

National Emergency Medical Services Advisory Council
Interim
Advisory and Recommendations

**Title: Establishing EMS Physician Practice Reimbursement Models for Improved Patient
Care and EMS Physician Oversight**

As prepared by the Subcommittee on **Sustainability & Efficiency**

A. Executive Summary

Emergency Medical Services (EMS) has provided a critical and essential healthcare service to their communities for several decades. The expansion and further development of all aspects of clinical care provided are under the responsibility and authority of the EMS system’s physician medical director. While it is considered a requirement for an EMS agency to have a medical director, the level of active engagement and involvement by the medical director is highly variable, and often directly correlated to the quality of care provided to patients.

Currently, EMS medical directors’ compensation models are widely variable, ranging from volunteer to employee to independent contractor, and from a few hours per month to full-time hours. While they do provide a valuable and necessary patient care service to the EMS agency, the EMS practitioners, and the patients within the service area, there is no current model to directly reimburse EMS physicians or the EMS agencies themselves for the indirect patient care performed by the EMS physician. Although physician-led, the majority of care is delegated through evidence-based clinical guidelines, training, education, credentialing, and oversight of EMS clinicians, and often with online medical control provided in real-time. Occasionally, in many EMS systems across the United States, the EMS physician also performs direct patient care in the out-of-hospital setting, ranging from life-saving interventions to assisting with chronic disease management and patient navigation.

As many EMS agencies have been struggling financially over the past few years, with reimbursements struggling to keep up with rising operational costs, they cannot afford to have a higher quality or time commitment for EMS physician oversight to assist with improved patient care and outcomes. If a model existed for the EMS agency and/or the EMS physician to submit claims and receive reimbursements for the direct and indirect patient care provided, the quality of care would presumably increase, as would the bottom line of the EMS agency. Simply put, it is a long overdue potential source of additional revenue for an EMS agency. In our current financial model, EMS physicians are a line-item expense for EMS agencies with no potential for financial recuperation or revenue generation, and EMS agencies cannot capitalize on the investment that the EMS physician provides to the EMS agency and patient care. Those EMS agencies that cannot afford such an expense to obtain quality oversight often experience

43 disparities in the care they can provide to their community.

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45 As EMS has been widely recognized as a subspecialty of medicine since 2010 (American
46 College of Emergency Physicians, 2010), many physicians who have dedicated themselves to
47 mastering this subspecialty have found it to be financially unfeasible as anything other than a
48 part-time side job, often having limited financial support or incentive to positively impact
49 patient care and outcomes and improved overall community health.

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51 In summary, many EMS agencies cannot afford to pay for high-quality EMS physician
52 oversight, and EMS physicians cannot be expected to work for free or extremely limited wages
53 to perform valuable direct or indirect patient care to an entire community and provide medical
54 oversight to their system of EMS practitioners.

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56 This Advisory will explore the underlying causes and further define this problem, discuss how
57 it negatively impacts patients and systems of care, and offer recommendations to the appropriate
58 target audiences who retain statutory authority to resolve this dilemma.

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60 **B. Recommendations**

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62 **Federal Interagency Committee on Emergency Medical Services**

63 NEMSAC recommendations for consideration to FICEMS via NHTSA

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65 **Recommendation 1:**

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- 67 • Via FICEMS member Centers for Medicare and Medicaid Services (CMS), further
68 explore and utilize the taxonomy code 207PE0004X (Emergency Medical Services) for
69 utilization by EMS physician medical directors, including the provision of guidance on
70 best practices for use of this taxonomy code and tying it to both a provider's and EMS
71 agency's NPI number to enable EMS agencies to submit claims on behalf of the EMS
72 physician. Given that EMS is rarely a primary specialty for EMS physicians, the EMS
73 taxonomy code is often used as a secondary taxonomy code, if at all. This can negatively
74 impact the ability to submit and be reimbursed for claims of services provided by an
75 EMS physician who is often using an alternative taxonomy code (i.e. Emergency
76 Medicine) for their primary specialty.

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78 **Recommendation 2:**

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- 80 • Via FICEMS member CMS, establish new mechanisms for reimbursing federally
81 recognized EMS physicians and EMS Advanced Practice Practitioners for the
82 unscheduled emergent or urgent direct patient care provided in the prehospital or out-of-
83 hospital setting, including allowed use of Evaluation and Management (E&M) Codes
84 and Current Procedural Terminology (CPT) Codes.

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Recommendation 3:

- Via FICEMS member CMS, establish new mechanisms for reimbursing federally recognized EMS physicians and EMS Advanced Practice Practitioners for the unscheduled emergent or urgent indirect patient care provided in the prehospital or out-of-hospital setting, including but not limited to online medical control and telemedicine services, regardless of whether the patient was transported to a receiving facility.

Recommendation 4:

- Via FICEMS member Health Resources and Services Administration (HRSA), via the Federal Office of Rural Health Policy (FORHP), explore opportunities to establish funding mechanisms for reimbursement of EMS physicians who provide unscheduled emergent or urgent care, directly or indirectly, through telehealth services specifically to rural, underserved regions as a mechanism to increase health equity and encourage more broad oversight support for the EMS agencies who serve those regions. It should be noted that although this recommendation is specifically for underserved regions within rural areas, there are a large number of underserved regions within urban and suburban areas as well, defined as “urban deserts.” HRSA may provide additional recommendations for funding mechanisms to support these urban and suburban deserts as well.

Recommendation 5:

- Via FICEMS member HRSA, explore opportunities to establish funding mechanisms for reimbursement of EMS physicians who provide unscheduled emergent or urgent care, directly or indirectly, specifically to underserved populations, such as pediatrics (i.e. EMSC Innovation and Improvement Center), maternal care (i.e. Maternal and Child Health Bureau), and racial and ethnic minorities (i.e. Office of Health Equity and Office of Civil Rights, Diversity, and Inclusion).

Recommendation 6:

- Via FICEMS member Office of the Assistant Secretary for Preparedness and Response (ASPR), explore opportunities to establish funding mechanisms for reimbursement of EMS physicians who provide unscheduled emergent or urgent care, directly or indirectly, as a function of improving overall public health and community health.

Recommendation 7:

- Via FICEMS member CMS and other relevant federal and non-federal partners (including Centers for Medicare and Medicaid Improvement), consider expanding the expired 1135 waiver from the COVID-19 pandemic to a permanent option regarding

129 audio-only telehealth services as a function of telephone-based “online” EMS physician
130 medical control calls for emergent patient care (Centers for Medicare and Medicaid
131 Services, 2021). Traditionally, outside the waiver, telehealth calls require audio and
132 video communication for reimbursement. There has also been language regarding the
133 need for a previously established patient-physician relationship. Neither of these
134 requirements are feasible in the setting of emergent or urgent patient care provided in
135 the prehospital or out-of-hospital setting, especially in rural areas. Additionally, the
136 expansion of audio-only telehealth visits from EMS physicians must include new options
137 under the Healthcare Common Procedure Coding System (HCPCS) for telehealth
138 encounters commensurate with this interaction (Centers for Medicare and Medicaid
139 Services, 2023).

141 C. Scope and Definition

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143 The mantra of “if you’ve seen one EMS system, you’ve seen one EMS system” also holds true
144 regarding the multitude of various employment models for EMS physicians. However, the
145 discussion of the various models and their benefits, pros, and cons of each is beyond the scope
146 of this Advisory. Additionally, this Advisory is not seeking to increase the funding directly to
147 the EMS physician, unless the EMS agency and EMS physician choose to set up that model.
148 Instead, it is intended that the majority of EMS agencies would bill and collect on behalf of the
149 EMS physician. Therefore, this Advisory seeks to highlight and describe the benefit of
150 developing mechanisms for an alternative and additional revenue source for EMS agencies
151 which can in turn result in improved overall EMS physician engagement, leading to better
152 clinical oversight, and therefore likely improved patient outcomes and EMS clinician
153 satisfaction.

154
155 EMS is the practice of medicine and as such, any of the activities that constitute EMS require
156 oversight by a physician (National Association of State EMS Officials, 2012). EMS has
157 formally been considered a subspecialty of medicine since 2010, housed within the American
158 Board of Emergency Medicine, with the first board certification offered to qualified physicians
159 in 2013 (American Board of Emergency Medicine, n.d.). As of June 30, 2024, there are 1,151
160 board-certified EMS physicians under the American Board of Emergency Medicine (American
161 Board of Emergency Medicine, n.d.).

162
163 While board certification in EMS is considered the gold standard for establishing competency,
164 it is certainly not a requirement for the role of an EMS physician medical director in the vast
165 majority of EMS systems in the United States. While the exact breakdown is unknown, the
166 majority of physicians who serve as EMS Medical Directors most likely work full-time roles
167 as Emergency Medicine physicians, with others as Family Medicine, Internal Medicine,
168 Surgery, Pediatrics, etc. The role of a full-time EMS Medical Director is rare and usually
169 reserved for extremely busy, highly populated, well-resourced urban EMS systems, with broad
170 tax base and municipal support.

171

172 EMS agencies and systems are required to have a Medical Director who will oversee all
173 clinical aspects, including but not limited to dispatch, development of evidence-based
174 treatment protocols and guidelines, medication formulary, initial and continuing education,
175 credentialing, and quality management. Additionally, the EMS physician will usually serve
176 as a liaison between their agency and healthcare facilities for collaboration to improve systems
177 of care, system efficiency, and overall patient care and outcomes for the community. As the
178 workload can vary depending on the size of the agency, factoring in the number of licensed
179 EMS clinicians, run volume, and complexity of the system, the hours requirement for
180 satisfactory performance by the EMS physician can also vary.

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182 **D. Analysis**

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184 When a physician is employed or contracted to work within a hospital or clinic setting, the
185 facility under which they work often bills on behalf of that physician and the services
186 performed directly or indirectly by that physician, including supervision of delegated practice
187 to other licensed and credentialed healthcare professionals (i.e. Advanced Practice Providers,
188 Certified Registered Nurses Anesthetists, etc). In return, the physician is paid wages on either
189 an hourly or salary basis, sometimes with additional incentive packages based on clinical
190 productivity, etc.

191

192 Physicians who serve as EMS Medical Directors are usually employed by a healthcare facility
193 as their full-time employment and serve part-time as an EMS Medical Director to support their
194 local EMS agency and community. Occasionally, the EMS agency contracts directly with the
195 healthcare facility to purchase the EMS physician's time, and therefore the time owed by the
196 physician is shared and split between the facility and the EMS agency. However, this is just
197 one of many various employment models. Most other models require the EMS physician to
198 spend additional time with their EMS agency, beyond their primary clinical obligations, rather
199 than replace their clinical obligations.

200

201 Currently, regardless of the employment model, the wages paid by an EMS agency to support
202 the EMS physician are often considered a line-item budget expense with no opportunity for
203 financial recovery of that expense. In short, it is the same as purchasing fuel for the
204 ambulances, or office supplies for business operations. The EMS physician, although
205 performing patient care duties and activities, is currently unable to generate revenue for the
206 EMS agency or agencies they serve.

207

208 As a result, EMS agencies that do not possess the financial resources to have such a budget
209 expenditure are often obligated, and rightfully so, to spend their resources on the continued
210 operations of the EMS agency. EMS agencies that fall into this category are often those in
211 lower-resourced, underserved, rural communities. Thus, the communities that most need the
212 support of a qualified EMS physician to oversee competent clinical care and all other clinical
213 aspects of an EMS operation are the ones that cannot afford such a resource.

214

215 By utilizing the recommendations above, it is believed that an EMS agency would be able to
216 bill CMS and other payers on behalf of the services provided by the EMS physician. This
217 would include, but not limited to:

- 218
- 219 • Direct patient care provided in the field on an emergent or urgent basis
 - 220 • Direct patient care provided in the field as part of an alternative treatment or transport
221 model
 - 222 • Unscheduled indirect patient care provided remotely through telephone-based, audio-
223 only, calls from field EMS clinicians for medical direction (i.e. “online medical control”) and support while engaged in emergent or urgent patient care
 - 224 • Unscheduled indirect patient care provided remotely through telehealth channels as
225 part of an alternative treatment or transport model
 - 226 • Scheduled indirect patient care provided through delegated and credentialed EMS
227 clinicians operating under medical treatment guidelines and protocols to manage
228 homebound patients with chronic diseases as part of a formal community paramedic or
229 mobile integrated health program, reviewed and signed off by the EMS physician
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232 Once the mechanisms are in place for the submission of reimbursement of claims, further
233 discussions would be required for credentialing of EMS physicians with individual payers to
234 avoid “out of network” fees for the patient whenever possible. Similar to the employment
235 model of physicians within hospitals and other healthcare facilities, an EMS agency, and thus
236 their licensed EMS clinicians, are credentialed and considered “in-network” with multiple
237 payers and it would be expected that the EMS physician would similarly be included in that
238 credentialing bundle. However, in the event the patient is “out of network” or uninsured, the
239 claims would be made on behalf of the EMS physician similarly to how the EMS agency
240 currently bills their patients for services rendered.

241

242 **E. Strategic Vision**

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244 It is the vision of the NEMSAC that the above recommendations, once implemented, would
245 allow EMS agencies to have an additional funding revenue source to improve their overall
246 clinical operations and provide financial support for one or more highly qualified and engaged
247 EMS physicians within their agency. Additionally, it is believed that this would result in
248 improved patient care and outcomes, improved systems of care for the community, improved
249 community preparedness and response capabilities (due to having a higher level of care
250 available in the field), improved evidence-based clinical protocols or guidelines, better clinical
251 oversight of all patient care due to more quality management activities, and could possibly
252 result in improved alternative treatment and destination options which would help to decrease
253 unnecessary emergency department visits.

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255 **F. Crosswalk With Previous Advisories**

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257 The recommendations and vision outlined in this Advisory are crosswalked from multiple

258 previous advisories, including:

- 259
- 260 • Biennial State of EMS System Financing (National EMS Advisory Council, 2023)
 - 261 • Ensuring Optimal Emergency Response via a Fully Integrated 911 and Emergency
 - 262 Medical Dispatch System (National EMS Advisory Council, 2023)
 - 263 • Strengthening Emergency Medical Services (EMS) and Hospital Relationships to
 - 264 Improve Efficiencies and Positively Impact Patient Outcomes (National EMS
 - 265 Advisory Council, 2022)
 - 266 • EMS Star of Rights (National EMS Advisory Council, 2022)
 - 267 • Telehealth as a Strategy for EMS Care, where the audio-only telehealth
 - 268 recommendation was made to support rural communities in 2020 (National EMS
 - 269 Advisory Council, 2020)
 - 270 • EMS System Performance-Based Funding and Reimbursement Model, published
 - 271 initially in 2012, then revised and updated in 2016 and again in 2019 (National EMS
 - 272 Advisory Council, 2019)
 - 273

274 G. Strategic Goals

- 275
- 276 • Within one year of the publication of this Advisory, CMS will provide written guidance
 - 277 to EMS physicians on best practices for utilization of the EMS physician taxonomy code
 - 278 as a secondary taxonomy code and how an EMS agency should utilize the assigned NPI
 - 279 numbers for both the agency and provider to submit claims for reimbursement on behalf
 - 280 of the EMS physician.
 - 281
 - 282 • Within one year of the publication of this Advisory, CMS will publish a plan with a
 - 283 timeline on the ability to submit claims and be reimbursed for direct patient care
 - 284 provided in the prehospital and out-of-hospital setting by EMS physicians and/or EMS
 - 285 Advanced Practice Providers.
 - 286
 - 287 • Within two years of the publication of this Advisory, CMS will publish a plan with a
 - 288 timeline on the ability to submit claims and be reimbursed for indirect patient care
 - 289 provided via audio-only online medical control or telehealth consultation by EMS
 - 290 physicians and/or EMS Advanced Practice Providers.
 - 291
 - 292 • Within one year of the publication of this Advisory, HRSA will publish a plan with a
 - 293 timeline to establish funding mechanisms for reimbursement for EMS physicians who
 - 294 provide unscheduled emergent or urgent care, directly or indirectly, to underserved
 - 295 regions and underserved populations.
 - 296
 - 297 • Within one year of the publication of this Advisory, ASPR will publish a plan with a
 - 298 timeline to establish funding mechanisms for reimbursement for EMS physicians who
 - 299 provide unscheduled emergent or urgent care, directly or indirectly, as a function of
 - 300 improving overall public health and community health.

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- Within one year of the publication of this Advisory, the DHHS designee (i.e. CMS, etc) will publish guidance on the use of audio-only telehealth services and consultation by the EMS physician, including the ability to submit claims and be reimbursed, as well as updated clarification on the requirement for a previously established patient-physician relationship which will be lacking in these EMS encounters.

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308 H. References

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310 American Board of Emergency Medicine. (n.d.). Retrieved August 2024, from Emergency Medical
311 Services: [https://www.abem.org/public/become-certified/subspecialties/emergency-](https://www.abem.org/public/become-certified/subspecialties/emergency-medical-services)
312 [medical-services](https://www.abem.org/public/become-certified/subspecialties/emergency-medical-services)

313 American Board of Emergency Medicine. (n.d.). Retrieved August 2024, from Exam Certification
314 and Statistics: [https://www.abem.org/public/resources/exam-certification-](https://www.abem.org/public/resources/exam-certification-statistics#:~:text=A%20total%20of%2046%2C421%20physicians,as%20of%20June%2030%2C%202024.)
315 [statistics#:~:text=A%20total%20of%2046%2C421%20physicians,as%20of%20June%2030](https://www.abem.org/public/resources/exam-certification-statistics#:~:text=A%20total%20of%2046%2C421%20physicians,as%20of%20June%2030%2C%202024.)
316 [%2C%202024.](https://www.abem.org/public/resources/exam-certification-statistics#:~:text=A%20total%20of%2046%2C421%20physicians,as%20of%20June%2030%2C%202024.)

317 American College of Emergency Physicians. (2010, November 1). Retrieved from EMS the
318 Newest Subspecialty of Emergency Medicine: [https://www.acepnow.com/article/ems-](https://www.acepnow.com/article/ems-newest-subspecialty-emergency-medicine/)
319 [newest-subspecialty-emergency-medicine/](https://www.acepnow.com/article/ems-newest-subspecialty-emergency-medicine/)

320 Centers for Medicare and Medicaid Services. (2021, May 24). Retrieved from COVID-19
321 Emergency Declaration Blanket Waivers for Health Care Providers:
322 [https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-](https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)
323 [waivers.pdf](https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)

324 Centers for Medicare and Medicaid Services. (2023, November 13). Retrieved from CMS List of
325 Telehealth Services: <https://www.cms.gov/medicare/coverage/telehealth/list-services>

326 National Association of State EMS Officials. (2012, September 26). Retrieved from The Definition
327 of EMS: <https://nasemso.org/wp-content/uploads/Definition-of-EMS-2012.pdf>

328 National EMS Advisory Council. (2019, September 1). Retrieved from EMS System Performance-
329 Based Funding and Reimbursement Model:
330 [https://www.ems.gov/assets/NEMSAC_Advisory_EMS_System_Funding_Reimbursement](https://www.ems.gov/assets/NEMSAC_Advisory_EMS_System_Funding_Reimbursement_Sep_2019.pdf)
331 [_Sep_2019.pdf](https://www.ems.gov/assets/NEMSAC_Advisory_EMS_System_Funding_Reimbursement_Sep_2019.pdf)

332 National EMS Advisory Council. (2020, August 19). Retrieved from Telehealth as a Strategy for
333 EMS Care:
334 https://www.ems.gov/assets/Telehealth_as_a_Strategy_for_EMS_Care_Aug_2020.pdf

335 National EMS Advisory Council. (2022, November 3). Retrieved from Strengthening Emergency
336 Medical Services (EMS) and Hospital Relationships to Improve Efficiencies and Positively
337 Impact Patient Outcomes: [https://www.ems.gov/assets/FINAL---\[ai\]---Strengthening-EMS-](https://www.ems.gov/assets/FINAL---[ai]---Strengthening-EMS-&-Hospital-Relationships-to-Improve-Efficiencies-and-Impacts-to-Patient-Outcomes---2022NOV03.pdf)
338 [&-Hospital-Relationships-to-Improve-Efficiencies-and-Impacts-to-Patient-Outcomes---](https://www.ems.gov/assets/FINAL---[ai]---Strengthening-EMS-&-Hospital-Relationships-to-Improve-Efficiencies-and-Impacts-to-Patient-Outcomes---2022NOV03.pdf)
339 [2022NOV03.pdf](https://www.ems.gov/assets/FINAL---[ai]---Strengthening-EMS-&-Hospital-Relationships-to-Improve-Efficiencies-and-Impacts-to-Patient-Outcomes---2022NOV03.pdf)

340 National EMS Advisory Council. (2022, November 3). Retrieved from EMS Star of Rights:
341 [https://www.ems.gov/assets/FINAL---\[se\]---EMS-Star-of-Rights---2022NOV03.pdf](https://www.ems.gov/assets/FINAL---[se]---EMS-Star-of-Rights---2022NOV03.pdf)

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- 342 National EMS Advisory Council. (2023, November 16). Retrieved from Biennial State of EMS
343 System Financing: [https://www.ems.gov/assets/FINAL----\[se\]---2023-Biennial-State-of-](https://www.ems.gov/assets/FINAL----[se]---2023-Biennial-State-of-)
344 [EMS-Systems-Funding----2023NOV16.pdf](https://www.ems.gov/assets/FINAL----[se]---2023-Biennial-State-of-EMS-Systems-Funding----2023NOV16.pdf)
345 National EMS Advisory Council. (2023, August 10). Retrieved from Ensuring Optimal Emergency
346 Response via a Fully Integrated 911 and Emergency Medical Dispatch System:
347 [https://www.ems.gov/assets/FINAL---\[pe\]---Ensuring-Optimal-Response...EMD---](https://www.ems.gov/assets/FINAL---[pe]---Ensuring-Optimal-Response...EMD---)
348 [2023AUG10-\(1\).pdf](https://www.ems.gov/assets/FINAL---[pe]---Ensuring-Optimal-Response...EMD---2023AUG10-(1).pdf)
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