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CMA Monthly Column

EMERGENCY AMBULANCE SERVICES

Most beneficiaries know that Medicare does not cover everything. However, most would assume that Medicare covers emergency ambulance services. That is, beneficiaries believe that if their life is in jeopardy, that the ambulance ride to the hospital would surely be covered by Medicare. Yet, shockingly, Medicare often does *not* cover the full cost of emergency ambulance services.

For example, a beneficiary experiencing chest pain calls 911. Given the gravity of the situation, the 911 operator sends the local volunteer ambulance as well as a paramedic from an emergency response company. With the paramedic aboard the ambulance, the beneficiary is safely transported to the hospital where she is successfully treated for a heart attack. A month later, the beneficiary receives a Medicare Summary Notice indicating that Medicare has paid for her ambulance transportation. However, she also received a bill from the emergency response company. The bill was for \$304.80. One would reasonably ask, "Why didn't the emergency response company bill Medicare?"

The answer is due to the very restrictive nature of the Medicare statute and regulations. When a volunteer ambulance company provides ambulance transportation and an emergency response company provides a paramedic, it is called a paramedic intercept. Under these circumstances, the emergency response company is prohibited from billing for the paramedic intercept service unless very specific conditions exist. Specifically, amongst other requirements, the paramedic intercept service must be performed in a rural area under a contract with the volunteer ambulance company *and* the volunteer ambulance company must be prohibited by state law from billing anyone for any service.

Connecticut, like most states, does not prohibit volunteer ambulance companies from billing for any services. Therefore, emergency responders who provide paramedic intercept services in Connecticut are barred from billing Medicare. Emergency response companies do have the option of entering into billing contracts with volunteer ambulance companies. If such a contract exists, the volunteer ambulance company bills Medicare at a higher rate which incorporates the cost of the paramedic. After the ambulance company receives its payment from Medicare, it then pays the emergency response company for the cost of the paramedic. Unfortunately, there is no legal requirement for volunteer companies and emergency response companies to enter into billing contracts. Moreover, if the emergency response company enters into a contract with a volunteer ambulance company, it will be paid significantly less per paramedic intercept service than if it bills Medicare beneficiaries directly. Thus emergency response companies are not inclined to enter into Medicare billing arrangements.

It was evidently not the intent of Congress to prohibit Medicare beneficiaries from receiving full coverage for emergency ambulance services. And yet currently, due to poorly written laws and billing policy, it is very likely that Medicare beneficiaries will not receive full coverage for their emergency ambulance services. This is a serious issue and one that should be addressed by both Congress and by the Centers for Medicare and Medicaid Services.

The Center for Medicare Advocacy, Inc. is a national, non-partisan education and advocacy organization that promotes fair access to Medicare and health care. The Center's national office is in Mansfield with offices in Washington DC and throughout the country. For more information contact Attorney Terry Berthelot at (860)456-7790 or visit the Center's website: www.medicareadvocacy.org. Se habla español.