CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 68	**Date: MARCH 30, 2007**
	Change Request 5533

Subject: Ambulance Fee Schedule - Ground Ambulance Services - Revision to the Specialty Care Transport (SCT) Definition

I. SUMMARY OF CHANGES: This transmittal revises this definition for SCT to include the term "interfacility."

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: April 30, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/30/30.1.1/ Ground Ambulance Services

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 68	Date: March 30, 2007	Change Request: 5533

SUBJECT: Ambulance Fee Schedule – Ground Ambulance Services – Revision to the Specialty Care Transport (SCT) Definition

Effective Date: January 01, 2007

Implementation Date: April 30, 2007

I. GENERAL INFORMATION

A. Background: In the February 27, 2002 **Federal Register** (67 FR 9100), CMS published a final rule with comment period entitled "Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services" that implemented the ambulance fee schedule. In that final rule, CMS implemented the SCT level of payment for hospital-to-hospital ground ambulance transports upon implementation of the ambulance fee schedule on April 1, 2002, and CMS defined SCT at Section 414.605 of the Code of Federal Regulations (CFR). The definition of SCT in 42 CFR 414.605 refers to "interfacility transportation."

In the December 1, 2006 (71 FR 69716) final rule, CMS expanded the definition of "interfacility" to include both hospitals and SNFs. In addition, CMS further clarified the kinds of facilities that CMS includes as origin or destination points for "interfacility" transport for SCT purposes. Therefore, for purposes of SCT payment, CMS considers a "facility" to include only a SNF or a hospital that participates in the Medicare program, or a hospital-based facility that meets CMS' requirements for provider-based status. Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute-care hospitals, and sole community hospitals (SCHs).

B. Policy: This transmittal revises the definition for SCT to include the term "interfacility."

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5533.1	Contractors shall pay for SCT where the origin and destination points are among Medicare participating SNFs or hospitals, or hospital-based facilities that meet CMS' requirements for provider-based status as defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, Section 30.1.1	X		X	X							
5533.2	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	X		X	X							

III. PROVIDER EDUCATION TABLE

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Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5533.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Roechel Kujawa, Roechel.kujawa@cms.hhs.gov or on 410-786-9111

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use the following statement:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts alloted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.1.1 - Ground Ambulance Services

(Rev. 68; Issued: 03-30-07; Effective: 01-01-07; Implementation: 04-30-07)

Refer to the Medicare Claims Processing Manual, Chapter 15, "Ambulance," §10.3, for additional definitions and their applications.

1. Basic Life Support (BLS)

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.

2. Basic Life Support (BLS) - Emergency

When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. 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.

3. Advanced Life Support, Level 1 (ALS1)

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**.**

An 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.

An advanced life support (ALS) intervention is a procedure that is in accordance with State and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

4. Advanced Life Support, Level 1 (ALS1) - Emergency

When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. 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.

5. Advanced Life Support, Level 2 (ALS2)

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, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

a. Manual defibrillation/cardioversion;

b. Endotracheal intubation;

c. Central venous line;

d. Cardiac pacing;

e. Chest decompression;

f. Surgical airway; or

g. Intraosseous line.

6. Specialty Care Transport (SCT)

Specialty care transport (SCT) is the *interfacility* 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.

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 (for example, 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.

7. Paramedic Intercept (PI)

Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only basic life support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or I.V. therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to March 1, 1999, Medicare payment could be made for these services, but only when the claim was submitted by the entity that actually furnished the ambulance transport. Payment could not be made directly to the intercept service provider. In those areas where State laws prohibit volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service.

Paramedic intercept services furnished on or after March 1, 1999, may be payable separate from the ambulance transport, subject to the requirements specified below.

The intercept service(s) is:

- Furnished in a rural area;
- Furnished under a contract with one or more volunteer ambulance services; and,
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

In addition, the volunteer ambulance service involved must:

- Meet the program's certification requirements for furnishing ambulance services;
- Furnish services only at the BLS level at the time of the intercept; and,
- Be prohibited by State law from billing anyone for any service.

Finally, the entity furnishing the ALS paramedic intercept service must:

- Meet the program's certification requirements for furnishing ALS services, and,

- Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or any area outside of a Metropolitan Statistical Area or in New England, outside a New England County Metropolitan Area as defined by the Office of Management and Budget. The current list of these areas is periodically published in the Federal Register.

See the Medicare Claims Processing Manual, Chapter 15, "Ambulance," for payment of paramedic intercept services.