)	Svc. Lev.	Comments
		Non-Emergency		
72	Bed confined (at the time of transport)	*Unable to get up without assistance; and. *Unable to ambulate; and *Unable to sit in a chair or wheelchair	BLS	Patient is going to a medical procedure, treatment, testing, or evaluation that is medically necessary.
73	ALS monitoring, required	Cardiac/hemodynamic monitoring required en route.	ALS	Expectation monitoring is needed before and after transport.
74	ALS monitoring, required	Advanced airway management	ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.
75	ALS monitoring, required	IV meds required en route	ALS	Does not apply to self-administered IV medications.
76	ALS monitoring, required	Chemical restraint	ALS	
77	BLS monitoring required	Suctioning required en route	BLS	Per transfer instructions.
78	BLS monitoring required	Airway control/positioning required en route.	BLS	Per transfer instructions.
79	BLS monitoring required	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.	BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.
80	Specialty care monitoring	A level of service provided to a critically injured or ill patient beyond the scope of the national paramedic curriculum.	SCT	

81	Medical conditions that contraindicate transport by other means.	Patient Safety: Danger to self or others.	In restraints	BLS	Refer to definition in the CFR—sec. 482.13(e).
82	Medical conditions that contraindicate transport by other means.	Patient safety: Danger to self or others.	Monitoring	BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.

83	Medical conditions that contraindicate transport by other means.	Patient safety: Danger to self or others.	Seclusion (Flight risk).	BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. CFR sec. 482.13(f)(2) for definition.
84	Medical conditions that contraindicate transport by other means.	Patient safety	Risk of falling off wheel chair or stretcher while in motion.	BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.
85	Medical conditions that contraindicate transport by other means.	Special handling en route.	Isolation	BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.
86	Medical conditions that contraindicate transport by other means.	Special handling en route.	Patient Size	BLS	Morbid obesity which requires additional personnel or equipment to transfer.
87	Medical conditions that contraindicate transport by other means.	Special handling en route.	Orthopedic device ...	BLS	Backboard, halotraction, use of pins and traction, *etc.*
88	Medical conditions that contraindicate transport by other means.	Special handling en route.	1 person for physical assistance in transfers.	BLS	
89	Medical conditions that contraindicate transport by other means.	Special handling en route.	Severe pain	BLS	Pain must be aggravated by transfers or moving vehicle such that trained expertise of EMT required (pain scale). Pain is present, but is not sole reason for transport.
90	Medical conditions that contraindicate transport by other means.	Special handling en route.	Positioning requires specialized handling.	BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures—post-op hip as an example.

#	Reason for transfer (general)	Reason for transfer (specific)	Ser. Lev.	Comments
		Inter-facility		
91	EMTALA-certified inter-facility transfer to a higher level of care.	Physician has made the determination that this transfer is needed—Carrier only needs to know the level of care and mode of transport.	BLS, ALS, SCT, FW, RW ..	Excludes patient-requested EMTALA transfer.
92	Service not available at originating facility, *and* must meet one or more emergency or non-emergency conditions.	.....	BLS, ALS, SCT, FW, RW ..	Specify what service is not available.
93	Service not covered	Indicates to Carrier that claim should be automatically denied.		

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