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JUN - 6 2006

DATE: May 28, 2006  
TO: CMS and HHS  
FROM: David Abrams, Esq.  
RE: **CMS 1317-P - Emergency Response and SCT**

Dear CMS and HHS:

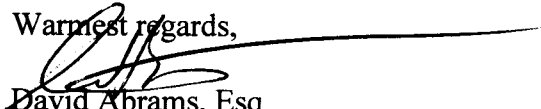
Enclosed are two objections to your proposed changes to defining EMERGENCY RESPONSE and SPECIALTY CARE TRANSPORT (SCT). When read together, it is hard to ignore the fact the private non-hospital based ambulance providers will be at a great disadvantage in recouping fees for services at the same level as other entities regarding emergent hospital to hospital services.

The EMERGENCY RESPONSE language only allows hospital based providers the approval for emergency response payments originating at a hospital while the SCT language will not allow paramedic level services to bill for anything other than ALS1 or ALS2, regardless of the needs or condition of the beneficiary.

The result of these two proposals, when read in tandem, limits non-hospital based approved payment only to the level of non-emergent ALS charges. The condition of the patient is totally disregarded and focus is wholly placed on who owns the ambulance or operates the service.

Please make sure the approved language includes the ability for private services to charge the same amount and be paid the same amount for hospital based emergent transports as those units owned and operated by a hospital system. The life of your beneficiaries depends on it.

Warmest regards,

  
David Abrams, Esq  
Member-Manager  
Family Medical Transport, LLC  
GA BAR 001454

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TO: CMS and HHS

FROM: David Abrams, Esq.  
Member Manager  
Family Medical Transport, LLC

RE: CMS 1317-P

SPECIALTY CARE TRANSPORTS

**Definition:** Highly skilled level-of care of a critically injured or ill patient during transfer from one hospital to another.

**Present Assumptions:** Payment is not based on patient condition, but rather on the level of crew qualifications. Presently the statute assumes a high level of care is synonymous with greater-than-paramedic level of training. The Statute also presumes a consistent national or regional level of paramedic abilities and neglects areas or states where some skills may be so blurred as to be non-existent. Medical control directives also vary from agency to agency and exigent circumstances sometimes dictate levels of care during transports.

**Assumptions not supported:** CMS has determined in all other circumstances that payment is not based on the level of the responding crew, but on the needs and condition of the patient. Merely having a paramedic respond on a 911 call does not give the ambulance company the right to bill ALS emergency when the condition of the patient did not warrant ALS treatment.

**Assumptions cause inconsistency:** SCT should be determined in the same manner as BLS and ALS by determining the needs of the patient in a given transport scenario. ALS2 exists for 911 units out of the hospitals in the arrest situation, but what about for the hospital-to-hospital cardiac arrest or post-arrest on multiple drips and vent support? The needs of the beneficiary should govern the coding classification for services rendered.

**Facts:** We are an ALS private ambulance service who runs cardiac arrest from ill-equipped hospitals to hospitals equipped with invasive cardiac catheter labs. This usually takes two crews and two paramedics with ventilators normally operated by RN's or RT's. Our paramedics are well versed in the Impact 750 Critical Care Ventilator. Also, we transport patients on many drips, sometimes needing up to five IV pump chambers to handle all the medications. 100% of our units are ALS equipped for the benefit of these beneficiaries.

**Disparate Impact:** Our service will be denied additional payment of a SCT payment for a transport that, in many other systems or states, would clearly be a well-defined SCT.

**Suggestion on proposed rule:** By qualifying certain automatic patient criteria or conditions for hospital-to-hospital transports, the disparate impact of this rule will be minimized. For instance, perhaps SCT could also include that:

*Any patient presently requiring external cardiac compressions, or whose present condition was preceded by a cessation or life-threatening cardiac compromise; or any patient presently requiring external respiratory assistance by mechanical ventilator; or any patient who is on three or more IV medication drips determined to be life-sustaining AND who is picked up at a Hospital and is transported to a Hospital.*

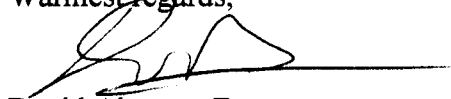
**Conclusion:** The present rule and proposed rule continue to look to the level of caregiver training, which is inconsistent with other methods of payment based on the condition and needs of the beneficiary. While many assumptions are made for SCT situations, many facts are disregarded. To minimize confusion and unfair impacts on ambulance providers "left behind" for the highest levels of transports, certain automatic patient conditions should statutorily be defined.

**Broad Spectrum Conclusion:** When the proposed changes to SCT transports and Emergency Response, one result is clear: the impact is to severely harm private ambulance services. First, the SCT rule states only greater-than-paramedic level crews may charge for SCT regardless of the patient condition, number of medics or resources required from a private service. Then the EMERGENCY RESPONSE proposal states that private services will be unable to charge for emergent calls coming from a hospital. When read together, a private service transporting a beneficiary of any condition, regardless of how emergent or how severe, will NEVER be able to charge anything more than ALS non-emergent.

The first rule kicks paramedic level services out of SCT billing and the second limits emergency response pays to hospital based ambulance providers only.

All in all - that is a very unfair and unwarranted result to the private sector.

Warmest regards,

A handwritten signature in black ink, appearing to read 'David Abrams', is written over a horizontal line.

David Abrams, Esq  
Member-Manager  
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