

CMS-1317-P-1

Medicare Program; Revisions to the Payment Policies of Ambulance Services under the Fee Schedule for Ambulance Services

Submitter :

Date & Time: 06/07/2006

Organization : Regional Emergency Medical Services Authority

Category : Other Health Care Provider

Issue Areas/Comments

**Recalibration of the
Ambulance Fee Schedule
Conversion**

Recalibration of the Ambulance Fee Schedule Conversion

"SPECIALTY CARE TRANSPORT" If the final rule for SCT = Hospital to Hospital only, what classification (modifiers and or level of service) does a patient become when their transport requires care beyond the scope of a paramedic? Example: Patient being transported to Skilled Nursing Facility and said patient has a running IV with heprain. Per the Nevada State EMS protocols a nurse or doctor has to monitor that patient during the transport. This cannot be classified as an ALS2 because 3 separate drugs are not being administered. Thank you for allowing us to express our concerns.

Submitter :

Date: 06/08/2006

Organization : East TX Medical Center Emergency Medical Service

Category : Other Health Care Provider

Issue Areas/Comments

**Recalibration of the Ambulance Fee
Schedule Conversion**

Recalibration of the Ambulance Fee Schedule Conversion

We disagree with your clarification on the definition of SCT. Periodically, there is a need to transport patients from one facility to another, one or neither of which may be a hospital. There are numerous specialty care facilities such as skilled nursing facilities, sub-acute care facilities, and burn facilities that request transports of critical patients. These patients sometimes require SCT level of care. We utilize system resources to respond which are equipped and trained to provide SCT care. We believe it is reasonable, given the transports meet all other criteria, that the definition should include all origins or destinations. The Federal Register indicates that the basis for the clarification is that the Study of Financial Impact only included hospitals. We do not believe this is an appropriate basis for limiting origin/destination.

Specialty Care Transport

Specialty Care Transport

Prior to implementation of this rule, we would like to see a publication which gives each zip code, the current classification (ie, urban, rural, or super rural), and what it would be under the CBSAs. We have no idea on how this will impact our reimbursement and have a wide mix of urban, rural, and super rural service areas. Provision of this file will enable us to project the financial impact. Once this listing is published, we would like further time to comment on the proposed classifications and their appropriateness.

Submitter : Dr. Richard Aud
 Organization : University of Louisville
 Category : Physician

Date: 06/09/2006

Issue Areas/Comments

**CBSAs-Revised OMB Metropolitan
 Area Definitions**

CBSAs-Revised OMB Metropolitan Area Definitions

I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. BackgroundThe proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care. This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs. Residency Program Activities and Patient CareI firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner. In addition, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS's newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden. To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.