

applied in determining the fee schedule amounts and payment limits for ambulance services.

DATES: *Effective date:* These revisions are effective on January 1, 2004. The ambulance inflation factor for 2004 applies to ambulance services furnished during the period January 1, 2004, through December 31, 2004.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 29, 2004.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1232-FC, P.O. Box 8013, Baltimore, MD 21244-8013.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Hubert H. Humphrey Building, Room 443-G, 200 Independence Avenue, SW., Washington, DC 20201, or Centers for Medicare & Medicaid Services, Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-8013.

Comments mailed to those addresses designated for courier delivery may be delayed and could be considered late. Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Please refer to file code CMS-1232-FC on each comment. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of this document, in Room C5-12-08 of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, Monday through Friday of each week from 8:30 a.m. to 4 p.m. Please call (410) 786-7197 to make an appointment to view comments.

FOR FURTHER INFORMATION CONTACT:

Anne E. Tayloe, (410) 786-4546.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory History

Under section 1861(s)(7) of the Social Security Act (the Act), Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated. The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 legislation creating the Social Security Act suggest that the Congress

intended that (1) the ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition, and (2) only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and S. Rep. No. 404, 89th Cong., 1st Sess., Pt I, 43 (1965)). The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

Our regulations relating to ambulance services are located at 42 CFR part 410, subpart B and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations included at § 410.40. Part 414, subpart H describes how payment is made for ambulance services covered by Medicare.

The Medicare program pays for ambulance services for Medicare beneficiaries when other means of transportation are contraindicated. Ambulance services are divided into different levels of services based on the medically necessary treatment provided during transport as well as into ground (including water) and air ambulance services. These services include the levels of service listed below.

For ground:

- Basic Life Support (BLS)
- Advanced Life Support, Level 1 (ALS1)
- Advanced Life Support, Level 2 (ALS2)
- Specialty Care Transport (SCT)
- Paramedic ALS Intercept (PI)

For air:

- Fixed Wing Air Ambulance (FW)
- Rotary Wing Air Ambulance (RW)

Historically, payment levels for ambulance services depended, in part, upon the entity that furnished the services. Prior to implementation of the ambulance fee schedule on April 1, 2002, providers (hospitals, including critical access hospitals, skilled nursing facilities, and home health agencies) were paid on a retrospective reasonable cost basis. Suppliers, which are entities that are independent of any provider, were paid on a reasonable charge basis.

On February 27, 2002, a final rule was published in the **Federal Register** (67 FR 9100) that established a fee schedule for the payment of ambulance services

under the Medicare program, effective for services furnished on or after April 1, 2002. This rule implemented section 1834(l) of the Act. The fee schedule described in the final rule replaced the retrospective reasonable cost payment system for providers and the reasonable charge system for suppliers of ambulance services. In addition, that final rule implemented that statutory requirement that ambulance suppliers accept Medicare assignment; codified the establishment of new Health Care Common Procedure Coding System (HCPCS) codes to be reported on claims for ambulance services; established increased payment under the fee schedule for ambulance services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance; and revised the certification requirements for coverage of nonemergency ambulance services. The final rule also provided for a 5-year transition period during which program payment for Medicare covered ambulance services would be based upon a blended rate comprised of a fee schedule portion and a reasonable cost (providers) or reasonable charge (suppliers) portion. We are now in the second year of that transition over to full payment based solely on the fee schedule amount.

B. Transitional Assistance for Rural Mileage 18 through 50—Section 221 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

Section 221 of BIPA provided that, for services furnished during the period July 1, 2001 through, December 31, 2003, a bonus payment, not less than one-half of the bonus paid under the ambulance fee schedule for rural mileage 1 through 17 miles, would be paid for rural mileage 18 through 50. This provision was implemented by § 414.610(c) with the ambulance fee schedule.

The statute provided for this bonus payment only for the interim period specified. We inadvertently omitted from the regulation the time period during which this benefit is payable. Therefore, we are revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period. This revision to the regulation is a technical correction to conform the regulation to the statute. Therefore, we believe that notice and comment are unnecessary, and we are waiving proposed rulemaking.