

this guidance will be a valuable tool in the development and continuation of ambulance suppliers' compliance programs.

Appendix A—Additional Risk Areas

1. "No Transport" Calls and Pronouncement of Death

If an ambulance supplier responds to an emergency call, but a patient is not transported due to death, three Medicare rules apply. If an individual is pronounced dead prior to the time the ambulance was requested, there is no payment. If the individual is pronounced dead after the ambulance has been requested, but before any services are rendered, a BLS payment will be made and no mileage will be paid. If the individual is pronounced dead after being loaded into the ambulance, the same payment rules apply as if the beneficiary were alive. Ambulance suppliers should accurately represent the time of death and request payment based on the aforementioned criteria.

2. Multiple Patient Transports

On occasion, it may be necessary for an ambulance to transport multiple patients concurrently. If more than one patient is transported concurrently in one ambulance, the amount billed should be consistent with the multiple transport guidelines established by the payor in that region. Under CMS's new fee schedule rules for multiple transports, Medicare will pay a percentage of the payment allowance for the base rate applicable to the level of care furnished to the Medicare beneficiary (e.g., if two patients are transported simultaneously, 75 percent of the applicable base rate will be reimbursed for each of the Medicare beneficiaries). Coinsurance and deductible amounts will apply to the prorated amounts.

3. Multiple Ambulances Called to Respond to Emergency Call

On occasion, more than one ambulance supplier responds to an emergency call and is present to transport a beneficiary. These are often referred to as "dual transports." In such cases, only the transporting ambulance supplier may bill Medicare for the service provided. If payment is desired for services provided to a patient, the non-transporting ambulance company should receive it directly from the transporting supplier based on a negotiated arrangement. These payments should be fair market value for services actually rendered by the non-transporting supplier, and the parties should review these payment arrangements for compliance with the anti-kickback statute. On occasion, when multiple ambulance crews respond to a call, a BLS ambulance may provide the transport, but the level of services provided may be at the ALS level. If a BLS supplier is billing at the ALS level because of services furnished by an additional ALS crew member, appropriate documentation should accompany the claim to indicate to the payor that dual transportation was provided. In any event, only one supplier may submit the claim for payment.

4. Billing Medicare "Substantially in Excess" of Usual Charges

Ambulance suppliers generally may not charge Medicare or Medicaid patients substantially more than they usually charge everyone else. If they do, they are subject to exclusion by the OIG. This exclusion authority is not implicated unless the supplier's charge for Medicare or Medicaid patients is substantially more than its median non-Medicare/Medicaid charge. In other words, the supplier need not worry unless it is discounting close to half of its non-Medicare/Medicaid business. Ambulance suppliers should review charging practices with respect to Medicare and Medicaid billing to ensure that they are not charging Medicare or Medicaid substantially more than they usually charge other customers for comparable services. It is appropriate for an ambulance supplier to determine its usual charge with reference to its total charges to non-Medicare/Medicaid customers for an ambulance transport (whether or not the charges are structured as base rate plus mileage or otherwise) and then to compare the resulting "usual charge" to its total charge to Medicare (i.e., base rate plus mileage) or Medicaid for comparable transport.

Appendix B—OIG/HHS Information

The OIG's web site (<http://oig.hhs.gov>) contains various links describing the following: (1) Authorities and **Federal Register** Notices, (2) Publications, (3) Reports, (4) Hearing Testimony, (5) Fraud Prevention and Detection, (6) Reading Room, (7) OIG Organization and (8) Employment Opportunities. Such information is frequently updated and is a useful tool for ambulance providers seeking additional OIG resources.

Also listed on the OIG's web site is the OIG Hotline Number. One method for providers to report potential fraud, waste and abuse is to contact the OIG Hotline number. All HHS and contractor employees have a responsibility to assist in combating fraud, waste, and abuse in all departmental programs. As such, providers are encouraged to report matters involving fraud, waste and mismanagement in any departmental program to the OIG. The OIG maintains a hotline that offers a confidential means for reporting these matters.

Contacting the OIG Hotline

By Phone: 1-800-HHS-TIPS (1-800-447-8477).

By Fax: 1-800-223-8164.

By E-Mail: Htips@oig.hhs.gov.

By TTY: 1-800-377-4950.

By Mail: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW., Washington, DC 20201.

When contacting the hotline, please provide the following information to the best of your ability:

- Type of Complaint: Medicare Part A
- Medicare Part B
- Indian Health Service
- TRICARE
- Other (please specify)

—HHS department or program being affected by your allegation of fraud, waste, abuse/mismanagement: Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) Indian Health Service Other (please specify)

—Please provide the following information (however, if you would like your referral to be submitted anonymously, please indicate such in your correspondence or phone call): Your Name
Your Street Address
Your City/County
Your State
Your Zip Code
Your E-mail Address

—Subject/Person/Business/Department that allegation is against: Name of Subject
Title of Subject
Subject's Street Address
Subject's City/County
Subject's State
Subject's Zip Code

—Please provide a brief summary of your allegation and the relevant facts.

Appendix C—Carrier Contact Information

1. Medicare

A complete list of contact information (address, phone number, e-mail address) for Medicare Part A Fiscal Intermediaries, Medicare Part B Carriers, Regional Home Health Intermediaries, and Durable Medical Equipment Regional Carriers can be found on the CMS Web site at <http://cms.hhs.gov/contacts/incardir.asp>.

2. Medicaid

Contact information (address, phone number, e-mail address) for each state Medicaid director can be found on the CMS Web site at <http://cms.hhs.gov/mcicaid/mcontact.asp>. In addition to a list of state Medicaid directors, the Web site includes contact information for each state survey agency and the CMS Regional Offices.

3. Ambulance Fee Schedule

Information related to the development of the ambulance fee schedule is located at <http://cms.hhs.gov/suppliers/afs/default.asp>.

Appendix D—Internet Resources

1. Centers for Medicare and Medicaid Services

The CMS Web site (<http://cms.hhs.gov/>) includes information on a wide array of topics, including Medicare's National Coverage Database, National Coverage Policies, Laws and Regulations and State Waiver and Demonstration Programs. In addition, this Web site contains information related to Medicaid including a General Medicaid Overview, State and Federal Health Program Contacts, State Medicaid Manual, State Medicaid Plans, State Waivers and Demonstration Programs, Letters to State Officials, and CMS Publications.

2. CMS Medicare Training

This CMS Web site (<http://www.cms.hhs.gov/medlearn/cbts.asp>) provides computer-based training related to CMS's purpose and history, the three types