NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES
OPERATIONS UNIT

TO: Mr. Chairman and the Systems Committee

FROM: Dana Jonas

DATE: March 30, 2011

SUBJECT: Operations Report

This represents a summary of activities the Operations Unit has been involved with since your last meeting. As you read through this report, please feel free to ask questions.

The Department has been extremely busy handling CON transactions for regional councils and responding to requests for Fitness & Competency Reviews (F&C’s). Including several in process applications and those listed below the Department has handled some 20 CON requests since last SEMSCO. With shortages of funding, staffing, physical resources and support personnel, it is important that regions schedule CON actions to allow sufficient time for the handling of F&C’s and other CON support functions. When your council deems a CON application to be complete it must make written notice and provide certain documents to the Department within 5 business days. The Department would like to remind all regional councils that F&C filing is required of all regular CON actions.

- **Appeals to Article 30 actions** – In addition to the appeal before Systems today, the following REMSCO determinations are being reviewed by the Bureau of Adjudication. Also, the City of Utica appeal is still in court with no outcome yet.
  - Bridgewater Fire Company, Inc. (Expansion of Operating Territory)
  - City of Oneonta Ambulance (Expansion of Operating Territory)

- **Municipal CON Declarations** – The following municipal entities have filed under PHL 3008(7)(a)
  - Bainbridge Fire District (ambulance)
  - Town of New Berlin
  - Town of Corinth
  - Village of Corinth

- **Municipal conversions to permanent status (rollovers) completed or in process now**
  - City of White Plains (Police Dept Tactical ALSFR)
  - City of Watervliet (FD Ambulance)
  - Albany County (Sheriff’s Dept Ambulance)

- **New CON authorities approved (non-muni declarations)**
  - Fly Creek Volunteer Fire Company (Ambulance)

- **Transfers of Operating Authority completed or in process**
  - Rensselaer Falls Fire & Rescue to Rensselaer Falls Volunteer Rescue Squad, Inc.
  - Philmont Rescue Squad, Inc. to Greenport Rescue Squad, Inc.
  - Lebanon Valley Protective Association, Inc. to Chatham Rescue Squad, Inc.
  - Navarino Fire Department to Marcellus Ambulance Voluntary Emergency Services, Inc.
  - Theresa, Antwerp & Phildelphia FD’s merger to Indian River Ambulance Service, Inc.
  - Alexander Fire Company to Alexander EMS, Inc.
  - Oakfield Fire Dept. Inc. to Oakfield Ambulance Service, Inc.
  - Ripley Hose Company to Ripley Fire District
  - Houghton VFD to Houghton Volunteer Ambulance Service, Inc.
• Expansions of Operating Territory (REMSCO CON Actions) –
  • Cambridge Valley Rescue Squad – EOT denied

• COTs (Clarification of Operating Authority) – The following councils conducted territory descriptor rewording actions. The Department continues to work on a policy that provides specific guidance to councils on this process.
  • Adirondack Appalachian REMSCO
  • Hudson Mohawk REMSCO

• Medicaid & Medicare related news – At the October 2010 SEMSCO, we promised to provide updates to whatever was learned about the unique county wide municipally declared ambulance service implemented by Columbia County. OHIP (NYS Medicaid) worked with the county to clarify guidelines and rules that permitted the contracted ambulance services, holding their own NPI#’s, to seek payment for services rendered as a contractor to the County that is the A30 PHL CON holder county wide. Attached to this staff report is new information provided by CMS when asked if a “license holder” (CON holder) must have an NPI# issued to it, under which payments are sought, in instances where a 3rd party ambulance entity is contracted to deliver the actual services rendered. The short answer appears to be “yes”.

Also related to billing / fees for services, see the memorandum from one of the major 3rd party billing / service bureaus clarifying the need to document “fractional mileage”. We’ve received questions from providers asking if there is any “operational impact” if PCR forms are used such that the last digit in the 6 boxes used for Mileage is documented in tenths of a mile. The answer is absolutely no impact, so feel free to have your provider agencies use the last box for tenths of a mile. Note that the incoming NEMSIS data set allows for fractional mileage reporting.

And lastly in the billing / fees for services and contracting arena, the Office of Health Insurance Programs (OHIP) has been instrumental in reviewing several of the recently executed inter-municipal contracts done between municipalities that hold an ambulance operating authority, the operation of which is contracted out to another municipal ambulance service. Note that while BEMS may require a certificate holder that does not operate its own ambulance to have an appropriate contract, obtaining approval from regulatory entities having oversight authority (eg: OHIP, Office of State Comptroller, NYS AG or in extremely unique instances the state legislature), is the CON holder’s responsibility.

• Other CON action related issues

True to our promise made at last report, the Department has refused or returned a number of CON actions and applications that were deemed to be deficient. A rewrite and update of DOH Policy #06-06 is in the works, however we’d like to remind councils that until replaced, this policy establishes the key process steps that must be followed.

The following web links are URLs to the DOH Policy Statements released since last SEMSCO.

  * http://www.health.state.ny.us/nysdoh/ems/pdf/11-03.pdf
  * http://www.health.state.ny.us/nysdoh/ems/pdf/11-02.pdf
  * http://www.health.state.ny.us/nysdoh/ems/pdf/11-01.pdf

To save on trees, only the most recently released, Providing Medical Direction, is actually printed here. We’d like to bring your attention to the inclusion of BLSFR service issues in the revised release of this policy. The revisions also clarify and provide more specific guidance to REMAC roles and documentation activities.

• Basic Life Support First Response (BLSFR) services

The Department has seen a significant increase in interest by various entities to provide BLSFR services and receive a DOH issued EMS ID#. Note that all new BLSFR services are required to fully document participation, integration and specific governing municipal authority to provide EMS, and then receive a regional council endorsement before the Department will issue a new EMS ID#. Additionally, the Department will be deactivating the EMS agency ID’s of any existing BLSFR entity that does not have a documentable primary role to respond and collaboratively provide EMS on a regular and ongoing basis. The Department will also deactivate EMS agency ID’s of entities that do not meet specific eligibility criteria.
December 13, 2010
In Any Inquiry Refer to
4010347789040

Dear Dana Jones:

Thank you for contacting our office. We received your inquiry on
October 29, 2010. This letter is in response to the billing of
ambulance services.

In order to receive payments, as a Medicare provider, the authorized
license holder would need to submit the applicable enrollment forms
to Medicare and receive a Provider Transaction Access Number (PTAN).
Once a claim is submitted to Medicare, the provider is permitted to
seek payment from all parties to which the services were rendered.
Our office cannot determine what rules or regulations Medicaid or any
other insurance plan other than Medicare utilizes. I apologize for
any inconvenience this may have caused.

If you have any questions regarding this letter or require additional
information, please do not hesitate to contact our office. You may
do this either by telephone or in writing. You may call our office
at the phone numbers listed below:

- Customer Care Representatives: 1-866-837-0241
- Interactive Voice Recognition (IVR): 1-877-869-6504
  The IVR system must be used to answer questions
regarding, but not limited to, eligibility, claim
status, deductible, and check information
- For the hearing impaired - Telecommunications Device for
  the Deaf (TDD): 1-866-786-7155
- Provider Enrollment: 1-888-379-3807

Written correspondence should be sent to:

National Government Services, Inc.
P.O. Box 7052
Indianapolis, IN 46207-7052

Please be sure to reference the case number in the upper right-hand
MultiMed Memorandum

Date: November 16, 2010
To: All MultiMed Clients
From: Bill Shipman
Re: CMS Final Rule On Fractional Mileage Policy Change

On November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) issued an advance copy of a Final Rule that will require ambulance service suppliers and providers to bill Medicare based on fractional mileage. The policy change is part of the Final Rule on the “Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011” which is scheduled to be published in the Federal Register on November 29, 2010. The change would take effect on January 1, 2011.

For all Medicare claims with dates of service on and after January 1, 2011, CMS states that ambulance services will be required to report mileage to the nearest tenth of a mile. The policy will apply to all claims with mileage up to 100 loaded miles. For example, if a Medicare patient was in the ambulance for 5.1 miles, the ambulance service would report 5.1 miles on the claim form, instead of rounding up to 6 miles (as CMS had previously instructed providers to do). CMS also states that ambulance services that track hundredths of miles should always round up the hundredths place. For example, if the mileage was 4.32 miles, the provider would bill 4.4 miles.

All Medicare claims with mileage over 100 loaded miles will continue to be rounded up to the nearest whole number. For example, if the patient was in the ambulance for 110.2 miles, the ambulance service would report 111 miles on the claim form as it had previously done. The new policy applies to both ground and air ambulance mileage and to both paper and electronic claims.

CMS stated they “believe that tools used to measure distance traveled (such as GPS navigation equipment) are readily available to the average consumer at a low cost.” According to CMS, such providers are “responsible for ensuring that they have the necessary equipment to measure fractional mileage to the tenth of a mile, and ensuring that onboard vehicle gauges measuring trip mileage are in working order.” Therefore, CMS is now placing the burden on all ambulance services to obtain, and maintain in working order, equipment to track fractional mileage. Such equipment includes, but is not limited to: digital or analog odometers, trip odometers, GPS navigation, onboard trip computers or navigation systems.

Please don’t hesitate to contact me at 800-927-5845 with any questions.
Ambulance driver cited in Sunday crash

Jeffrey Blackwell • Staff writer • February 7, 2011

Two paramedics were discharged from Strong Memorial Hospital following a two-vehicle crash that fatally injured the patient they were transporting yesterday afternoon. The ambulance driver has been ticketed for failure to yield the right of way during a left turn.

The crash occurred on South Winton Road, near Interstate 590 in Brighton about 2:20 p.m., said LaShay Harris of Rural/Metro ambulance service.

The ambulance was headed north on South Winton Road and making a left turn to enter the ramp that leads motorists to the southbound lanes of I-590 ramp when it collided with a southbound vehicle, said Brighton Police Sgt. Michael DeSain. The ambulance was on a non-emergency run and did not have its emergency lights or sirens on, he said.

The two-person crew was transporting Erwin Leonard, 82, to Highland Hospital from the Jewish Home, said Capt. Robert Cline of the Brighton Police Department. Leonard had fallen at the Jewish Home yesterday afternoon.

Leonard was one of five people taken to Strong Memorial Hospital after the crash. He died there yesterday evening.

Two Rural/Metro employees — Melissa Onderdonk, 43, who was driving the ambulance, and Dennis Paseone, Jr., 27, who was in the back with Leonard — were also injured in the crash. They were taken to Strong.

Two people in the other vehicle were also injured. Edith Warner, 84, of Rochester and her passenger as Abe Levitt, 98, of Rochester were listed in satisfactory condition today. Cline said their conditions were initially considered serious because of their age, but are no longer considered life-threatening.

The crash remains under investigation today. Cline said.

Rural/Metro officials said in a statement today that they are cooperating with the police investigation and will also conduct an internal inquiry that will look at applicable company policies and the procedures used in the case.

JBLACKWELL@DemocratandChronicle.com
Includes reporting by staff writer Victoria E. Freile

An ambulance was struck by a car as it attempted to make a left turn onto Interstate 590 from South Winton Road in Brighton on Sunday. (SCOTT ELLMAN)
Kiryas Joel ambulance driver cited for 21 traffic violations

By John Sullivan
Times Herald-Record
Published: 2:00 AM - 03/21/11
CHESTER — A Kiryas Joel ambulance corps member faces charges of reckless driving for allegedly running a patrol officer and other motorists off the road in a frantic dash to get to a traffic accident on Route 17.

Officers arrested Menachem Kramer and cited him for 21 violations of vehicle and traffic laws in the Feb. 18 incident. He is scheduled to appear in village court April 7.

According to a police report, Kramer's gray 1999 Chevrolet Tahoe sped head-on toward a Village of Chester patrol officer on Brookside Avenue, forcing the officer to quickly maneuver his vehicle out of the way.

Kramer had his lights and sirens on in an apparent attempt to get to a Route 17 rollover that already was in the process of being cleared by Chester rescue workers, according to the report.

The victims in that rollover also had been determined to be uninjured, and they had refused medical attention, the police report said.

It was unclear Tuesday who had made the call to Kiryas Joel Ambulance, but it is well known that EMS workers from the Hasidic village rush to calls from members of their religion, even if other first responders already are at the scene tending to the wounded.

According to the report, Kramer drove at excessive speeds, as well as down the center of Brookside Avenue, forcing cars in the turning lanes to quickly veer out of the way — some into the path of oncoming traffic.

The Hasidic EMS worker then went through the red light at the intersection of Brookside and Summerville Way, where he made a left to get to the Route 17 Exit 126 on-ramp, the report said.

The pursuing Village of Chester officer called ahead to State Police, who were at the scene of the rollover, and asked them to detain Kramer upon his arrival.

Kramer was given 15 different traffic tickets by Chester village police, as well as an additional six tickets from state police, whose troopers also cited Kramer for driving recklessly.

Kramer and his attorney declined comment. Calls to the Kiryas Joel Ambulance Corps, known as Hatzolah in its community, went unreturned.

Village of Chester police Chief Peter Graziano said ambulance corps members, like all first responders, have leeway in obeying traffic laws when responding to emergencies, but they must use "due care."

"Running people off the road just isn't allowed," he said. The chief added that emergency officials in the village doesn't often drive carelessly.

"Just because you're a first responder, it doesn't give you the excuse to drive like a maniac," Graziano said.
I. Purpose

This policy is intended to provide assistance to Emergency Medical Service (EMS) agencies and physician medical directors so that they may better understand medical direction for patients of all ages at the agency level. The policy should clarify and expand upon the definitions contained in Policy Statement 95-01, Medical Control, issued May 31, 1995. It is also the intent of this policy to define the roles and responsibilities of the service, the service medical director the Regional EMS Council (REMSCO) and the Regional Emergency Medical Advisory Committee (REMAC) in relation to this topic. While the Department recommends that every agency providing pre-hospital emergency medical care have a physician medical director, it is a requirement for those agencies described below:

- All Ambulance Services providing Defibrillation.
- All Ambulance Services providing any level of Advanced Life Support (ALS).
- All Advanced Life Support First Response Agencies.
- All Basic Life Support First Response agencies providing Defibrillation and/or possessing a DOH issued EMS Agency ID code number that also have REMAC issued authority to provide any adjunct level of BLS care such as Albuterol or Blood Glucometry. ¹
- All entities authorized to provide Public Access Defibrillation under § 3000-b of Public Health Law (PHL) shall have an Emergency Health Care Provider (EHCP).
- All entities authorized to provide Epinephrine Auto Injectors under § 3000-c of Public Health Law (PHL) must have an Emergency Health Care Provider (EHCP).

An EMS Service Medical Director shall mean a physician, licensed by New York State and approved by the local REMAC with whom the agency has a professional relationship.

An Emergency Health Care Provider (EHCP) means: (I) a physician with knowledge and experience in the delivery of emergency medical care; or (II) a hospital licensed under article twenty-eight of the NYS Public Health Law that provides emergency medical care and with whom the Public Access Defibrillation or Epinephrine Auto Injector program provider entity has a written collaborative agreement.

¹ While Basic Life Support First Response agencies are encouraged to interact with a physician medical director for all patient care responses, these agencies are only required to have a medical director involved in training, use and quality improvement of the public access defibrillation and/or epinephrine auto-injector program. If such agency holds a DOH issued EMS Agency ID# and has also been granted REMAC authority to provide adjunct levels of BLS care (eg: Albuterol and/or Blood Glucometry) then the agency is required to have a REMAC approved physician service medical director as an eligibility requirement for the EMS Agency ID.
II Selecting an EMS Agency Medical Director

- For Basic Life Support (BLS) and Advanced Life Support (ALS) ambulance services or Advanced Life Support First Response Services (ALS-FR), the provisions of Policy Statement 95-01 regarding service medical director states that the physician must be approved by the REMAC as having met their credentialing policies and procedures.

The Responsibilities of the EMS Service Medical Director

Unless otherwise provided for in statute, rule or policy the responsibilities of an EMS Service Medical Director shall include, but not be limited to:

1) Assure that service certified EMS personnel are oriented to the protocols promulgated by the SEMAC and the REMAC(s) for the area(s) of operation of the service,

2) Interact with REMAC in the development of protocols, the regional Quality Improvement (QI) process and in disciplinary issues,

3) Active development, review and participation in the Quality Improvement program developed by the service as part of the Regional Council’s Quality Improvement program, as required in PHL §3006, or §3004-a,

4) Working with the service’s providers on issues and questions regarding all ages of patient care,

5) Participate/interact in other activities that relate to the provision of medical care or affect the patient care provided by the EMS service,

6) Participate, as necessary, with the service’s certified EMS personnel in Continuing Education Programs and the re-certification process,

7) Verify, by affirmation provided by the department (DOH-4362 Medical Director Verification form), that he/she serves as the medical director for the EMS service, providing medical oversight inclusive of the levels of care and/or BLS adjunct treatment protocols specified on the form,

8) In accordance with NYS law, regulation or department policy submit any documentation required for additional level of care approvals obtained by the EMS agency represented.

Immunity from Liability for Medical Direction

Article 30 § 3013 (5), of PHL: Notwithstanding any inconsistent provision of any general, special or local law, any physician who voluntarily and without the expectation of monetary compensation provides indirect medical control\(^2\), shall not be liable for damages for injuries or death alleged to have been sustained by any person as a result of such medical direction unless it is established that such injuries or death were caused by gross negligence on the part of such physician.

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\(^2\) PHL Article 30 § 3001 (15) "Medical control" means: (a) advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility and (b) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation developed by the state emergency medical advisory committee, approved by the state emergency medical services council and the commissioner, and implemented by regional medical advisory committees.
III Selecting an Emergency Health Care Provider for Public Access Defibrillation or Epinephrine Auto Injector Programs

- For organizations engaged in the PAD program, PHL §3000-b 1 (B) requires the selection of an Emergency Health Care Provider (EHCP). An EHCP is defined as "(I) a physician with knowledge and experience in the delivery of emergency cardiac care; or (II) a hospital licensed under article twenty-eight of this chapter that provides emergency cardiac care."
- For organizations engaged in the epi-pen program PHL §3000-c 1(B) requires the selection of an Emergency Health Care Provider (EHCP). An EHCP is defined as (i) a physician with knowledge and experience in the delivery of emergency care; or (ii) a hospital licensed under article twenty-eight of this chapter that provides emergency care.

IV Responsibilities of a Public Access Defibrillation Program EHCP

1) §3000-b.1(E) states that, "The Emergency Health Care Provider (EHCP) shall participate in the regional quality improvement program pursuant to subdivision one of section three thousand four-A of this article."

2) §3000-b.1(D) requires every use of the defibrillator to be reported promptly to the agency's EHCP. It will be the EHCP's responsibility to receive and review these reports of use. They must also communicate any concerns relating to the use of the device to the provider.

3) Serve as the physician of record for the purposes of purchasing the AED by the PAD program.

V Responsibilities of an Epinephrine Auto-Injector Program EHCP

1) §3000-c.3(c) requires every use of an epinephrine auto injector to be reported to the agency's EHCP. It will be the EHCP's responsibility to receive and review these reports of use. They must also communicate any concerns relating to the use of the device to the provider.

2) It will be the responsibility of the EHCP to oversee the acquisition and deployment of the devices and to assure the quality control standards implemented by the manufacturer are maintained.

3) Serve as the physician of record for the purposes of purchasing or issuing a prescription for the program to obtain epinephrine auto injectors.

VI Immunity from Liability for EHCP

3000-B (4) Application of other laws.
   a. Operation of an automated external defibrillator pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
   b. Operation of an automated external defibrillator pursuant to this section shall not constitute the unlawful practice of a profession under title VIII of the education law.

3000-C (4) Application of other laws.
   a. Use of an epinephrine auto-injector device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
   b. Purchase, acquisition, possession or use of an epinephrine auto-injector device pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight of the education law or article thirty-three of this chapter.
c. Any person otherwise authorized to sell or provide an epinephrine auto-injector device may sell or provide it to a person authorized to possess it pursuant to this section.

VII Implementation:

- All EMS agencies should immediately identify a physician medical director that meets the criteria set forth by the REMAC.

- All EMS agencies should carry a copy of off-line written protocols either on-person and/or on the responding vehicle(s); off-line written protocols need to be available to the provider from the time of dispatch through patient transport to a definitive care facility.

- REMSCOs, when receiving a Notice of Intent to provide Public Access Defibrillation or Epinephrine auto-injectors, shall assure the Emergency Health Care Provider meets the requirements detailed in the applicable laws.

REMACs shall establish, maintain and make available, annually, the policies and procedures established for the credentialing of physicians as service medical directors in the region. They shall also maintain and make available, annually, the list of physicians who have met those credentialing policies and procedures and are serving as medical directors. REMACs shall only grant ALS, and/or BLS adjunct levels of care, authority to agencies that are either certified or recognized by the Department and are under the medical direction of a physician credentialled by the REMAC. REMACs are encouraged to collaborate with adjoining region REMACs to promote availability of medical oversight to agencies routinely operating in more than one region.

Physicians asked to serve as EMS agency Medical Directors of BLS Ambulance or First Response services shall maintain a ratio of physician to certified providers that is no greater than 500:1. An Advanced Life Support Ambulance or First Response service must maintain a physician to certified provider ratio of no greater than 100:1. However, physician may not be the medical director for more than 10 services, unless approved by the local REMAC. These ratios were developed and approved by the SEMAC as part of Policy Statement 95-01.

Issued and Authorized
Lee Burns, Acting Director - Bureau of EMS
Opinion 2010 - 4

This opinion represents the views of the Office of the State Comptroller at the time it was rendered. The opinion may no longer represent those views if, among other things, there have been subsequent court cases or statutory amendments that bear on the issues discussed in the opinion.

AMBULANCE SERVICE - - Contracts (by fire district for “back up” services with private ambulance company) -- Fees (imposition of by fire districts for “back up” services provided under contract with private ambulance company) -- Fire Districts (contracts for “back up” services with private ambulance company)

FEES -- Imposition of (by fire districts for “back up” services provided under contract with private ambulance company)

FIRE DISTRICTS -- Ambulance Service (“back up” services provided under contract with private ambulance company); (imposition of fees for “back up” services provided under contract with private ambulance company) – Powers and Duties (contract for “back up” services provided by private ambulance company); (imposition of fees for “back up” services provided under contract with private ambulance company); (by fire districts for “back up” services provided under contract with private ambulance company)

GENERAL MUNICIPAL LAW §§ 122-b (5), 209-b (3-a) (a): A fire district that has in its fire department an emergency first aid and rescue squad comprised mainly of volunteer firefighters may authorize the squad to contract with “ambulance services,” as defined in Public Health Law § 3001 (2) and (3), to provide services when the squad is unavailable. In addition, a fire district may contract with an appropriate private ambulance company for prehospital treatment if: (1) the fire district, as a part of a fire protection contract, provides general and/or emergency ambulance service pursuant to General Municipal Law § 209-b and article 30 of the Public Health Law, (2) a town or village has not designated itself as the primary provider of, or otherwise contracted for, an emergency ambulance, a general ambulance service or a combination of such services acting individually or jointly, and (3) the services are limited to the furnishing of supplemental personnel, equipment or service to cover instances or periods of time when the fire district's service may not be readily available. In neither situation, however, may a fee be imposed upon the person served for the services provided under the contract with the private ambulance company.

You ask whether a fire district may enter into a contract with an incorporated private voluntary ambulance service under which the ambulance service would provide emergency medical services to the fire district. The ambulance service would also bill and collect fees that would be charged to the users of the services, and retain the fees for its own use and benefit.
Initially, we note that it is a fundamental principle that fire districts only have those powers expressly granted by statute or necessarily implied therefrom (Town Law § 176 [21]; see e.g., 2008 Ops St Comp No. 2008-3; 2003 Ops St Comp No. 2003-4, at 10; cf. Wells v Town of Salina, 119 NY 280). There are several statutes that authorize fire districts to contract to receive emergency medical services. A fire district whose own fire department has not been authorized to render emergency ambulance service may contract to obtain that service from another city, town, village or fire district that has in its fire department an emergency rescue and first aid squad duly authorized to render emergency ambulance service (General Municipal Law § 209-b [1] [b]).

In addition, a fire district, as part of a fire protection contract with a city, village or fire district, or an incorporated fire company having its headquarters outside the district, may contract for emergency ambulance service (Town Law § 176 [22]). If the fire department or fire company furnishing fire protection under the contract does not maintain and operate an ambulance, the fire district may separately contract for emergency ambulance service with a city, village, fire district or fire company under certain circumstances (id.).

Prior to 2003, fire districts were not authorized to contract to receive emergency medical services from an entity other than a fire department or fire company, such as from a private ambulance company (1998 Ops St Comp No. 98-21, at 51). Chapter 378 of the Laws of 2003, however, added subdivision 3-a to General Municipal Law § 209-b and subdivision 5 to General Municipal Law § 122-b, to provide limited grants of authority for fire districts to contract with, among other entities, private “commercial” ambulance companies to receive “back-up” services (see New York State Assembly Mem in Support of Legislation, Budget Report on Bills, Letter to Counsel to the Governor, United New York Ambulance Network, August 15, 2003, Bill Jacket, L 2003, ch 378, at 3, 4 and 10, respectively).

Under General Municipal Law § 209-b (3-a) (a), a fire district that has in its fire department an emergency first aid and rescue squad comprised mainly of volunteer firefighters may authorize the squad to contract with “ambulance services,” as defined in Public Health Law § 3001 (2) and (3), 2 to provide services when the squad is unavailable. 2 Subdivision 5 of General Municipal Law § 122-b provides as follows:

Fire districts, which, as part of a fire protection contract, may provide general ambulance and/or emergency ambulance service pursuant to section two hundred nine-b of this chapter and article thirty of the public health law where a town or village has not designated itself as the primary provider of or otherwise contracted for an emergency ambulance, a general ambulance service, or a combination of such service acting individually or jointly, may contract with one or more individuals, municipal corporations, or other organizations having sufficient trained personnel, vehicles or combination of personnel and vehicles suitable to provide prehospital emergency treatment, for the furnishing of supplemental personnel, equipment or service to cover instances or periods of time when its service may not be readily available.
Thus, pursuant to General Municipal Law § 122-b (5), fire districts may contract with, among others, appropriate private ambulance companies for prehospital treatment, but only if: (1) the fire district, as a part of a fire protection contract, provides general and/or emergency ambulance service pursuant to General Municipal Law § 209-b and article 30 of the Public Health Law, 4 (2) a town or village has not designated itself as the primary provider of, or otherwise contracted for, an emergency ambulance, a general ambulance service or a combination of such services acting individually or jointly, and (3) the services are limited to the furnishing of "supplemental personnel, equipment or service to cover instances or periods of time when its [the fire district's] service may not be readily available."

Even if the fire district here meets the requirements of General Municipal Law §§ 209-b (3-a) or 122-b (5) for contracting with a private ambulance company for "back-up" emergency medical services, however, there is no authority in either statute for the imposition of fees upon users of the fire district's contracted services, whether the fees are billed and collected by the private ambulance company or by the fire district. General Municipal Law § 122-b (1) authorizes a county, town, village or city, but not a fire district, to provide an emergency medical service, general ambulance service or a combination of such services for the purpose of providing prehospital emergency treatment or transporting sick or injured person found within the boundaries "of the municipality" to a place for treatment. General Municipal Law § 122-b (2) authorizes "[s]uch municipality" to fix a schedule of fees and charges to be paid by persons requesting use of the services, and provide for the collection of the fees and charges or formulate rules and regulations for the collection of the fees and charges by organizations providing the service under contract. It is evident that the term "such municipality" as used in General Municipal Law § 122-b (2) in the grant of authority for the imposition of fees is intended to refer back to the cities, towns, villages and counties authorized under General Municipal Law § 122-b (1) to provide emergency medical and general ambulance services (see also General Municipal Law § 2 [defining the term "municipal corporation," as used in the General Municipal Law, to include only a county, town, city and village]).

In contrast to General Municipal Law § 122-b (2), there is no indication in General Municipal Law § 122-b (5), General Municipal Law § 209-b (3-a), or the legislative history of chapter 378 of the Laws of 2003, to suggest that fees may be imposed upon users of the fire district services provided under contracts pursuant to those provisions. § In fact, General Municipal Law § 209-b (4) expressly states that emergency and general ambulance services authorized pursuant to section 209-b must be furnished without cost to the person served. §

Accordingly, a fire district that has in its fire department an emergency first aid and rescue squad comprised mainly of volunteer firefighters may authorize the squad to contract with "ambulance services," as defined in Public Health Law § 3001 (2) and (3), to provide services when the squad is unavailable. In addition, a fire district may contract with an appropriate private ambulance company for prehospital
treatment if: (1) the fire district, as a part of a fire protection contract, may provide general and/or emergency ambulance service pursuant to General Municipal Law § 209-b and article 30 of the Public Health Law, (2) a town or village has not designated itself as the primary provider of, or otherwise contracted for, an emergency ambulance, a general ambulance service or a combination of such services acting individually or jointly, and (3) the services are limited to the furnishing of supplemental personnel, equipment or service to cover instances or periods of time when the fire district’s service may not be readily available. In neither situation, however, may a fee be imposed upon the person served for the services provided under the contract with the private ambulance company.

November 22, 2010

Ronald P. Bennett, Esq., Town Attorney
Town of Holland

1General Municipal Law § 209-b authorizes the board of fire commissioners of a fire district to organize, within the fire district fire department, emergency rescue and first aid squads composed of firefighters who are members of the department (General Municipal Law §209-b[1][a]). The squad may render services in cases of accidents, calamities or other emergencies in connection with which the services of firefighters may be required (id.).

2Public Health Law § 3001 (2) defines “[a]mbulance service” to mean “an individual, partnership, association, corporation, municipality or any legal or public entity or subdivision thereof engaged in providing emergency medical care and the transportation of sick or injured persons by motor vehicle, aircraft or other forms of transportation to, from, or between general hospitals or other health care facilities.” Public Health Law § 3001 (3) defines “[v]oluntary ambulance service” to mean “an ambulance service (i) operating not for pecuniary profit or financial gain, and (ii) no part of the assets or income of which is distributable to, or enures to the benefit of, its members, directors or officers except to the extent permitted under this article.”

3 General Municipal Law § 209-b (3-a) (a) also authorizes “mutual aid agreements,” as defined in Public Health Law § 3001 (20).

4 General Municipal Law § 122-b (5) literally states, as one of the criteria that must be met in order for a fire district to contract for supplemental service, that the fire district, “as part of a fire protection contract, may provide ” general or emergency ambulance service (emphasis added). This provision could be read to mean that the fire district merely must have the authority to contract to provide such services, and not that the fire district, in fact, has contracted to provide the ambulance services. It is evident, however, that, when General Municipal Law § 122-b (5) is read as a whole, the purpose of the
amendment is to give a fire district that has actually agreed to provide ambulance services as part of a fire protection contract the authority to contract for supplemental services for situations when the fire district’s own services to be provided under the fire protection contract are not “readily available” (see also State of New York Department of State, Approval Mem, July 14, 2003, Bill Jacket, L 2003, ch 378, at 5).

5 It should also be noted that the fees imposed pursuant to General Municipal Law § 122-b (2) are municipal charges for a municipal function, and constitute monies of the town, village, city or county, as the case may be (1998 Ops St Comp No. 98-9, at 22). Although section 122-b (2) authorizes the municipality to provide, in rules and regulations, for the collection of the fees and charges by the contracting service provider, the service provider should remit the monies collected to the municipality (2005 Ops St Comp No. 2005-1, at 1, footnote 1). Therefore, even if the authorization for the imposition of fees in General Municipal Law § 122-b (2) were to apply here, the fees would not be retained by the ambulance company.

6 General Municipal Law § 209-b (4) further provides, as noted in the letter of inquiry, that the acceptance by any firefighter of any personal remuneration or gratuity, directly or indirectly, from a person served shall be a ground for expulsion or suspension as a member of the fire department or fire company. The letter of inquiry also notes that the not-for-profit corporation in question would be formed by members of the fire district fire department, and that the services would be provided by members of the fire department who would also be members of the ambulance corporation (see 1997 Ops St Comp No. 97-23, at 43 [no statutory prohibition against an individual becoming a member of a volunteer fire company and a volunteer ambulance corps at the same time]). For purposes of this inquiry, we assume that all services by such individuals would be performed solely in their discrete capacities as members of an ambulance corps, separate and distinct from the fire department, and not in their capacities as volunteer firefighters. In that case, it would appear that the prohibition in General Municipal Law § 209-b (4) against the acceptance of gratuities by a volunteer firefighter would not be relevant to this inquiry (see Mem of Joint Legis Comm on Fire Laws, 1957 McKinney’s Session Law of NY, at 2171 [purpose of General Municipal Law § 209-b (4), in part, was to prohibit acceptance of any remuneration or gratuity by a firefighter for services by an “emergency relief squad,” now referred to in General Municipal Law § 209-b as “emergency rescue and first aid squads”].