

contemplating such arrangements should consider obtaining an OIG advisory opinion. While cities and other EMS sponsors may charge ambulance suppliers amounts to cover the costs of services provided to the suppliers, they should not solicit inflated payments in exchange for access to EMS patients, including access to dispatch services under “9–1–1” or comparable systems.

A city or other political subdivision of a state (e.g., fire district, county, or parish) may not require a contracting ambulance supplier to waive copayments for its residents, but it may pay uncollected, out-of-pocket copayments on behalf of its residents. Such payments may be made through lump sum or periodic payments, if the aggregate payments reasonably approximate the otherwise uncollected cost-sharing amounts. However, a city or other political subdivision that *owns and operates* its own ambulance service is permitted to waive cost-sharing amounts for its residents under a special CMS rule. (See CMS *Carrier Manual*, section 2309.4; CMS *Intermediary Manual*, section 3153.3A; see also, e.g., OIG Advisory Opinion No. 01–10 and 01–11.)

#### b. Ambulance Restocking

Another common EMS arrangement involves the restocking of supplies and drugs used in connection with patients transported to hospitals or other emergency receiving facilities. These arrangements typically do not raise anti-kickback concerns. However, ambulance suppliers participating in such arrangements can eliminate risk altogether by complying with the ambulance restocking safe harbor at 42 CFR 1001.952(v). In general, the safe harbor requires that EMS restocking arrangements involving free or reduced price supplies or drugs be conducted in an open, public, and uniform manner, although hospitals may elect to restock only certain categories of ambulance suppliers (e.g., nonprofits or volunteers). Restocking must be accurately documented using trip sheets, patient care reports, patient encounter reports, or other documentation that records the specific type and amount of supplies or drugs used on the transported EMS patient and subsequently restocked. The documentation must be maintained for 5 years. The safe harbor also covers fair market value restocking arrangements and government-mandated restocking arrangements. The safe harbor conditions are set forth with specificity in the regulations.

Wholly apart from anti-kickback concerns, ambulance stocking

arrangements raise issues with respect to proper billing for restocked supplies and drugs. Payment and coverage rules are set by the health care program that covers the patient (e.g., Medicare or Medicaid). To determine proper billing for restocked supplies or drugs, ambulance suppliers should consult the relevant program payment rules or contact the relevant payment entity.

Under the Medicare program, in almost all circumstances the ambulance supplier—not the hospital—will be the party entitled to bill for the restocked supplies or drugs used in connection with an ambulance transport, even if they are obtained through a restocking program. However, under the ambulance fee schedule, supplies and drugs are included in the bill for the base rate and are not separately billable. Ambulance suppliers should consult with their payor to confirm appropriate billing during the new ambulance fee schedule transition period.

#### 2. Arrangements With Other Responders

In many situations, it is common practice for a paramedic intercept or other first responder to treat a patient in the field, with a second responder transporting the patient to the hospital. In some cases, the first responder is in a position to influence the selection of the transporting entity. While fair market value payments for services actually provided by the first responder are appropriate, inflated payments by ambulance suppliers to generate business are prohibited, and the government will scrutinize such payments to ensure that they are not disguised payments to generate calls to the transporting entity.

#### 3. Arrangements With Hospitals and Nursing Facilities

Because hospitals and nursing facilities are key sources of non-emergency ambulance business, ambulance suppliers need to take particular care when entering into arrangements with such institutions. (See section F above.)

#### 4. Arrangements With Patients

Arrangements that offer patients incentives to select particular ambulance suppliers may violate the anti-kickback statute, as well as the CMP law that prohibits giving inducements to Medicare and Medicaid beneficiaries that the giver knows, or should know, are likely to influence the beneficiary to choose a particular practitioner, provider, or supplier of items or services payable by Medicare or Medicaid. (See section 1128A(a)(5) of the Act (42 U.S.C. 1320a-7a(a)(5).)

Prohibited incentives include, without limitation, free goods and services and copayment waivers. The statute contains several narrow exceptions, including financial hardship copayment waivers and incentives to promote the delivery of preventive care services as defined in regulations. In addition, items or services of nominal value (less than \$10 per item or service or \$50 in the aggregate annually) and any payment that fits into an anti-kickback safe harbor are permitted.

An ambulance supplier should not routinely waive federal health care program copayments (e.g., no “insurance only” billing), although the supplier may waive a patient’s copayment if it makes a good faith, individualized assessment of the patient’s financial need.<sup>(16)</sup> Financial hardship waivers may not be routine or advertised. As discussed in section G above, cities and other political subdivisions are permitted to waive copayments for services provided directly to their residents.

Subscription or membership programs that offer patients purported coverage only for the ambulance supplier’s services are also problematic because such programs can be used to disguise the routine waiver of cost-sharing amounts. To reduce their risk under the anti-kickback statute, ambulance suppliers offering subscription programs should carefully review them to ensure that the subscription or membership fees collected from subscribers or members, in the aggregate, reasonably approximate—from an actuarial or historical perspective—the amounts that the subscribers or members would expect to spend for cost-sharing amounts over the period covered by the subscription or membership agreement.

#### VI. Conclusion

This ambulance compliance program guidance is intended as a resource for ambulance suppliers to decrease the incidence of fraud and abuse as well as errors that might occur due to inadequate training or inadvertent noncompliance. We encourage ambulance suppliers to scrutinize their internal practices to ensure the development of a comprehensive compliance program.

Compliance programs should reflect each ambulance supplier’s individual and unique circumstances. It has been the OIG’s experience that those health care providers and suppliers that have developed compliance programs not only better understand applicable federal health care program requirements, but also their own internal operations. We are hopeful that