AMBULANCE SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2020

Payment system changes during the COVID-19 public health emergency

During the COVID-19 public health emergency, Medicare is paying to transport beneficiaries between a wider variety of locations, as long as they are equipped to treat a patient's condition consistent with emergency medical services protocols established by state and/or local laws. For example, Medicare will now pay for a transport from any point of origin to a COVID-19 testing facility, a hospital's alternative site, an urgent care facility, or a physician's office, to name a few permitted locations.

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 2018 (not including cost sharing paid by beneficiaries) was $4.5 billion, or about 1 percent of total Medicare FFS spending, and approximately 11 percent of all Medicare FFS beneficiaries used ambulance services.

Coverage

Medicare Part B covers ambulance services to an appropriate destination in cases where other transportation could endanger the life of the beneficiary and the transportation is not part of a Part A service.[1]

During a Medicare Part A–covered inpatient 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. Ambulance transports that precede a Medicare Part A stay are also reimbursed under Part B.[2]

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 ($198 in 2020).[3]

Defining the care Medicare pays for

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.

The policies discussed in this document were current as of September 15, 2020, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

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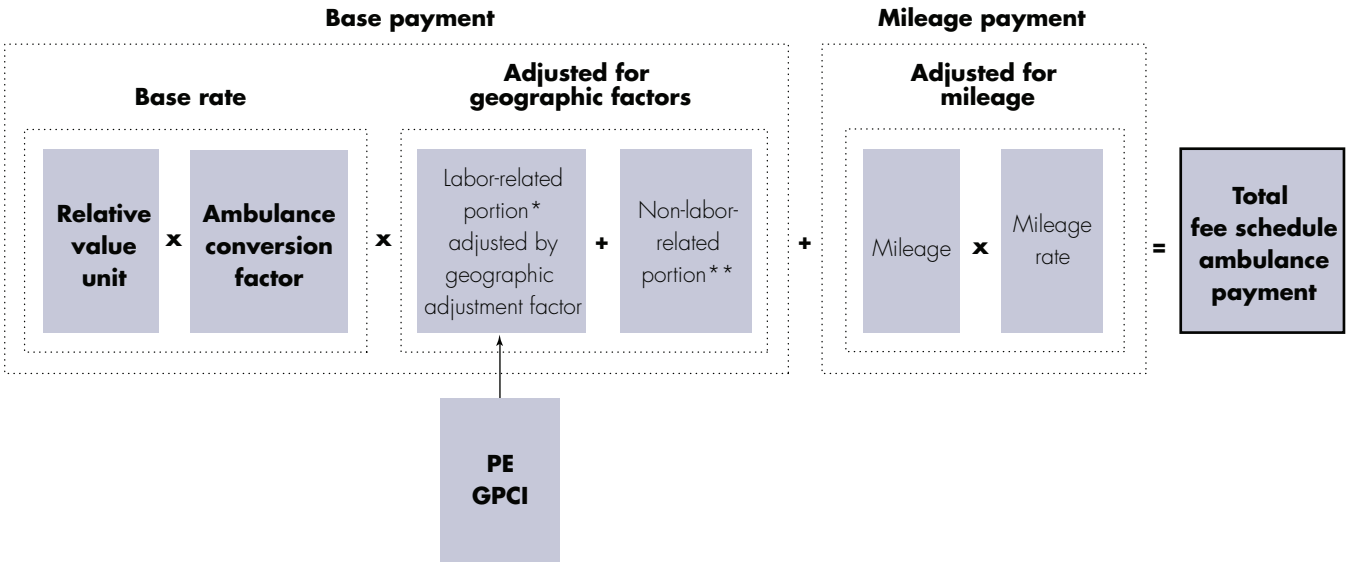
Figure 1 Ambulance fee schedule equation



Note: PE (practice expense), GPCI (geographic practice cost index).
*The labor portion is 70 percent for ground ambulance transports and 50 percent for air ambulance transports.
**The non-labor portion is 30 percent for ground ambulance transports and 50 percent for air ambulance transports.

Setting the payment rates

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 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 seven distinct levels of ground transport 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 (BLS) staff or advanced life support (ALS) staff). RVUs for six categories of ground ambulance transport are set relative to the value of the lowest intensity service, BLS nonemergency ground ambulance transport, which is assigned an RVU of 1.00. Two additional service levels are specific to air ambulance transports. The RVU for both of the air ambulance transport levels is set at 1.00, but much higher CFs account for the higher costs associated with air transports.

The conversion factor used for the ambulance fee schedule is a dollar amount that converts the RVU of a given ambulance case into a payment. For 2020, the CF for all ground ambulance transports was $231.98; for air transport, the fixed-wing (FW) CF is $3,147.91 and the rotary-wing (RW) CF is $3,659.92.

The non-facility practice expense component of the geographic practice cost index (GPCI) is the geographic adjustment factor 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' refers to 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 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 2020 the ground ambulance mileage rate was $7.47 per statute mile, the FW mileage rate was $8.93, and the RW mileage rate was $23.83.

Add-on payments

The ambulance fee schedule system incorporates several add-on payment policies tied to the mode of ambulance transportation and/or the geographic location of the point of pickup.

The rural short-mileage ground ambulance add-on payment policy 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. The rural air transport add-on payment policy 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. In addition, two temporary add-on payments are written into law and are set to expire after December 31, 2022. The ground ambulance add-on payment policy 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, while the super-rural add-on payment policy increases the base payment for ground ambulance transports by 22.6 percent where the point-of-pickup ZIP code is designated as super-rural.[4] 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 also contains a payment adjustment whereby a 23 percent reduction is made to payments for nonemergency basic life support transports of an individual with end-stage renal disease for renal dialysis services.

Table 1 Medicare ambulance service levels and conversion factors, 2020

Ambulance service level	RVU	CF
Ground transports		
BLS nonemergency	1.00	$231.98
BLS emergency	1.60	$231.98
ALS nonemergency	1.20	$231.98
ALS emergency (level 1)	1.90	$231.98
ALS emergency (level 2)	2.75	$231.98
Specialty care transport	3.25	$231.98
Paramedic ALS intercept	1.75	$231.98
Air transports		
Fixed wing	1.00	$3,147.91
Rotary wing	1.00	$3,659.92

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

Source: CMS.

Updating payments

The current RVU scale remains the same in 2020 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 2020 was 0.9 percent. ■

1 Medicare covers transports: from any point of origin to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF); from a hospital, CAH, or SNF to a beneficiary's home; between a SNF and the nearest supplier of medically necessary services; and between a renal dialysis facility and a beneficiary's home. 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.

2 Under Medicare's three-day payment window policy, outpatient hospital services provided in the three days prior to an inpatient admission to the same inpatient prospective payment system (IPPS) hospital are included in the payment for that admission and not separately billable.

3 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.

4 Super-rural ZIP codes are unique to the ambulance fee schedule and are defined as those located in a rural county that is among the lowest quartile of all rural counties, by population density.