



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: July 2, 2013

Posted: July 9, 2013

[Name and address redacted]

Re: OIG Advisory Opinion No. 13-08

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding a fire protection district's policy of billing only individuals who reside outside the fire protection district for emergency medical services (the "Arrangement"). Specifically, you have inquired whether the Arrangement constitutes grounds for permissive exclusion under the exclusion authority at section 1128(b)(6) of the Social Security Act (the "Act").

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 Arrangement does not constitute grounds for the imposition of permissive exclusion under section 1128(b)(6) of the Act. This opinion is limited to the 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] (the “District”) is a fire protection district duly incorporated under the laws of the State of [state redacted]. The [state redacted] Fire Protection District Act grants to the Board of Trustees of a fire protection district the authority to fix, charge, and collect fees for emergency ambulance services provided both within and outside of the fire protection district. The District renders emergency medical services to resident and non-resident persons, businesses and other entities in the performance of its obligations to the public.

In November 2006, the voters of the District passed a tax referendum to cover the rising costs of providing emergency medical services. Pursuant to this referendum, the Board of Trustees adopted an ordinance (the “Ordinance”) regarding charges and fees for emergency medical services. In accordance with the Ordinance, the District does not bill any residents or their insurers (including Federal health care programs) for emergency medical services. However, the District bills all non-residents and their insurers (including Federal health care programs) for emergency medical services pursuant to a fee schedule. All non-residents are charged the rates on the fee schedule, which vary based on level of service and mileage, but do not take into account payor source.

II. LEGAL ANALYSIS

A. Law

Section 1128(b)(6)(A) of the Act permits the Secretary of Health and Human Services (the “Secretary”) to exclude any individual or entity that the Secretary determines submitted or caused to be submitted bills or requests for payment to Medicare or a State health care program containing charges for items or services furnished substantially in excess of such individual’s or entity’s usual charges (or, in applicable cases, substantially in excess of such individual’s or entity’s costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs.¹

B. Analysis

Under the Arrangement, the District charges non-residents and their insurers (including Federal health care programs) for emergency medical services but does not charge

¹ The other subsections of section 1128(b)(6) of the Act, subsections (B)-(D), are clearly not implicated by the Arrangement.

residents for those same services. Because the Medicare and Medicaid programs are charged for services provided to non-residents but are not charged for services provided to residents, the District seeks guidance on whether its bills for non-resident services are “substantially in excess” of the District’s usual charges.

The District, in effect, provides emergency medical services to two categories of patients: residents and non-residents. The District does not charge residents (regardless of payor source) or their insurers for emergency medical services. In contrast, the second category of patients, the non-residents (and their insurers), are charged for emergency medical services.

We conclude that the District’s bills to Medicare and Medicaid for non-residents are not substantially in excess of its usual charges. Rather than charging its residents or their insurers for emergency medical services, the District has elected to cover these costs through tax revenues; the voters of the District passed a tax referendum expressly to cover the rising costs of providing emergency medical services. This choice does not require the District also to provide emergency medical services to non-residents without charge. Although the District categorizes its patients as residents or non-residents, its billing practices for the patients (and their insurers) within each category are consistent: no member of the former category is billed for emergency medical services, whereas all members of the latter category are billed on equal terms. The District’s distinction between residents and non-residents, and its decision to bill the latter but not the former, is reasonable and falls within the District’s discretion.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that Arrangement does not constitute grounds for permissive exclusion under the exclusion authority at section 1128(b)(6) of the Act. This opinion is limited to the 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 Arrangement, 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 arrangement 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 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 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 that is part of the Arrangement 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