AMBULANCE SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2018

Ambulance services include both emergency and nonemergency transport from the point of patient pick-up to an appropriate medical facility. Medicare beneficiaries use ambulance services for a variety of reasons, such as unscheduled emergency transports to a hospital emergency department; scheduled nonemergency transports from inpatient care to a skilled nursing facility (SNF); and scheduled repetitive nonemergency transports to and from dialysis facilities. Entities providing ambulance services are defined as either suppliers (non-institutionally based, e.g., the local fire department or private for-profit entities) or providers (institution based, e.g., affiliated with the local hospital). Medicare fee-for-service (FFS) program spending for ambulance services in 2016 was $5.5 billion, or about 1 percent of total Medicare spending, and approximately 12 percent of all Medicare beneficiaries used ambulance services.

Ambulance services are largely a Medicare Part B service, and Medicare pays for Part B ambulance services using a dedicated fee schedule, which has payment rates for nine separate payment categories covering ground and air ambulance transports. In determining payment rates for each category of services, the Centers for Medicare & Medicaid Services (CMS) considered the historical costs associated with each payment category to establish relative values for each. These relative values are multiplied by a dollar amount that is standard across all of the nine categories, adjusted for geographic differences, and added to the mileage component of the payment to arrive at a payment amount. Medicare payments for ambulance services may also be adjusted through one of several add-on payments based on additional geographic characteristics of the transport.

Coverage

Medicare Part B covers ambulance services in cases where other transportation could endanger the life of the beneficiary. Specifically, Medicare pays for ambulance services furnished to a beneficiary only if: actual transportation of the beneficiary occurs, the beneficiary is transported to an appropriate destination, the transportation by ambulance is medically necessary (i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated), the ambulance supplier/provider meets all applicable state requirements, and the transportation is not part of a Part A service.[1] In addition, Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare for ambulance transports.

Medicare Part B covers 80 percent of the Medicare-approved amount of the ambulance trip. Therefore, the beneficiary pays approximately 20 percent of the Medicare approved amount, after the beneficiary has paid the yearly Part B deductible ($183 in 2018).[2]

Ambulance transports occurring during a Medicare Part A stay in an inpatient hospital or SNF are generally included within the Part A payment and do not result in a separate Part B payment. Once the beneficiary has been admitted into a Medicare Part A stay, a separate Part B payment is allowed for an ambulance transport when a beneficiary is transported: from the SNF to a hospital for the specific purpose of receiving emergency services or intensive outpatient services not available at the SNF, from the SNF to a dialysis facility, or between two separate Part A stays. In addition, ambulance transports that

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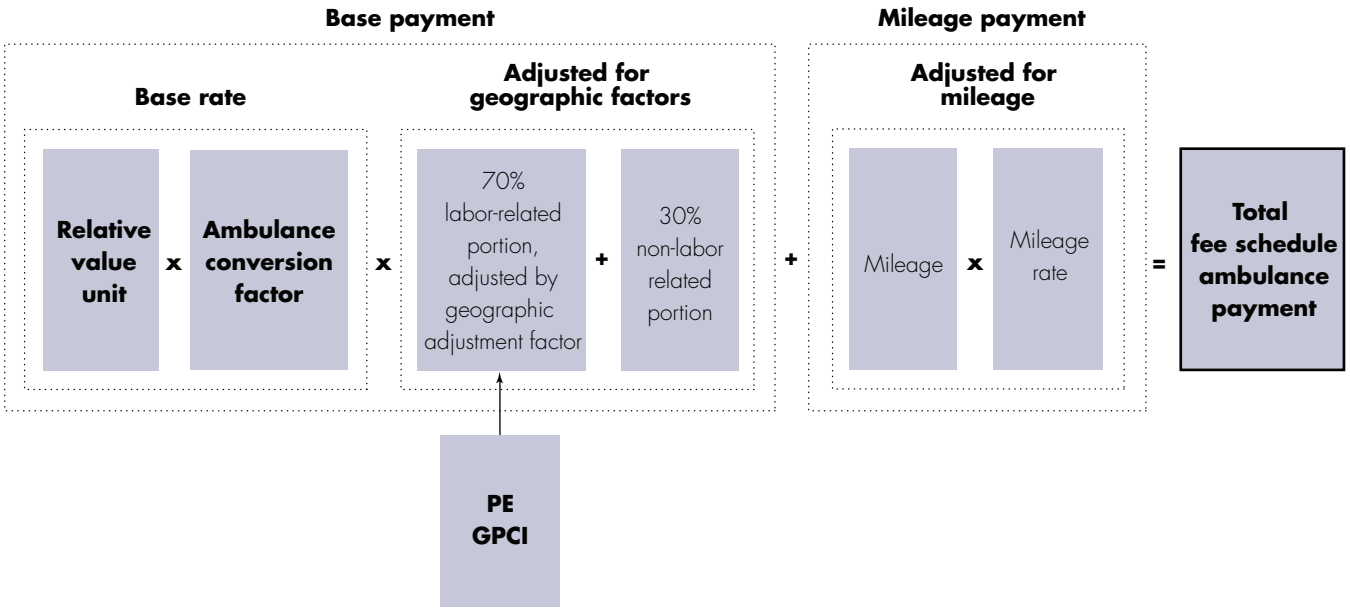
Figure 1 Ambulance fee schedule equation



Note: PE (practice expense), GPCI (geographic practice cost index).

precede a Medicare Part A stay are reimbursed under Part B and are not bundled into the Part A stay as a part of Medicare's 72-hour rule.

Setting the payment rates

Medicare's ambulance fee schedule pays suppliers and providers a single payment to cover both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with the transport. Therefore, the single payment is inclusive of items and services such as oxygen, drugs, extra attendants, and EKG testing when such services are medically necessary.

Standard fee schedule formula The ambulance fee schedule has two components: a base payment and a mileage payment, which are summed to arrive at the total Medicare payment for each ambulance transport. The base payment consists of the product of three distinct pieces: the relative value unit (RVU), which determines the relative intensity or service level of the ambulance transport; a conversion factor (CF), which is used to convert the RVU into a payment expressed in monetary terms; and a geographic adjustment factor (GAF) to account for the geographic differences in the cost of providing ambulance services. The payment for the mileage component of the ambulance fee schedule reflects the costs attributable to the use of the ambulance vehicle (for example, maintenance, fuel, and depreciation), and is the product of miles traveled with the patient and a mileage rate determined by CMS (Figure 1).

Base payment The ambulance fee schedule contains nine distinct levels of ambulance service, and each of these is assigned a different RVU representing the varying levels of service intensity required to serve the patient (Table 1). Service intensity varies based on whether the transport is emergency or nonemergency and the level of clinical staff required (basic life support staff (BLS) or advanced life support (ALS) staff). RVUs for eight categories of ambulance transports are set relative to the value of the lowest intensity service,

BLS nonemergency ambulance transport, which is assigned an RVU of 1.00. Seven of the service levels are specific to ground ambulance transports, and two are specific to air ambulance transports. Despite a generally higher level of service intensity, the RVU for both of the air ambulance transport levels is set at 1.00, and the fee schedule accounts for higher costs associated with air transports through the conversion factor.

The conversion factor used for the ambulance fee schedule is a dollar amount used to convert the RVU of a given ambulance case into a payment. For 2018, the CF for all ground ambulance transports was $224.74. The two types of air ambulance transports each have their own CF to account for the higher costs and service intensity associated which each type of service. For 2018, the fixed-wing (FW) CF is $3,049.69 and the rotary-wing (RW) CF is $3,545.72.

The non-facility practice expense component of the geographic practice cost index (GPCI) is the GAF that is used to address regional differences in the cost of furnishing ambulance services within the national ambulance fee schedule. The ZIP code in which the Medicare beneficiary was picked up by the ambulance, referred to as the point-of-pickup ZIP code, establishes which GPCI is applied to generate the base payment. The GPCI applies to 70 percent of the base payment for ground ambulance transports and to 50 percent of the base payment for air ambulance transports.

Mileage payment The payment for the mileage component of the ambulance fee schedule reflects the costs attributable to the use of the ambulance vehicle (e.g., fuel, maintenance, and depreciation) and is the product of two parts: raw mileage multiplied by a mileage rate determined by CMS. The term 'mileage' is referred to by CMS as 'loaded miles,' or the miles an ambulance travels with the beneficiary from the point-of-pickup to the location of the nearest appropriate facility. This amount is reported by the provider or supplier of the ambulance, reported on the claim submitted to Medicare, and used to calculate the payment amount for the claim. The mileage rate is a standardized amount established by CMS and differs for ground and for the two modes of air ambulance transport. In calendar year 2018 the ground ambulance mileage rate was $7.23 per statute mile, the FW mileage rate was $8.65, and the RW mileage rate was $23.09.

Table 1 Medicare ambulance service levels and conversion factors, 2018

Ambulance service level	RVU	CF
Ground transports		
BLS nonemergency	1.00	$224.74
BLS emergency	1.60	$224.74
ALS nonemergency	1.20	$224.74
ALS emergency (level 1)	1.90	$224.74
ALS emergency (level 2)	2.75	$224.74
Specialty care transport	3.25	$224.74
Paramedic ALS intercept	1.75	$224.74
Air transports		
Fixed wing	1.00	$3,049.69
Rotary wing	1.00	$3,545.72

Note: RVU (relative value units), CF (conversion factor), BLS (basic life support), ALS (advanced life support).

Source: CMS.

Add-on payments

The ambulance fee schedule system incorporates several add-on payment policies tied to either the mode of ambulance transportation or the geographic location of the point of pickup. The add-on payment policies have varied between 2002 and 2018, but all of the add-on payment policies that are currently in use hinge upon CMS's geographic categorization (urban, rural, super-rural) of the point-of-pickup ZIP code attached to each ambulance transport. Urban and

rural zip codes are defined generally as those located inside (urban) or outside (rural) of a metropolitan statistical area. Super-rural ZIP codes are unique to the ambulance fee schedule and are defined as those which are located in a rural county that is among the lowest quartile of all rural counties, by population density.

The ambulance fee schedule system currently contains two permanent and two temporary add-on payment policies. The permanent add-on policies are written into law without an expiration date and include: 1) *the rural short-mileage ground ambulance add-on payment policy,* which increases the standard mileage rate by 50 percent for the first 17 miles of a ground transport if the pick-up ZIP code is rural; and 2) *the rural air transport add-on payment policy,* which reimburses providers and suppliers 50 percent more than the urban air ambulance base payment and the mileage rate if the point-of-pickup ZIP code is rural. The temporary add-on payment policies are written into law with expiration dates and include: 1) *the ground ambulance add-on payment policy,* which increases the base payment and mileage rate for ground transports by 3 percent for transports originating in rural ZIP codes and by 2 percent for transports originating in urban ZIP codes; and 2) *the super-rural add-on payment policy,* which increases the base payment for ground ambulance transports by 22.6 percent where the point-of-pickup ZIP code is designated as super-rural. All Medicare ambulance transports are eligible for one of the four add-on payment policies, and many are eligible for multiple add-on policies if they originate in rural ZIP codes.

The ambulance fee schedule system also contains a payment adjustment whereby a 23 percent reduction to the fee schedule payment amount is to be made to ambulance transports consisting of nonemergency basic life support transports of an individual with end-stage renal disease for renal dialysis services. This adjustment affects services furnished on or after October 1, 2018.

Updating payments

The current RVU scale remains the same in 2018 as when it was implemented in 2002.

Ambulance fee schedule payment rates are updated annually through the conversion factor and the mileage rates. The ground and air CFs, as well as the mileage rates, are updated annually by the ambulance inflation factor. This factor is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI–U) reduced by the 10-year moving average of multi-factor productivity. The update for 2018 was 1.1 percent. ■

1 An appropriate destination can be defined as any of the following: hospital, skilled nursing facility (SNF), physician's office, freestanding or hospital-based dialysis facility, diagnostic or therapeutic service site other than a hospital or physician's office, residence, custodial care facility, intermediate stop at a physician's office on the way to the hospital, or a site of transfer between modes of ambulance transport.

2 Medicare beneficiaries served by a provider owned or operated by a critical access hospital may be responsible for more than 20 percent of the Medicare-approved amount for that service because these providers are reimbursed on the basis of reasonable cost, rather than through a prospective payment system. For a critical access hospital to be eligible for reasonable cost ambulance reimbursement, this entity must be the only supplier or provider of ambulance services within a 35-mile drive of that entity. Conversely, the beneficiary's coinsurance may be less than 20 percent if they possess medigap insurance or are dually eligible for Medicare and Medicaid.