

May 1, 2009

## **Licensed and Certified Emergency and Non-Emergency Transporting Service Providers**

### **Re: Short-Form Rate Application Package for Requesting 2010 Rates**

This **Short-Form Rate Application Package** is to be used for requesting emergency and non-emergency service rates for 2010. All providers that received a 2009 Rate Schedule from the Office of Emergency Medical Services (OEMS), including those that have not yet begun to impose approved charges, must complete the 2010 Rate application, as detailed below.

Non-charging providers interested in obtaining approval to charge should contact me at the number below rather than complete the enclosed information that is meant for those services that have an OEMS Rate Schedule for 2009.

#### **The 2010 Rate Application package contains the following:**

- **Proposed Statewide Rate Schedule of Maximum Allowable Rates for 2010**
- **Waiver Form A**, to be signed by providers that accept the 2010 Statewide Rate Schedule. All providers that plan to continue charging in 2010, including those that have not yet begun to impose approved charges, must sign and return one of the enclosed Waiver forms.
- **Waiver Form B**, to be signed by providers requesting a rate increase to their 2009 rates that does not exceed the 4% CPI. The spreadsheet for each of the eligible providers also incorporates the 4% CPI increase to their 2009 rates. **Only providers that submitted either a Long Form or a Waiver B last year may submit a Waiver B in 2010.**
- **Certification Form**, which must to be completed, notarized and submitted with all Rate Applications
- **Instructions** for Preparing the Short-Form Rate Application for 2010
- Short-Form Rate Application Spreadsheet
- A Rate Application **Checklist**

#### **Changes to the 2010 Rate Schedule Include:**

1. The 2010 rates were calculated by applying a weight formula to the 2009 rates **plus the 4% CPI inflation** factor.

**If you wish to request more than the 4% CPI increase in 2010 for any of your approved 2009 rate categories, you must contact me for a 2010 Full Rate Application package.**

### **General Guidelines:**

- All providers are eligible to use the Statewide Rate Schedule for 2010, pursuant to CGS Section 19a-177(9)
- Providers may use the Short-Form Rate Application to request rates if they:
  - (1) accept all rates specified on the Schedule of Maximum Allowable Rates for 2010; or
  - (2) request increases to their currently approved 2009 maximum allowable rates that do not exceed ??????%.
- Providers submitting a Short Form rate application do not need to file financial statements pursuant to the reduced reporting requirements contained in Public Act 03-46 that was enacted in October 2003.
- **An electronic or hard copy of the Application must be received by the deadline specified below.**

### **Filing Requirements and Due Date:**

The Office of Emergency Medical Services (OEMS) must receive in Hartford by no later than **the close of business (4:30 p.m.) on August 14, 2009**, the following:

- Notarized Certification;
- Waiver form;
- Short-Form Rate Application Spreadsheet; and
- Rate Application Checklist form

### **Scope of OEMS Reviews**

Desk reviews will be performed on selected Short-Form Rate Applications.

Please contact me at the phone number below or at **sean.anderson@ct.gov** if you need a copy of the Full Rate Application or, if you have any questions. Thank you.

Sincerely,

Sean Anderson  
Health Program Associate  
Office of Emergency Medical Services  
(860) 509-7973

**SCHEDULE OF MAXIMUM ALLOWABLE RATES**

**EFFECTIVE**

**January 1, 2010 through December 31, 2010**

**PROPOSED RATE SCHEDULE FOR 2010**

**AMBULANCE SERVICE RATE SCHEDULE**

|   |            |
|---|------------|
| Basic Life Support (BLS) Rate                 | \$514.00   |
| Advanced Life Support Level 1 Non-ER          | \$518.00   |
| Advanced Life Support Level 1ER               | \$816.00   |
| Advanced Life Support Level 2                 | \$842.00   |
| Paramedic Intercept                           | \$580.00   |
| Basic Life Support (BLS) Helicopter Assist    | \$339.00   |
| Advanced Life Support (ALS) Helicopter Assist | \$526.00   |
| Specialty Care Transport                      | \$1,121.00 |

**ANCILLARY CHARGES**

|                          |          |
|--------------------------|----------|
| Waiting Time Charge      | \$138.00 |
| Per Mile Charge          | \$ 12.54 |
| Special Attendant Charge | \$102.00 |

**INVALID COACH RATE SCHEDULE**

|              |           |
|--------------|-----------|
| Base Rate    | \$ 89.00  |
| Two Patients | \$ 114.00 |

**ANCILLARY CHARGES**

|                         |          |
|-------------------------|----------|
| Per Mile Charge         | \$ 7.79  |
| Second Attendant Charge | \$ 51.00 |
| Waiting Time Charge     | \$ 77.00 |

All charges must be in conformance with the definitions on the subsequent pages entitled "Explanatory Notes On The Implementation of the 2010 Schedule of Maximum Allowable Rates," which are attached to, and become part of, this Rate Schedule.

Certified to be the maximum allowable rates by: \_\_\_\_\_

Date Certified: \_\_\_\_\_

## EXPLANATORY NOTES FOR THE IMPLEMENTATION OF THE 2010 SCHEDULE OF MAXIMUM ALLOWABLE RATES

**Not Applicable or “N/A”** – indicates that charges are not applicable in this category for the provider named on page one of this Schedule. Connecticut issues rates consistent with the provider’s certification/licensure level.

**Basic Life Support** – means transportation by ground ambulance vehicle and supplies and services, plus the provision of BLS ambulance services. 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).

An emergency response by a certified or licensed ambulance provider, when no transportation is provided due to the fact that the patient is pronounced/presumed dead by an individual authorized by the State to make such pronouncement/presumption after the ambulance is called. **No ancillary fees, including mileage, may be added to this rate for patients that are pronounced dead.**

The ambulance service and personnel must comply with all relevant CT General Statutes and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements specified, and cited, in DPH Regulations Section 19a-179-10 (b) “Basic Ambulance Service.” Basic life support level services are those performed by personnel certified in Connecticut as Emergency Medical Technicians (EMT).

**Advanced Life Support Level 1 Non-Emergency (ALS Non-ER)** – the maximum charge, in addition to applicable ancillary fees, that may be assessed a patient who is transported in a ground ambulance vehicle by a **licensed** provider for the purposes of receiving, **non-emergency, ambulance services at the Advanced Life Support Level 1**. The ambulance service and personnel must comply with all relevant CT General Statutes and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements specified, and cited, in DPH Regulations Section 19a-179-10 (c) “Mobile Intensive Care-Intermediate Level (MIC-I) Service.” Advanced Life Support Level 1 services are those performed by personnel certified in Connecticut as an Emergency Medical Technician -Intermediate (EMT-I) or Paramedic.

Non-emergency ALS services may include, but are not limited to the following:

1. Inter-facility transport to/from a hospital, skilled nursing facility or the patient’s home; and/or,
2. Round trip transportation to a hospital or non-hospital based out patient facility to obtain necessary diagnostic and/or therapeutic services such as a CT scan, radiation therapy or dialysis for renal disease.

## **EXPLANATORY NOTES FOR THE IMPLEMENTATION OF THE 2010 SCHEDULE OF MAXIMUM ALLOWABLE RATES**

**Advanced Life Support Level 1, Emergency (ALS 1, ER)** – means transportation by ground ambulance vehicle, supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention, in compliance with the CGS and DPH Regulations, **in the context of an emergency response to a 911 call or equivalent.** An emergency response is defined as responding immediately at the ALS 1 level of service to a 911 call or equivalent. An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support Level 1 (ALS 1) services include an assessment by ALS personnel or the provision of at least one ALS intervention. An ALS assessment is 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 to determine whether ALS interventions were needed, or may be needed, during transport. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service, or that ALS personnel accompany the patient during transport. It is incumbent on the ALS Service to verify that the call was dispatched as an ALS call according to Emergency Medical Dispatch (EMD) protocols pursuant to Public Act 00-151. **The transporting BLS service is entitled to the BLS Rate in the ALS Assessment billing process.**

An ALS provider is defined as a provider whose staff includes an individual trained and authorized at the EMT-Intermediate or Paramedic level. An ALS assessment charge is only relevant and reimbursable in an emergency response. The ALS 1 category replaced the Intermediate Surcharge definition used for the 2003 Rate Schedule.

**Advanced Life Support Level 2 (ALS 2)** – means either transportation by ground ambulance vehicle, 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.

ALS 2 services are those performed by personnel licensed in Connecticut as Paramedics pursuant to the provisions in CGS Section 20-206jj - 206nn. The ambulance service and personnel must comply with all other relevant CT General Statutes and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements specified, and cited, in DPH Regulations Section 19a-179-10, (d) "Mobile Intensive Care-Paramedic Level (MIC-P)."

**Paramedic Intercept** – means EMT-Paramedic services furnished by an entity that does not furnish the ground ambulance transport. The provider must be able to document that:

1. Paramedic/ALS services were provided in accordance with medical direction and control.
2. The paramedic accompanied the patient to the hospital in the patient transport vehicle

## **EXPLANATORY NOTES ON THE IMPLEMENTATION OF THE 2010 SCHEDULE OF MAXIMUM ALLOWABLE RATES**

**BLS Helicopter Assist** – Indicates the maximum charge that may be assessed a patient, including applicable ancillary fees, for a Basic Life Support Ambulance Service providing care at the scene to such patient when such patient is ultimately transported by a state certified or licensed air ambulance.

**ALS Helicopter Assist** - Indicates the maximum charge that may be assessed a patient, including applicable ancillary fees, for an Advanced Life Support Service providing care at the scene to such patient when such patient is ultimately transported by a state certified or licensed air ambulance.

**Specialty Care Transport (SCT)** - means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including 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.

To assess the SCT charge a provider must be authorized at the paramedic level and must provide such care in accordance with medical direction and/or authorized protocols and applicable Connecticut statutes and DPH Regulations, including, but not limited to, those specified above in ALS 2.

**Waiting Time Charge** –may be assessed, in addition to the applicable ground ambulance transport charge, on the basis of a minimum wait of one hour. When waiting time exceeds one hour, additional time shall be charged in quarter hour increments.

**Per Mile Charge** – may be assessed, in addition to the applicable ambulance transport charge, from the point of origin to the point where the patient is transported. Mileage reimbursement shall be based on the number of actual miles the patient is transported.

**Special Attendant Charge**– may be assessed, in addition to the applicable ambulance transport charge, for the use of attendants with characteristics specifically requested by or on behalf of the patient. Such special characteristics include, but are not limited to, special training or experience or an attendant of a specific gender. There shall be no additional charge if an attendant with the requested characteristics has already been scheduled by the provider.

**Bundle Billing** – It is permissible for a BLS ambulance service to bill for ALS assessment and interventions provided that the ALS care is rendered by an EMS service, authorized at the paramedic level, which has entered into a bundle billing agreement with the BLS service that submits the bill.

## WAIVER A FOR 2010 RATES

As the Chief Executive Officer of the licensed or certified service provider identified below, I am aware of the right to a hearing regarding the annual establishment of maximum allowable rates for emergency or non-emergency services pursuant to Section 19a-179-21 (h) (1) (A) of the Regulations of Connecticut State Agencies.

I willingly waive the right to such hearing regarding the establishment of maximum allowable rates for these services for the calendar year beginning January 1, 2010 through December 31, 2010 pursuant to Section 19a-179-21 (h) (1) (B) of the Regulations of Connecticut State Agencies.

**I hereby accept the applicable maximum allowable rates for emergency or non-emergency services contained in the Statewide Rate Schedule for 2010**, which have been approved by the Commissioner of the Department of Public Health to be effective for the calendar year January 1, 2010 through December 31, 2010.

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Name of Licensed or Certified Service Provider

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Name and Title of Chief Executive Officer

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Signature of Chief Executive Officer

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Business Phone Number

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Date

## **WAIVER B FOR 2010 RATES**

As the Chief Executive Officer of the licensed or certified service provider identified below, I am aware of the right to a hearing regarding the annual establishment of maximum allowable rates for emergency or non-emergency services pursuant to Section 19a-179-21 (h) (1) (A) of the Regulations of Connecticut State Agencies.

I willingly waive the right to such hearing regarding the establishment of maximum allowable rates for these services for the calendar year beginning January 1, 2010 through December 31, 2010 pursuant to Section 19a-179-21 (h) (1) (B) of the Regulations of Connecticut State Agencies.

I hereby declare that the licensed or certified service provider identified below, for the calendar year January 1, 2010 through December 31, 2010, will not increase its maximum allowable rates for emergency and non-emergency services more than 4% from its currently approved schedule of maximum allowable rates, as noted in the attached rate application form.

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Name of Licensed or Certified Service Provider

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Name and Title of Chief Executive Officer

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Signature of Chief Executive Officer

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Date

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Business Phone Number

**CERTIFICATION  
TO BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC**

**2009 Application for 2010 Schedule of Rates**

STATEMENT: I solemnly swear that the statements and information contained in this Rate Application for 2010 rates, including the Rate Model, financial statements and all supporting schedules and documentation, are to the best of my knowledge and belief, true and accurate, and that only business expenses related to regulated ambulances and/or invalid coaches are included in the financial and statistical data submitted.

\_\_\_\_\_  
Printed Name of Service Provider

\_\_\_\_\_  
License or Certification Number

\_\_\_\_\_  
Address of Service Provider

\_\_\_\_\_  
Printed Name and Title of Chief Executive Officer

\_\_\_\_\_  
Signature of Chief Executive Officer

\_\_\_\_\_  
Business Telephone Number

\_\_\_\_\_  
Business E-mail address

Subscribed and sworn to me on \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Notary Public / Commissioner of Superior Court

\_\_\_\_\_  
Signature of Notary Public / Commissioner of Superior Court

**All service providers that charge for services rendered must sign and submit this Certification with their completed Rate Application to the Office of Emergency Medical Services no later than close of business (4:30 p.m.) on August 14, 2009.** The Rate Application shall be deemed incomplete unless ALL required information including this Certification form and any applicable Waiver form are completed and submitted to OEMS.

**Department of Public Health**  
**Instructions for Preparing the Short-Form Rate Application**

1. **SUBMISSION DUE DATE** – Ensure that your **Short-Form Rate application, Waiver Form,** and notarized **Certification,** are physically received by the Office of Emergency Medical Services in Hartford by **no later than the close of business (4:30 p.m.) on August 14, 2009.**
2. **SERVICE INFORMATION** – Provide the name, address and fiscal year of the service provider as well as the name, title, telephone number and e-mail address of the contact person responsible for completing the rate application.
3. **2009 REVENUE INFORMATION** – Line 18 of the spreadsheet (**Total Revenue**) is the only information required for this section. The additional fields are voluntary.
4. **2009 EXPENSE INFORMATION** – Line 41 of the spreadsheet (**Total Expenses**) is the only information required for this section. The additional fields are voluntary.
5. **BASE CALL VOLUME** – Line 66 of the spreadsheet (**Total Ambulance Base Calls**) is the only information required for this section. The additional fields are voluntary.
6. **CANCELLED AMBULANCE BASE CALLS** – Provide the number of cancelled base calls.
7. **2009 REQUESTED RATES** – Indicate “Yes” if you are requesting the Statewide Rate Schedule for 2009. Indicate “Yes” in cell C72 if you are requesting an increase in your currently approved maximum allowable rates that does not exceed 4% as calculated and presented on the spreadsheet for those providers that submitted a Waiver B form last year.

## 2010 Short-Form Rate Application Checklist

Provider: \_\_\_\_\_

**Ensure the following items are included in your rate application submission.**

**Return the signed, completed Checklist with your rate application submission:**

### 2010 Short-Form Rate Application

1. Completed spreadsheet

### Certification Form

2. Certification form signed by the Chief Executive Officer and notarized

### Waiver Form

3. Waiver Form signed by the Chief Executive Officer

• Waiver A – accept Statewide Rate Schedule, or

• Waiver B – request rate increases not exceeding 4%

\_\_\_\_\_  
Name and Title of Preparer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Preparer

\_\_\_\_\_  
Phone Number of Preparer

\_\_\_\_\_  
Email Address of Preparer