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(2) The trained technician travels to more than one location for specimen collection from more than one Medicare beneficiary.

(iii) *Travel allowance amount*—(A) *Eligible miles*. Eligible miles begin at the laboratory or the starting point of the technician's travel for specimen collection as specified in paragraph (a)(1) of this section, and end at the laboratory or the ending point of the technician's travel for specimen collection as specified in paragraph (a)(1) of this section. Eligible miles do not include miles traveled for any purpose unrelated to specimen collection as specified in paragraph (a)(1) of this section, such as collecting specimens from non-Medicare beneficiaries or for personal reasons.

(B) *Travel allowance mileage rate*. The travel allowance mileage rate is equal to the IRS standard mileage rate plus an amount to cover expenses for a trained technician equal to the most recent median hourly wage for phlebotomists, as published by the United States Bureau of Labor Statistics, divided by 40 to represent an average miles-per-hour driving speed.

(C) *Travel allowance amount calculation*. (1) For the flat-rate travel allowance basis specified in paragraph (a)(2)(ii)(A) of this section, the travel allowance amount is the travel allowance mileage rate specified in paragraph (a)(2)(iii)(B) of this section multiplied by ten, divided by the number of beneficiaries for whom a specimen collection fee is paid under paragraph (a)(1) of this section.

(2) For the per-mile travel allowance basis specified in paragraph (a)(2)(ii)(B) of this section, the travel allowance amount is the number of eligible miles multiplied by the travel allowance mileage rate specified in paragraph (a)(2)(iii)(B) of this section, divided by the number of beneficiaries for whom a specimen collection fee is paid under paragraph (a)(1) of this section.

(b) [Reserved]

[87 FR 70225, Nov. 18, 2022]

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Subpart H—Fee Schedule for Ambulance Services

SOURCE: 67 FR 9132, Feb. 27, 2002, unless otherwise noted.

§ 414.601 Purpose.

This subpart implements section 1834(l) of the Act by establishing a fee schedule for the payment of ambulance services. Section 1834(l) of the Act requires that, except for services furnished by certain critical access hospitals (see § 413.70(b)(5) of this chapter), payment for all ambulance services, otherwise previously payable on a reasonable charge basis or retrospective reasonable cost basis, be made under a fee schedule. Section 1834(l)(17) of the Act requires the development of a data collection system to collect cost, revenue, utilization, and other information determined appropriate from providers of services and suppliers of ground ambulance services.

[67 FR 9132, Feb. 27, 2002, as amended at 84 FR 63193, Nov. 15, 2019]

§ 414.605 Definitions.

As used in this subpart, the following definitions apply to both land and water (hereafter collectively referred to as “ground”) ambulance services and to air ambulance services unless otherwise specified:

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.

Advanced life support (ALS) intervention means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel.

Advanced life support, level 1 (ALS1) means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Advanced life support, level 2 (ALS2) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:

- (1) Manual defibrillation/cardioversion.
- (2) Endotracheal intubation.
- (3) Central venous line.
- (4) Cardiac pacing.
- (5) Chest decompression.
- (6) Surgical airway.
- (7) Intraosseous line.

Advanced life support (ALS) personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

Basic life support (BLS) means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished. Also, at least one of the staff members must be certified, at a minimum, as an emergency medical technician-basic (EMT-Basic) by the State or local authority where the services are furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from State to State.

Conversion factor (CF) is the dollar amount established by CMS that is multiplied by relative value units to produce ground ambulance service base rates.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.

Fixed wing air ambulance (FW) means transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance and such services and supplies as may be medically necessary.

Geographic adjustment factor (GAF) means the practice expense (PE) portion of the geographic practice cost index (GPCI) from the physician fee schedule as applied to a percentage of the base rate. For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the base rate for each level of service. For air ambulance services, the PE portion of the GPCI is applied to 50 percent of the applicable base rate.

Ground ambulance organization means a Medicare provider or supplier of ground ambulance services.

Loaded mileage means the number of miles the Medicare beneficiary is transported in the ambulance vehicle.

Paramedic ALS intercept (PI) means EMT-Paramedic services furnished by an entity that does not furnish the ground ambulance transport, provided the services meet the requirements specified in §410.40(d) of this chapter.

Point of pick-up means the location of the beneficiary at the time he or she is placed on board the ambulance.

Relative value units (RVUs) means a value assigned to a ground ambulance service.

Rotary wing air ambulance (RW) means transportation by a helicopter that is certified as an ambulance and such services and supplies as may be medically necessary.

Rural adjustment factor (RAF) means an adjustment applied to the base payment rate when the point of pick-up is located in a rural area.

Rural area means an area located outside an urban area, or a rural census

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tract within a Metropolitan Statistical Area as determined under the most recent version of the Goldsmith modification as determined by the Office of Rural Health Policy of the Health Resources and Services Administration.

Specialty care transport (SCT) means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including 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, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Urban area means a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

[67 FR 9132, Feb. 27, 2002, as amended at 68 FR 67693, Dec. 5, 2003; 71 FR 69787, Dec. 1, 2006; 80 FR 71382, Nov. 16, 2015; 84 FR 63193, Nov. 15, 2019]

§ 414.610 Basis of payment.

(a) *Method of payment.* Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage and applicable adjustment factors. Except for services furnished by certain critical access hospitals or entities owned and operated by them, as described in § 413.70(b) of this chapter, all ambulance services are paid under the fee schedule specified in this subpart (regardless of the vehicle furnishing the service).

(b) *Mandatory assignment.* Effective with implementation of the ambulance fee schedule described in § 414.601 (that is, for services furnished on or after April 1, 2002), all payments made for ambulance services are made only on an assignment-related basis. Ambulance suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount other than the unmet Part B deductible and Part B

coinsurance amounts. Violations of this requirement may subject the provider or supplier to sanctions, as provided by law (part 402 of this chapter).

(c) *Formula for computation of payment amounts.* The fee schedule payment amount for ambulance services is computed according to the following provisions:

(1) *Ground ambulance service levels.* The CF is multiplied by the applicable RVUs for each level of service to produce a service-level base rate.

(i) For services furnished during the period July 1, 2004 through December 31, 2006, ambulance services originating in—

(A) Urban areas (both base rate and mileage) are paid based on a rate that is 1 percent higher than otherwise is applicable under this section; and

(B) Rural areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section.

(ii) For services furnished during the period July 1, 2008 through December 31, 2022, ambulance services originating in—

(A) Urban areas (both base rate and mileage) are paid based on a rate that is 2 percent higher than otherwise is applicable under this section.

(B) Rural areas (both base rate and mileage) are paid based on a rate that is 3 percent higher than otherwise is applicable under this section.

(iii) The service-level base rate is then adjusted by the GAF. Compare this amount to the actual charge. The lesser of the actual charge or the GAF adjusted base rate amount is added to the lesser of the actual mileage charges or the payment rate per mile, multiplied by the number of miles that the beneficiary was transported. When applicable, the appropriate RAF is applied to the ground mileage rate to determine the appropriate payment rates. The RVU scale for the ambulance fee schedule is as follows:

Service level	Relative value units (RVUs)
BLS	1.00
BLS-Emergency	1.60
ALS1	1.20
ALS1-Emergency	1.90
ALS2	2.75
SCT	3.25

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Service level	Relative value units (RVUs)
PI	1.75

(2) *Air ambulance service levels.* The base payment rate for the applicable type of air ambulance service is adjusted by the GAF and, when applicable, by the appropriate RAF to determine the amount of payment. Air ambulance services have no CF or RVUs. This amount is compared to the actual charge. The lesser of the charge or the adjusted GAF rate amount is added to the payment rate per mile, multiplied by the number of miles that the beneficiary was transported. When applicable, the appropriate RAF is also applied to the air mileage rate.

(3) *Loaded mileage.* Payment is based on loaded miles. Payment for air mileage is based on loaded miles flown as expressed in statute miles. There are three mileage payment rates: a rate for FW services, a rate for RW services, and a rate for all levels of ground transportation.

(4) *Geographic adjustment factor (GAF).* For ground ambulance services, the PE portion of the GPCI from the physician fee schedule is applied to 70 percent of the base rate for ground ambulance services. For air ambulance services, the PE portion of the physician fee schedule GPCI is applied to 50 percent of the base rate for air ambulance services.

(5) *Rural adjustment factor (RAF).* (i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

(ii) For services furnished during the period July 1, 2004 through December 31, 2022, the payment amount for the ground ambulance base rate is in-

creased by 22.6 percent where the point of pickup is in a rural area determined to be in the lowest 25 percent of rural population arrayed by population density. The amount of this increase is based on CMS's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile of population compared to the average cost per trip for the rural areas in the highest quartile of population. In making this estimate, CMS may use data provided by the GAO.

(6) *Multiple patients.* The allowable amount per beneficiary for a single ambulance transport when more than one patient is transported simultaneously is based on the total number of patients (both Medicare and non-Medicare) on board. If two patients are transported simultaneously, then the payment allowance for the beneficiary (or for each of them if both patients are beneficiaries) is equal to 75 percent of the service payment allowance applicable for the level of care furnished to the beneficiary, plus 50 percent of the applicable mileage payment allowance. If three or more patients are transported simultaneously, the payment allowance for the beneficiary (or each of them) is equal to 60 percent of the service payment allowance applicable for the level of care furnished to the beneficiary, plus the applicable mileage payment allowance divided by the number of patients on board.

(7) *Payment rate for mileage greater than 50 miles.* For services furnished during the period July 1, 2004 through December 31, 2008, each loaded ambulance mile greater than 50 (that is, miles 51 and greater) for ambulance transports originating in either urban areas or in rural areas are paid based on a rate that is 25 percent higher than otherwise is applicable under this section.

(8) *Transport of an individual with end-stage renal disease for renal dialysis services.* For ambulance services furnished during the period October 1, 2013 through September 30, 2018, consisting of non-emergency basic life support (BLS) services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1881(b)(14)(B) of the

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Act) furnished other than on an emergency basis by a provider of services or a renal dialysis facility, the fee schedule amount otherwise applicable (both base rate and mileage) is reduced by 10 percent. For such services furnished on or after October 1, 2018, the fee schedule amount otherwise applicable (both base rate and mileage) is reduced by 23 percent.

(9) *Payment reduction for failure to report data.* In the case of a ground ambulance organization (as defined at §414.605) that is selected by CMS under §414.626(c) for a year that does not sufficiently submit data under §414.626(b) and is not granted a hardship exemption under §414.626(d), the payments made under this section are reduced by 10 percent for the applicable period. For purposes of this paragraph, the applicable period is the calendar year that begins following the date that CMS provided written notification to the ground ambulance organization under §414.626(e)(1) that the ground ambulance did not sufficiently submit the required data.

(d) *Payment.* Payment, in accordance with this subpart, represents payment in full (subject to applicable Medicare Part B deductible and coinsurance requirements as described in subpart G of part 409 of this chapter or in subpart I of part 410 of this chapter) for all services, supplies, and other costs for an ambulance service furnished to a Medicare beneficiary. No direct payment will be made under this subpart if billing for the ambulance service is required to be consolidated with billing for another benefit for which payment may be made under this chapter.

(e) *Point of pick-up.* The zip code of the point of pick-up must be reported on each claim for ambulance services so that the correct GAF and RAF may be applied, as appropriate.

(f) *Updates.* The CF, the air ambulance base rates, and the mileage rates are updated annually by an inflation factor established by law. The inflation factor is based on the consumer price index for all urban consumers (CPI-U) (U.S. city average) for the 12-month period ending with June of the previous year and, for 2011 and each subsequent year, is reduced by the productivity ad-

justment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(g) *Adjustments.* The Secretary monitors payment and billing data on an ongoing basis and adjusts the CF and air ambulance rates as appropriate to reflect actual practices under the fee schedule. These rates are not adjusted solely because of changes in the total number of ambulance transports.

(h) *Treatment of certain areas for payment for air ambulance services.* Any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, must be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through June 30, 2013.

[67 FR 9132, Feb. 27, 2002, as amended at 68 FR 67693, Dec. 5, 2003; 69 FR 40292, July 1, 2004; 71 FR 69787, Dec. 1, 2006; 73 FR 69937, Nov. 19, 2008; 74 FR 62012, Nov. 25, 2009; 75 FR 73625, Nov. 29, 2010; 76 FR 70315, Nov. 10, 2011; 77 FR 69368, Nov. 16, 2012; 78 FR 74820, Dec. 10, 2013; 79 FR 68005, Nov. 13, 2014; 80 FR 71382, Nov. 16, 2015; 83 FR 60074, Nov. 23, 2018; 84 FR 63193, Nov. 15, 2019]

§414.615 Transition to the ambulance fee schedule.

The fee schedule for ambulance services will be phased in over 5 years beginning April 1, 2002. Subject to the first sentence in §414.610(a), payment for services furnished during the transition period is made based on a combination of the fee schedule payment for ambulance services and the amount the program would have paid absent the fee schedule for ambulance services, as follows:

(a) *2002 Payment.* For services furnished in 2002, the payment for the service component, the mileage component and, if applicable, the supply component is based on 80 percent of the reasonable charge for independent suppliers or on 80 percent of reasonable cost for providers, plus 20 percent of the ambulance fee schedule amount for the service and mileage components. The reasonable charge or reasonable cost portion of payment in CY 2002 is equal to the supplier's reasonable

charge allowance or provider's reasonable cost allowance for CY 2001, multiplied by the statutory inflation factor for ambulance services.

(b) *2003 Payment.* For services furnished in CY 2003, payment is based on 60 percent of the reasonable charge or reasonable cost, as applicable, plus 40 percent of the ambulance fee schedule amount. The reasonable charge and reasonable cost portion in CY 2003 is equal to the supplier's reasonable charge or provider's reasonable cost for CY 2002, multiplied by the statutory inflation factor for ambulance services.

(c) *2004 Payment.* For services furnished in CY 2004, payment is based on 40 percent of the reasonable charge or reasonable cost, as applicable, plus 60 percent of the ambulance fee schedule amount. The reasonable charge and reasonable cost portion in CY 2004 is equal to the supplier's reasonable charge or provider's reasonable cost for CY 2003, multiplied by the statutory inflation factor for ambulance services.

(d) *2005 Payment.* For services furnished in CY 2005, payment is based on 20 percent of the reasonable charge or reasonable cost, as applicable, plus 80 percent of the ambulance fee schedule amount. The reasonable charge and reasonable cost portion in CY 2005 is equal to the supplier's reasonable charge or provider's reasonable cost for CY 2004, multiplied by the statutory inflation factor for ambulance services.

(e) *2006 and Beyond Payment.* For services furnished in CY 2006 and thereafter, the payment is based solely on the ambulance fee schedule amount.

(f) *Updates.* The portion of the transition payment that is based on the existing payment methodology (that is, the non-fee-schedule portion) is updated annually for inflation by a factor equal to the percentage increase in the CPI-U (U.S. city average) for the 12-month period ending with June of the previous year. The CY 2002 inflation update factor used to update the 2001 payment amounts is applied to the annualized (average) payment amounts for CY 2001. For the period January 1, 2001 through June 30, 2001, the inflation update factor is 2.7 percent. For the period July 1, 2001 through December 31, 2001, the inflation update factor is 4.7 percent. The average for the year is 3.7

percent. Thus, the annualized (average) CY 2001 payment amounts used to derive the CY 2002 payment amounts are equivalent to the CY 2001 payment amounts that would have been determined had the inflation update factor for the entire CY 2001 been 3.7 percent. Both portions of the transition payment (that is, the portion that is based on reasonable charge or reasonable cost and the portion that is based on the ambulance fee schedule) are updated annually for inflation by the inflation factor described in §414.610(f).

(g) *Exception.* There will be no blended payment allowance as described in paragraphs (a), (b), (c), and (d) of this section for ground mileage in those States where the Medicare carrier paid separately for all out-of-county ground ambulance mileage, but did not, before the implementation of the Medicare ambulance fee schedule, make a separate payment for any ground ambulance mileage within the county in which the beneficiary was transported. Payment for ground ambulance mileage in that State will be made based on the full ambulance fee schedule amount for ground mileage. This exception applies only to carrier-processed claims and only in those States in which the carrier paid separately for out-of-county ambulance mileage, but did not make separate payment for any in-county mileage throughout the entire State.

§414.617 Transition from regional to national ambulance fee schedule.

For services furnished during the period July 1, 2004 through December 31, 2009, the amount for the ground ambulance base rate is subject to a floor amount determined by establishing nine fee schedules based on each of the nine census divisions using the same methodology as used to establish the national fee schedule. If the regional fee schedule methodology for a given census division results in an amount that is less than or equal to the national ground base rate, then it is not used, and the national FS amount applies. If the regional fee schedule methodology for a given census division results in an amount that is greater than the national ground base rate, then the FS portion of the base rate for that

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census division is equal to a blend of the national rate and the regional rate in accordance with the following schedule:

Time period	Regional percent	National percent
7/1/04–12/31/04	80	20
CY 2005	60	40
CY 2006	40	60
CY 2007–CY 2009	20	80
CY 2010 and thereafter	0	100

[69 FR 40292, July 1, 2004]

§ 414.620 Publication of the ambulance fee schedule.

(a) Changes in payment rates resulting from incorporation of the annual inflation factor and the productivity adjustment as described in § 414.610(f) will be announced by CMS by instruction and on the CMS Web site.

(b) CMS will follow applicable rule-making procedures in publishing revisions to the fee schedule for ambulance services that result from any factors other than those described in § 414.610(f).

[75 FR 73626, Nov. 29, 2010]

§ 414.625 Limitation on review.

There will be no administrative or judicial review under section 1869 of the Act or otherwise of the amounts established under the fee schedule for ambulance services, including the following:

(a) Establishing mechanisms to control increases in expenditures for ambulance services.

(b) Establishing definitions for ambulance services that link payments to the type of services provided.

(c) Considering appropriate regional and operational differences.

(d) Considering adjustments to payment rates to account for inflation and other relevant factors.

(e) Phasing in the application of the payment rates under the fee schedule in an efficient and fair manner.

§ 414.626 Data reporting by ground ambulance organizations.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Data collection period means, with respect to a year, the 12-month period

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that reflects the ground ambulance organization's annual accounting period.

Data reporting period means, with respect to a year, the 5-month period that begins the day after the last day of the ground ambulance organization's data collection period.

For a year means one of the calendar years from 2020 through 2024.

Medicare Ground Ambulance Data Collection Instrument means the single survey-based data collection instrument that can be accessed by sampled ambulance organizations under this section via a secure web-based system for reporting data under this section.

(b) *Data collection and submission requirement.* Except as provided in paragraph (d) of this section, a ground ambulance organization selected by CMS under paragraph (c) of this section must do the following:

(1) Within 30 days of the date that CMS notifies a ground ambulance organization under paragraph (c)(3) of this section that it has selected the ground ambulance organization to report data under this section, the ground ambulance organization must select a data collection period that corresponds with its annual accounting period and provide the start date of that data collection period to CMS or its contractor.

(2) Collect during its selected data collection period the data necessary to complete the Medicare Ground Ambulance Data Collection Instrument.

(3) Submit to CMS a completed Medicare Ground Ambulance Data Collection Instrument during the data reporting period that corresponds to the ground ambulance organization's selected data collection period.

(c) *Representative sample.* (1) *Random sample.* For purposes of the data collection described in paragraph (b) of this section, and for a year, CMS will select a random sample of 25 percent of eligible ground ambulance organizations that is stratified based on:

(i) Provider versus supplier status and ownership (for-profit, non-profit, and government);

(ii) Service area population density (transports originating in primarily urban, rural, and super rural zip codes); and

(iii) Medicare-billed transport volume categories.

(2) *Selection eligibility.* A ground ambulance organization is eligible to be selected for data reporting under this section for a year if it is enrolled in Medicare and has submitted to CMS at least one Medicare ambulance transport claim during the year prior to the selection under paragraph (b)(1) of this section.

(3) *Notification of selection for a year.* CMS will notify an eligible ground ambulance organization that it has been selected to report data under this section for a year at least 30 days prior to the beginning of the calendar year in which the ground ambulance organization must begin to collect data by posting a list of selected organizations on the CMS web page and providing written notification to each selected ground ambulance organization via email or U.S. mail.

(4) *Limitation.* CMS will not select the same ground ambulance organization under this paragraph (c) in 2 consecutive years, to the extent practicable.

(d) *Hardship exemption.* A ground ambulance organization selected under paragraph (c) of this section may request and CMS may grant an exception to the reporting requirements under paragraph (b) of this section in the event of a significant hardship, such as a natural disaster, bankruptcy, or similar situation that the Secretary determines interfered with the ability of the ground ambulance organization to submit such information in a timely manner for the data collection period selected by the ground ambulance organization.

(1) To request a hardship exemption, the ground ambulance organization must submit a request to CMS, in the form and manner specified by CMS, within 90 calendar days of the date that CMS notified the ground ambulance organization that it would receive a 10 percent payment reduction as a result of not submitting sufficient information under the data collection system. The request form must include all of the following:

- (i) Ground ambulance organization name.
- (ii) NPI number.
- (iii) Ground ambulance organization address.

(iv) Chief executive officer and any other designated personnel contact information, including name, email address, telephone number and mailing address (must include a physical address, a post office box address is not acceptable).

(v) Reason for requesting a hardship exemption.

(vi) Evidence of the impact of the hardship (such as photographs, newspaper or other media articles, financial data, bankruptcy filing, etc.).

(vii) Date when the ground ambulance organization would be able to begin collecting data under paragraph (b) of this section.

(viii) Date and signature of the chief executive officer or other designated personnel of the ground ambulance organization.

(2) CMS will provide a written response to the hardship exemption request within 30 days of its receipt of the hardship exemption form.

(e) *Notification of non-compliance and informal review.* (1) *Notification of non-compliance.* A ground ambulance organization selected under paragraph (c) of this section for a year that does not sufficiently report data under paragraph (b) of this section, will receive written notification from CMS that it will receive a payment reduction under §414.610(c)(9).

(2) *Informal review.* A ground ambulance organization that receives a written notification under paragraph (e)(1) of a payment reduction under §414.610(c)(9) may submit a request for an informal review within 90 days of the date it received the notification by submitting a request to CMS, in the form and manner specified by CMS, that includes all of the following information:

(i) Ground ambulance organization name.

(ii) NPI number.

(iii) Chief executive officer and any other designated personnel contact information, including name, email address, telephone number and mailing address with the street location of the ground ambulance organization.

(iv) Ground ambulance organization's selected data collection period and data reporting period.

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(v) A statement of the reasons why the ground ambulance organization does not agree with CMS' determination and any supporting documentation.

(f) *Public availability of data.* Beginning in 2024, and at least once every 2 years thereafter, CMS will post on its website data that it collected under this section, including but not limited to summary statistics and ground ambulance organization characteristics.

(g) *Limitations on review.* There is no administrative or judicial review under section 1869 or section 1878 of the Act, or otherwise of the data required for submission under paragraph (b) of this section or the selection of ground ambulance organizations under paragraph (c) of this section.

[84 FR 63193, Nov. 15, 2019, as amended at 86 FR 65669, Nov. 19, 2021; 87 FR 70226, Nov. 18, 2022]

Subpart I—Payment for Drugs and Biologicals

SOURCE: 69 FR 1116, Jan. 7, 2004, unless otherwise noted.

§ 414.701 Purpose.

This subpart implements section 1842(o) of the Act by specifying the methodology for determining the payment allowance limit for drugs and biologicals covered under Part B of Title XVIII of the Act (hereafter in this subpart referred to as the “program”) that are not paid on a cost or prospective payment system basis. Examples of drugs that are subject to the rules contained in this subpart are: Drugs furnished incident to a physician's service; durable medical equipment (DME) drugs; separately billable drugs at independent dialysis facilities not under the ESRD composite rate; statutorily covered drugs, for example, influenza, pneumococcal, hepatitis, and COVID-19 vaccines, antigens, hemophilia blood clotting factor, immunosuppressive drugs and certain oral anticancer drugs.

[85 FR 71197, Nov. 6, 2020]

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§ 414.704 Definitions.

As used in this subpart, the following definition applies. *Drug* refers to both drugs and biologicals.

§ 414.707 Basis of payment.

(a) *Method of payment.* (1) Payment for a drug in calendar year 2004 is based on the lesser of—

(i) The actual charge on the claim for program benefits; or

(ii) 85 percent of the average wholesale price determined as of April 1, 2003, subject to the exceptions as specified in paragraphs (a)(2) through (a)(8) of this section.

(2) The payment limits for the following drugs are calculated using 95 percent of the average wholesale price:

(i) Blood clotting factors.

(ii) A drug or biological furnished during 2004 that was not available for Medicare payment as of April 1, 2003.

(iii) Pneumococcal, influenza, and COVID-19 vaccines as well as hepatitis B vaccine that is furnished to individuals at high or intermediate risk of contracting hepatitis B (as defined in § 410.63(a) of this subchapter).

(iv) A drug or biological furnished during 2004 in connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities.

(3) The payment limits for infusion drugs furnished through a covered item of durable medical equipment are calculated using 95 percent of the average wholesale price in effect on October 1, 2003.

(4) The payments limits for drugs contained in the following table are calculated based on the percentages of the average wholesale price determined as of April 1, 2003 that are specified in the table.

Drug	Percentage used to calculate 2004 payment limit
EPOETIN ALFA	87
LEUPROLIDE ACETATE	81
GOSERELIN ACETATE	80
RITUXIMAB	81
PACLITAXEL	81
DOCETAXEL	80
CARBOPLATIN	81
IRINOTECAN	80
GEMCITABINE HCL	80
PAMIDRONATE DISODIUM	85