AMBULANCE SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2023

The policies discussed in this document were current as of September 30, 2023. This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
www.medpac.gov

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 (noninstitutionally based, e.g., local fire departments or private for-profit entities) or providers (institutionally based, e.g., affiliated with hospitals). Medicare fee-for-service (FFS) program spending for ambulance services in 2021 (not including cost sharing paid by beneficiaries) was $4.0 billion, or about 1 percent of total Medicare FFS spending. Approximately 11 percent of all Medicare FFS beneficiaries used ambulance services in 2021.

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]

Ambulance transports occurring during a Medicare Part A stay in an inpatient hospital or SNF are generally included in the Part A payment and do not result in a separate Part B payment. But there are some exceptions to this rule. During a Medicare Part A–covered stay, a separate Part B payment is allowed for an ambulance transport when a beneficiary is transported from a SNF to a hospital to receive emergency services or intensive outpatient services not available at the SNF (and from the hospital back to the SNF), and from a SNF to a dialysis facility (and back to the SNF). Ambulance transports between two separate Part A stays and 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 their yearly Part B deductible ($240 in 2024).[3]

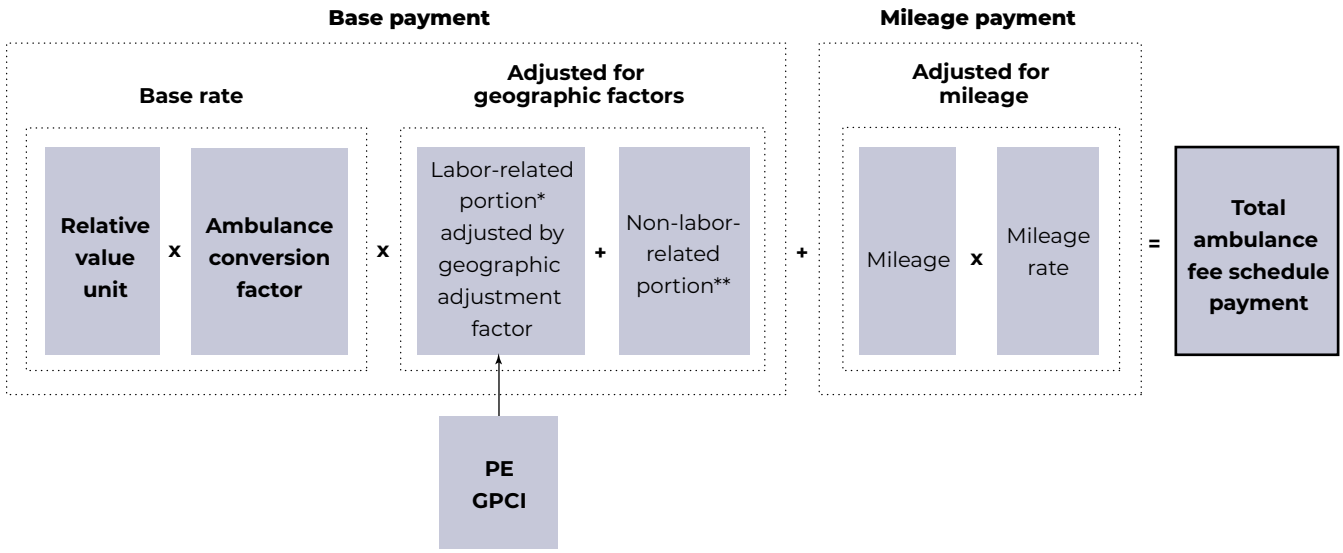
Defining the care Medicare pays for

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.

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 is the product of three distinct pieces: the relative value unit (RVU), which refers to the relative intensity or service level of the ambulance transport; a conversion factor, 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

Figure 1 Ambulance services payment system, 2023



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 nonlabor portion is 30 percent for ground ambulance transports and 50 percent for air ambulance transports.

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 conversion factors account for the higher costs associated with air transports.

The conversion factors (CFs) used in the ambulance fee schedule are specific dollar amounts that are multiplied by RVUs to produce a base payment amount. For 2023, the CF for all ground ambulance transports is $265.54; for air transport, the fixed-wing CF is $3,603.48 and the rotary-wing CF is $4,189.59.

CMS uses the nonfacility practice expense component of the geographic practice cost index (GPCI) as the ambulance payment system's geographic adjustment factor. 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 used. CMS applies the GPCI 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. The mileage rate is a standardized amount established by CMS and differs for ground and the two modes of air ambulance transport. In calendar year 2023, the ground ambulance mileage rate was $8.54 per statute mile, the fixed-wing air mileage rate was $10.23, and the rotary-wing air mileage rate was $27.28.

Add-on payments

The ambulance fee schedule incorporates several add-on payments 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 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 increases the base payment and the mileage rate by 50 percent if the point-of-pickup ZIP code is rural. In addition, several temporary add-on payments are available through December 31, 2024. The ground ambulance add-on payment increases the base payment and mileage rate for all ground transports by 3 percent for transports originating in rural ZIP codes and by 2 percent for transports originating in urban ZIP codes. The super-rural add-on payment increases the base payment by 22.6 percent for all ground ambulance transports where the point-of-pickup ZIP code is designated as super-rural.[4]

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, 2023

Ambulance service level	RVU	CF
Ground transports		
BLS nonemergency	1.00	$265.54
BLS emergency	1.60	$265.54
ALS nonemergency	1.20	$265.54
ALS emergency (Level 1)	1.90	$265.54
ALS emergency (Level 2)	2.75	$265.54
Specialty care transport	3.25	$265.54
Paramedic ALS intercept	1.75	$265.54
Air transports		
Fixed wing	1.00	$3,603.48
Rotary wing	1.00	$4,189.59

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

Source: CY 2023 ambulance fee schedule Public Use File, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.

Updating payments

The ambulance fee schedule conversion factors and 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 reduced by the 10-year moving average of multifactor productivity. The update for 2023 was 8.7 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.

2 Under Medicare's three-day payment window policy, outpatient hospital services provided in

the three days prior to an inpatient admission are included in the payment for that admission and not separately billable.

3 Medicare beneficiaries served by an ambulance 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. To be eligible for reasonable cost ambulance reimbursement, a critical access hospital must be the only supplier or provider of ambulance services within a 35-mile drive.

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.