



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



*[We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.]*

**Issued:** September 6, 2012

**Posted:** September 13, 2012

[Name and address redacted]

### **Re: OIG Advisory Opinion No. 12-12**

Dear Ladies and Gentlemen:

We are writing in response to your request for an advisory opinion regarding a proposed bundle billing arrangement for basic life support (“BLS”)/advanced life support (“ALS”) joint responses in [City redacted] (“City”), [State redacted] (“State”) (the “Proposed Arrangement”). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (the “Act”), or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute.

You have certified that all of the information provided in your request, including all supplemental submissions, is true and correct and constitutes a complete description of the relevant facts and agreements among the parties.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement would not generate prohibited remuneration under the anti-kickback statute and, therefore, the Proposed Arrangement would not constitute grounds for the Office of Inspector General (“OIG”) to impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of

the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act). This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request for an advisory opinion or supplemental submissions.

This opinion may not be relied on by any persons other than [name redacted], the requestor of this opinion, and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

## **I. FACTUAL BACKGROUND**

[Name redacted] (“BLS Supplier”) is a not-for-profit, 501(c)(3) corporation that holds the Primary Service Area Responder (“PSAR”) designation from the [State agency redacted] at the BLS level. As a result of its PSAR designation, BLS Supplier is the primary 911 responder at the BLS level within the City. [Name redacted] (“ALS Supplier”) is a not-for-profit, 501(c)(3) corporation that holds the PSAR designation from the [State agency redacted] at the ALS level and provides paramedic intercept services<sup>1</sup> in five communities, including the City.<sup>2</sup> BLS Supplier is required by State law to call ALS Supplier for paramedic intercept services within the City whenever ALS services are necessary (“BLS/ALS Joint Response”). BLS Supplier does not otherwise serve as a source of referrals of Federal health care program business or any other business to ALS Supplier. ALS Supplier does not have the ability to generate referrals of Federal health care program business or any other business to BLS Supplier.

The Centers for Medicare & Medicaid Services (“CMS”) Medicare Benefit Policy Manual states the following with respect to billing for BLS/ALS joint responses:

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS

---

<sup>1</sup> Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which an ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services, such as EKG monitoring, chest decompression, or I.V. therapy, a paramedic is dispatched to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient. See Centers for Medicare & Medicaid Services, Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 10, § 30.1.1.

<sup>2</sup> ALS Supplier was founded by five area PSAR ambulance service suppliers, including BLS Supplier. BLS Supplier and the City each have a representative on the ALS Supplier Board of Directors.

assessment, [p]aramedic [i]ntercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists prior to submitting the Medicare claim.<sup>3</sup> Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their intermediary or carrier upon request. Contractors must refer any issues that cannot be resolved to the regional office.

Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

CMS, Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 10, § 10.5 (emphasis omitted)(footnote added). Thus, CMS payment rules permit bundle billing of BLS and ALS services provided by different entities under certain circumstances. State Medicaid reimbursement rules also permit bundle billing in the same manner.

Currently, BLS Supplier and ALS Supplier do not have an agreement to bundle bill Medicare or Medicaid for BLS/ALS Joint Responses. BLS Supplier bills Medicare and Medicaid at the BLS rate, and ALS Supplier directly bills City residents the standard ALS Supplier paramedic intercept charge as allowed by the [State agency redacted] (in accordance with the Ambulance Fee Schedule for Maximum Allowable Rates published annually by the State).

Under the Proposed Arrangement, ALS Supplier and BLS Supplier would enter into a written bundle billing agreement setting forth the terms and conditions relating to BLS/ALS Joint Responses provided to Medicare and Medicaid patients.<sup>4</sup> Under this agreement, where BLS Supplier provides the transport and ALS Supplier provides paramedic services, BLS Supplier would submit claims at the ALS rate, as appropriate. Upon receipt of payment from Medicare or Medicaid, BLS Supplier would pay ALS Supplier the difference between BLS Supplier's customary BLS reimbursement and the

---

<sup>3</sup> We refer to such written agreements as "bundle billing" agreements throughout this opinion.

<sup>4</sup> The agreement would also govern BLS/ALS Joint Responses provided with respect to any other beneficiaries of Federal health care programs that do not permit separate paramedic intercept billing to their programs.

amount paid for the ALS bundle bill. BLS Supplier would also collect any applicable copayments from beneficiaries and pay ALS Supplier the difference between the portion of the copayment attributable to BLS services and the total copayment received. As these payment amounts likely would equate to a loss of income to ALS Supplier from the payment amounts it previously received from direct billing to City residents, BLS Supplier and/or the City may also pay ALS Supplier an additional amount negotiated under the terms of the bundle billing agreement, to be adjusted as necessary based on the parties' review of annual call volume experience. In no case would there be any remuneration of any kind from ALS Supplier to BLS Supplier under the Proposed Arrangement.

## **II. LEGAL ANALYSIS**

### **A. Law**

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir. 1985), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

### **B. Analysis**

In the absence of a written agreement between a BLS entity and an ALS entity to bundle bill Medicare and Medicaid for BLS/ALS joint responses, the ALS entity's services are not covered. See CMS, Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 10, § 10.5, quoted above. Only the BLS level of payment may be made, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the

scope of the BLS level of payment. The BLS entity may bill Medicare and Medicaid at the ALS rate for BLS/ALS joint responses only if a written agreement between the BLS and ALS entities exists.

Currently, BLS Supplier does not have a written agreement with ALS Supplier; therefore, ALS Supplier's paramedic services provided during BLS/ALS Joint Responses are not covered by Medicare or Medicaid, and the beneficiary is liable for the expense of any ALS services that exceed the BLS level of payment. Under the Proposed Arrangement, BLS Supplier and ALS Supplier would enter into a written agreement setting forth the terms and conditions relating to their BLS/ALS Joint Responses. BLS Supplier would then bill Medicare and Medicaid at the ALS rate, when appropriate, and pay ALS Supplier in accordance with the terms set forth in their written agreement.

The Proposed Arrangement is not an arrangement involving remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. ALS Supplier is a paramedic intercept supplier that is not in a position to refer or influence the referrals of Federal health care program business or any other business to BLS Supplier. In turn, BLS Supplier, under State law, must call ALS Supplier for paramedic intercept services within the City whenever ALS services are necessary. BLS Supplier does not otherwise serve as a source of referrals of Federal health care program business or any other business to ALS Supplier.

According to the Medicare Benefit Policy Manual, CMS does not regulate the compensation between the BLS and the ALS entities; should the parties decide to bundle bill Medicare and Medicaid, it is up to them to negotiate payment terms. While they may not divide the payment in such a way as to compensate either party for referring or generating Federal health care program business, nothing in the facts of the Proposed Arrangement suggests that this would occur here. BLS Supplier calls ALS Supplier for paramedic intercept services, as required by State law, and this may be considered a source of referrals to ALS Supplier. However, under the Proposed Arrangement, there is no remuneration of any kind from ALS Supplier to BLS Supplier. Accordingly, we conclude that the Proposed Arrangement between BLS Supplier and ALS Supplier would not implicate the anti-kickback statute.<sup>5</sup>

We note that our opinion relates only to the application of the anti-kickback statute. We have no authority and do not express any opinion as to whether the Proposed Arrangement complies with other Federal laws and regulations, including those administered by CMS, or with any state laws.

---

<sup>5</sup> We might have reached a different result if, for example, BLS Supplier's payment under the bundle billing agreement were not limited to the BLS rate of payment.

### **III. CONCLUSION**

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement would not generate prohibited remuneration under the anti-kickback statute and, therefore, the Proposed Arrangement would not constitute grounds for the OIG to impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act). This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request for an advisory opinion or supplemental submissions.

### **IV. LIMITATIONS**

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [name redacted], the requestor of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.
- This advisory opinion may not be introduced into evidence by a person or entity other than [name redacted] to prove that the person or entity did not violate the provisions of sections 1128, 1128A, or 1128B of the Act or any other law.
- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is expressed or implied herein with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Arrangements, including, without limitation, the physician self-referral law, section 1877 of the Act (or that provision's application to the Medicaid program at section 1903(s) of the Act).
- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.
- This advisory opinion is limited in scope to the specific arrangements described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.
- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against [name redacted] with respect to any action that is part of the Proposed Arrangement taken in good faith reliance upon this advisory opinion, as long as all of the material facts have been fully, completely, and accurately presented, and the Proposed Arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, to rescind, modify, or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against [name redacted] with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/Gregory E. Demske/

Gregory E. Demske  
Chief Counsel to the Inspector General