Medicare B Update!
A Newsletter for Florida Medicare Part B Providers

Special Issue

Important Information Regarding the Medicare Ambulance Fee Schedule

Clarifcation of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule

During implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen that require clarification. This *Medicare B Update!* Special Issue provides additional guidance on these issues, and supplements previously issued instructions regarding implementation of the ambulance fee schedule. It is not intended to replace previously issued instructions and does not encompass all issues that have been addressed to date through informal processes. The Centers for Medicare & Medicaid Service (CMS) will address additional issues in the future.

The following clarifications reflect Medicare policy regarding the implementation of the ambulance fee schedule.

Implementation of the Ambulance Fee Schedule

The ambulance final rule published on February 27, 2002, establishes a fee schedule for the payment of ambulance services under the Medicare program, thereby implementing section 1834(l) of the Social Security Act. The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. The final rule established a five-year transition period, during which time payment will be based on a blended amount, based in part on the ambulance fee schedule and in part on reasonable cost or reasonable charge, as applicable.

During the transition period, the fee schedule amount, blended with a provider's reasonable cost or supplier's reasonable charge portion of the payment, will determine the ambulance fee schedule blended rate for each transition year. Percentages for the blended rate during the transition period are provided on page 5.

The fee schedule effective date is based on the date of service for the claim, not the date of processing. Claims with a date of service prior to April 1, 2002, may not be resubmitted for processing under the new ambulance fee schedule guidelines. These claims are processed using the reasonable cost or reasonable charge methodology, as applicable, that was in place prior to the fee schedule.

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Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office Manager
- ❑ Billing/Vendor
- ❑ Nursing Staff
- ❑ Other _____
- _____
- _____

continued from front

Sources of Additional Information

Fee Schedule Formula/Payment Calculations. The ambulance fee schedule final rule, published in the *Federal Register* (67 FR 9100) on February 27, 2002, provides the formula for calculating the ambulance fee schedule amount and examples of payment rate calculations.

ZIP Code File and Fee Schedule File. The ZIP code public use file that can be used to determine the locality that applies for a particular geographic area, and the ambulance fee schedule public use file are posted on the CMS Web site located at *www.cms.hhs.gov/medlearn* (under Ambulance Fee Schedule, ZIP Code File for Ambulance Services).

No Transport

The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. This policy applies to situations in which the beneficiary refuses to be transported, even if medical services are provided prior to loading the beneficiary onto the ambulance (e.g., basic life support [BLS] or advanced life supprt [ALS] assessment). However, an entity that furnishes a noncovered service to a Medicare beneficiary may bill the beneficiary for the service.

ZIP Codes

Under the ambulance fee schedule, the point of pickup (POP), as reported by its five-digit ZIP code, determines the basis for payment. The ZIP code of the POP determines both the applicable locality fee schedule amount, and whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the ZIP code of the POP of the second or subsequent leg determines both the applicable fee for such leg and whether a rural adjustment applies. Accordingly, the ZIP code of the POP *must* be reported on every claim to determine both the correct fee schedule amount and, if applicable, any rural adjustment.

Areas without a ZIP Code. In areas without an apparent ZIP code, it is the provider's/supplier's responsibility to confirm that the POP does not have a ZIP code that has been assigned by the U.S. Postal Service (USPS). If the provider/supplier has made a good-faith effort to confirm that no ZIP code for the POP exists, it may use the ZIP code nearest to the POP. Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the POP does not have an assigned ZIP code and annotate the claim to indicate that a surrogate ZIP code has been used (e.g., "Surrogate ZIP code; POP in No-ZIP"). Providers and suppliers should maintain this documentation and provide it to Medicare upon request. Additional documentation will be requested from providers/suppliers when a claim submitted using a surrogate ZIP code does not contain sufficient information to determine a ZIP code does not exist for the POP.

New ZIP Codes. New ZIP codes are considered urban until CMS determines a ZIP code is located in a rural area. Thus, until a ZIP code is added to the Medicare ZIP code file with a rural designation, it will be considered an urban ZIP code. However, despite the default designation of new ZIP codes as "urban," Medicare contractors have discretion to determine that a new ZIP code is rural until designated otherwise. If the contractor designates a new ZIP code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment. Providers and suppliers should annotate claims using a new ZIP code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP code and provide it to their contractor upon request. If the provider or supplier believes a new ZIP code the contractor has designated as urban should be designated as rural (under the standard established by the Medicare fee schedule regulation), it may request an adjustment from the intermediary or appeal the determination with the carrier, as applicable, in accordance with standard procedures.

Reporting Inaccurate ZIP Code Information. Providers and suppliers that knowingly and willfully report a surrogate ZIP code because they do not know the proper ZIP code may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP code on a claim when not appropriate to do so, for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

Basic Life Support (BLS)/Advanced Life Support (ALS) Joint Responses

In situations where a BLS entity provides transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, paramedic intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their intermediary or carrier upon request.

While there must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service, Medicare does not regulate the compensation between the BLS entity and ALS entity. If there is no agreement between the BLS ambulance supplier and ALS entity furnishing the service, then only BLS level of payment may be made. In this situation, the ALS entity's services are not covered and the beneficiary is liable for the expense of ALS services to the extent these services are beyond the scope of BLS level of payment.

Ground to Air Ambulance Transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided, and mileage from the point-of-pickup to the point-of-transfer to the air ambulance.

Mileage

Local Billing Practices for Carrier-Based Mileage Calculations. Payment is allowed for all medically necessary mileage. That is, Medicare allows payment for mileage incurred transporting the beneficiary to the nearest appropriate facility (or transfer point in the case of an air to ground or ground to air transfer).

Rural Adjustment Versus Lower of Submitted Charge or Fee Schedule Amount. Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable fee schedule amount for mileage. Thus, when rural mileage is involved, the fee schedule rural mileage payment rate blended with the reasonable cost/charge mileage amount is compared to the provider's/supplier's actual charge for mileage.

Billing Rural Mileage. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item on the CMS-1500/CMS-1491/CMS-1450/ electronic claim form.

Calculating the Rural Adjustment. If the point-of-pickup is a rural ZIP code, the rural adjustment for ground mileage is 1.5 times the urban mileage allowance for the first 17 loaded miles, and 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. The rural adjustment for air ambulance services (fixed wing or rotary wing) is 1.5 times both the applicable air service base rate and total mileage amount.

Additional Air Mileage. Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA (Federal Aviation Administration) restrictions and prohibitions.
- Hazardous weather.
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

Payment for Supplies and Ancillary Services

Payment for supplies and ancillary services furnished incident to the ambulance transport are included in the ground and air base rates. Medicare will not make a separate, additional payment for supplies and services under the fee schedule. Under the ambulance fee schedule, this policy is unchanged.

Source: CMS Transmittal AB-02-131, CR 2297

Payment Policy When More Than One Patient Is Onboard an Ambulance

The final regulation to establish an ambulance fee schedule contains a provision that clarifies payment policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance. This policy applies to both ground and air transports (for purposes of this article, the term "ground transport" includes transport by water ambulance). This policy is effective for services provided on or after April 1, 2002, processed on or after October 30, 2002.

- When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport (the "allowed charge" for a single beneficiary transport is the lower of the submitted charge and the fee schedule amount for the service—which, during the fee schedule transition period, is a blended amount). The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.
- If two patients are transported at the same time in one ambulance to the same destination, the adjusted payment allowance for each Medicare beneficiary would equal 75 percent of the single-patient allowed amount applicable to the level of service furnished a beneficiary, plus 50 percent of the total mileage payment allowance for the entire trip. If three or more patients are transported at the same time in one ambulance to the same destination, the adjusted payment for each Medicare beneficiary would equal 60 percent of the single-patient allowed amount applicable to the level of service furnished that beneficiary plus a proportional mileage allowed amount, (i.e., the total mileage allowed amount divided by the number of all the patients onboard). See "Processing Multiple Patient Transports," below.
- The fact that the level of medically necessary service among the patients may be different is not relevant to this payment policy. The percentage is applied to the allowed amount applicable to the level of service that is medically necessary for each beneficiary.
- If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency versus non-emergency ground transport.

  For an emergency ground transport, which includes BLS-E, ALS1-E, ALS2, and SCT (see "Definitions of Ambulance Services," beginning on page 6), the mileage payment is based on the number of miles to the nearest appropriate facility for each patient, divided by the number of patients on board when the

vehicle arrives at the facility. This formula applies cumulatively for beneficiaries who are the second or third patient to be delivered. Absent evidence to the contrary, the carrier assumes the sequence of deliveries was predicated on the medical needs of each patient.

For a non-emergency ground transport, which includes BLS and ALS1, the mileage payment shall be based on the number of miles from the point of pick-up to the nearest appropriate facility for each beneficiary, divided by the number of beneficiaries on board at the point of pickup (POP). This formula applies cumulatively for beneficiaries for multiple POPs. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pick-up to the nearest appropriate facility is not covered. Thus, for non-emergency transports, the extra mileage that may be incurred by having multi-destinations shall not be taken into account.

For air transports the policy is the same as for emergency ground transports.

- If a Medicare beneficiary is furnished medically necessary supplies, and the supplier bills supplies separately, then the allowed amount of the supplies is not subject to an apportionment for multiple patients. The allowed amount for supplies should be determined in the same manner as if the beneficiary was the only patient onboard the vehicle.

Claim Submission Requirements

Suppliers must identify claims for multiple transports with modifier **GM** (multiple patients on one ambulance trip). Documentation to specify particulars of a multiple transport must be submitted that includes at a minimum the total number of patients transported in the vehicle at the same time, and the health insurance claim number for each Medicare beneficiary. Submit the charge applicable to the appropriate service rendered to each beneficiary, and the total mileage for the trip. Suppliers should make every effort to submit all associated Medicare claims for that multiple transport at the same time. Associated Medicare claims for multiple transport must be submitted within a reasonable number of days of submitting the first claim.

Failure to comply with the documentation requirements and timely filing of associated claims may result in a delay of payment determination, additional development requests, and possible denials.

Processing Multiple Patient Transports

Carriers will process claims for covered multiple patient transports as follows:

When two patients are transported, for each beneficiary the carrier will allow 75 percent of the allowed amount for a single-person transport (excluding separately billable mileage). For mileage to a single destination, half of the total mileage will be allowed. For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for the first leg is the amount for the mileage divided by two. The allowed amount for the second leg is the full mileage. Thus, payment on behalf of a beneficiary whose transport is to the first nearest appropriate facility is based on half the mileage amount to that facility. Payment on behalf of the second beneficiary, whose transport was to the next nearest appropriate facility, is based on half of the mileage to the first facility plus all of the mileage from the first facility to the second facility. For mileage for non-emergency ground transports, only the mileage from the POP to the nearest appropriate facility may be allowed. That amount is divided by the number of beneficiaries loaded on board at the POP. Mileage other than what would be incurred by transporting the beneficiary directly from the POP to the nearest appropriate facility is not covered.

When three or more patients are transported, for each beneficiary the carrier will allow 60 percent of the allowed amount for a single-person transport (excluding separately billable mileage). For mileage to a single destination, a pro rata share of the total mileage will be allowed. For mileage for emergency ground transports and all air transports to multiple destinations, the allowed amount for each leg of the transport is a pro rata share of the total mileage based on the number of patients on board upon arrival at each destination. For mileage for non-emergency ground transports, the allowed amount for each beneficiary is based on the mileage to the nearest appropriate facility divided by the number of beneficiaries loaded on board at the POP (including any intermediate POPs). Mileage other than what would be incurred by transporting each beneficiary directly from the POP to the nearest appropriate facility may not be taken into account.

Message codes **M16** (Please see the letter or bulletin of (date) for further information. [Note: Payer must supply the date of the letter/bulletin.]) and **N45** (Payment based on authorized amount.) will be used to indicate that there is a reduction.

Source: CMS Transmittal B-02-060, CR 1945

Transition Schedule for Implementation of the Ambulance Fee Schedule

On April 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented a fee schedule that applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers (i.e., hospitals, critical access hospitals, and skilled nursing facilities). The fee schedule was effective for claims with dates of service on or after April 1, 2002. Under the fee schedule, ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount.

The fee schedule will be phased in over a five year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

The transition schedule is as follows:

Year	Fee Schedule Percentage	Cost/Charge Percentage
Year 1 (4/1/02 – 12/31/02)	20%	80%
Year 2 (calendar year [CY] 2003)	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

The schedule signifies that, during the transition schedule, the Medicare allowed amount for ambulance services and separately billable supplies furnished, and mileage incurred, will comprise a blended rate. The blended rate will include a portion of the fee schedule, and a portion of the provider's reasonable cost or the supplier's reasonable charge.

- During year 1, the fee schedule amount comprises 20 percent of the blended amount and the remaining 80 percent of the blended amount is based on the supplier's reasonable charge.
- During year 2, the fee schedule amount will comprise 40 percent of the blended amount and the supplier's reasonable charge will comprise the remaining 60 percent.
- During year 3, the fee schedule amount will comprise 60 percent of the blended amount and the supplier's reasonable charge will comprise the remaining 40 percent.
- During year 4, the fee schedule amount will comprise 80 percent of the blended amount and the supplier's reasonable charge will comprise the remaining 20 percent.
- Beginning with year 5, and each year thereafter, the full fee schedule comprises the entire Medicare allowed amount and no portion of the supplier's reasonable charge shall be considered.

Source: CMS Transmittal AB-02-117, CR 2303

Reasonable Charge Data Disclosure for Ambulance Services

The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. The payment amounts during the next four years will be a blended payment amount; part ambulance fee schedule, and part reasonable charge reimbursement. See "Transition Schedule for Implementation of the Ambulance Fee Schedule" for percentages for the blended rate during the transition period.

To ensure suppliers receive the amounts reimbursable under each of these payment methods, the Centers for Medicare & Medicaid Services (CMS) will post a yearly fee schedule on the Web site *www.cms.hhs.gov/medlearn*. Carriers will supply the reasonable charge amounts through the disclosure process. Beginning February 28, 2003, and continuing through 2005 (see schedule below), carriers will disclose to each ambulance supplier the supplier's reasonable charge allowance for the forthcoming year (i.e., the full amount that would have been payable under reasonable charge for all ambulance services).

For each supplier, the carrier will prepare a reasonable charge disclosure package that includes reasonable charge amounts updated by the ambulance inflation factor (AIF) for each procedure code the supplier routinely bills in the range of HCPCS codes A0425-A0436.

Disclosure Schedule

On or before the dates specified in the following table, the carrier will mail to each ambulance supplier the supplier's reasonable charge allowance, updated by the AIF. If applicable, a crosswalk will be included that maps each HCPCS code to the new replacement procedure code. (Note: Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)

Year	Publication Date
2003	on or before February 28, 2003
2004	on or before December 31, 2003
2005	on or before December 31, 2004

Source: CMS Transmittal B-02-048, CR 2212

Definitions of Ambulance Services

The ambulance fee schedule final rule, published in the February 27, 2002, *Federal Register* established a fee schedule for payment of ambulance services covered under the Medicare program. After a transition period, the fee schedule described in this final rule will replace the former retrospective reasonable cost payment system for providers and the former reasonable charge system for suppliers of ambulance services. This final rule defined various levels of ambulance services.

The definitions provided alphbetically below apply to both land and water (hereafter collectively referred to as "ground") ambulance services unless otherwise specified as applying to air ambulance services. These definitions and accompanying policy applications are in effect upon implementation of the ambulance fee schedule, April 1, 2002.

Adjusted Base Rate
Definition: Adjusted base rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.
Application: With respect to ground service levels, the **adjusted base rate** is the payment amount that results from multiplying the **conversion factor** (CF) by the applicable relative value unit (RVU) and applying the **geographic adjustment factor** (GAF). With respect to fixed wing and rotary wing services, the **adjusted base rate** is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the fee schedule [FS] and is not calculated by means of a CF and RVU) adjusted by the provider's/supplier's GAF.

Advanced Life Support Assessment
Definition: Advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an **emergency response** that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.
Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced Life Support Intervention
Definition: Advanced life support (ALS) intervention is a procedure that is, in accordance with state and local laws, beyond the scope of practice of an emergency medical technician-basic (EMT-Basic).
Application: An ALS intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1
Definition: Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an **ALS assessment** or at least one **ALS intervention**.

Advanced Life Support, Level 2
Definition: Advanced life support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport and the provision of at least one of the ALS2 procedures listed below.
Application: Crystalloid fluids include fluids such as 5 percent dextrose in water, saline, and lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (e.g., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment. In other words, the administration of one third of a qualifying dose three times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given three times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal three times X. Thus, if three administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol. An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of intravenous (IV) epinephrine in the treatment of pulseless ventricular tachycardia/ventricular fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association's advanced cardiac life support (ACLS) protocol, calls for epinephrine to be administered in 1 mg increments every three to five minutes. Therefore, in order to receive payment for an ALS2 level of service, three separate administrations of epinephrine in 1 mg increments must be administered for

the treatment of pulseless VF/VT. A second example that would not qualify for the ALS2 payment level is the use of adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with paroxysmal supraventricular tachycardia (PSVT). According to ACLS guidelines, 6 mg of adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of adenosine can be administered for a total of 30 mg of adenosine. Three separate administrations of the drug adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

For purposes of this definition, the ALS2 procedures are:

(1) Manual defibrillation/cardioversion
(2) Endotracheal intubation
(3) Central venous line
(4) Cardiac pacing
(5) Chest decompression
(6) Surgical airway
(7) Intraosseous line

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS2 procedure.

Advanced Life Support (ALS) Personnel
Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (**EMT-Intermediate**) or paramedic.

Basic Life Support
Definition: Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from state to state or within a state. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Conversion Factor (CF)
Definition: CF is the nationally uniform dollar value that, when multiplied by **relative value units** for a service, results in the **unadjusted base rate** amount for that service.
Application: The CF is, in effect, equal to the unadjusted national ground base rate for a BLS transport. The CF is updated annually for inflation by a factor specified in the statute. The inflated CF is applied to the RVUs of the different levels of ground ambulance service resulting in payment amounts under the ambulance fee schedule.

Emergency Response
Definition: Emergency response is a BLS or ALS1 level of service has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.
Application: The phrase "911 call or equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911 even in areas where a 911 call system exists. However, the determination to respond emergently must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then both the protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the state, or if there is no similar jurisdiction, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (e.g., symptoms) at the scene determines the appropriate level of payment.

EMT-Intermediate
Definition: EMT-Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic
Definition: EMT-Paramedic possesses the qualifications of the **EMT-Intermediate** and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.

Fixed Wing (FW) Air Ambulance
Definition: FW air ambulance is the transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a **fixed wing air ambulance** and the provision of medically necessary services and supplies.

Geographic Adjustment Factor
Definition: Geographic adjustment factor (GAF) is a value that is applied to a portion of the **unadjusted base rate** amount in order to reflect the relative costs of furnishing ambulance services from one area of the country to another. The GAF is equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) from the physician fee schedule.

Application: For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the **unadjusted base rate**. For air ambulance services, the PE portion of the GPCI is applied to 50 percent of the **unadjusted base rate**.

Goldsmith Modification
Definition: Goldsmith modification is 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 as to be more rural than urban in character.

Loaded Mileage
Definition: Loaded mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.
Application: 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: 1) for ground and water; 2) for FW; and 3) for rotary wing (RW). For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Point of Pickup
Definition: Point of pickup (POP) is the location of the beneficiary at the time he or she is placed on board the ambulance.
Application: The ZIP code of the **POP** must be reported on each claim for ambulance services, so that the correct GAF and **rural adjustment factor** (RAF) may be applied, as appropriate.

Relative Value Units
Definition: Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.
Application: The RVUs for the ambulance fee schedule are as follows:

Service Level	RVUs
BLS	1.00
BLS – Emergency	1.60
ALS1	1.20
ALS1 – Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

RVUs are not applicable to FW and RW services.

Rotary Wing (RW) Air Ambulance
Definition: RW air ambulance is the transportation by a helicopter that is certified by the FAA as a rotary wing ambulance, including the provision of medically necessary supplies and services.

Rural Adjustment Factor (RAF)
Definition: RAF is an adjustment applied to the payment amount for ambulance services when the **POP** is in a rural area.
Application: For ground ambulance services, a 50 percent increase is applied to the ambulance fee schedule mileage rate for each of the first 17 miles; a 25 percent increase is applied to the ambulance fee schedule mileage rate for mileage between 18 and 50 miles; and the urban ambulance fee schedule mileage rate applies to every mile over 50 miles. For air ambulance services, a 50 percent increase is applied to the total air ambulance fee schedule amount for air services; that is, the adjustment applies to the sum of the **adjusted base rate** and ambulance fee schedule rate for all of the loaded air mileage.

Services in a Rural Area
Definition: Services in a rural area are services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or, (2) in New England, outside a New England County Metropolitan Area (NECMA); or, (3) an area identified as rural using the **Goldsmith modification** even though the area is within an MSA.

Specialty Care Transport
Definition: Specialty care transport (SCT) is hospital-to-hospital transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the **EMT-Paramedic**. SCT 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, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.
Application: SCT 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. The **EMT-Paramedic** level of care is set by each state. Care above that level that is medically necessary and that is furnished at a level of service above the **EMT-Paramedic** level of care is considered SCT. That is to say, if **EMT-Paramedics**—without specialty care certification or qualification—are permitted to furnish a given service in a state, then that service does **not** qualify for SCT. The phrase "**EMT-Paramedic** with additional training" recognizes that a state may permit a person who is not only certified as an **EMT-Paramedic**, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or critically injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (e.g., a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

Unadjusted Base Rate
Definition: Unadjusted base rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them.
Application: The **unadjusted base rate** is the payment amount that results from multiplying the CF by the RVU without applying the GAF.

Source: CMS Transmittal AB-02-130, CR 2295

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MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC. P.O. BOX 2078 JACKSONVILLE, FL 32231-0048

*** ATTENTION BILLING MANAGER***