

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAYMENTS FOR
AMBULANCE TRANSPORTS**



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E X E C U T I V E S U M M A R Y

OBJECTIVE

To evaluate whether ambulance transports met Medicare's coverage and level of service criteria and to evaluate safeguards in place to identify improper payments.

BACKGROUND

Medicare covers and pays for emergency and nonemergency ambulance transports when a beneficiary's medical condition, at the time of transport, is such that other means of transportation, such as taxi, private car, wheelchair van, or other type of vehicle, would jeopardize his or her health. Generally, nonemergency transports involve a beneficiary who is bed-confined. In calendar year (CY) 2002, Medicare allowed almost \$3 billion for ambulance transports.

Previous Office of Inspector General (OIG) studies indicated that Medicare's ambulance transport benefit was highly vulnerable to abuse. A 1994 inspection found that 70 percent of sampled dialysis-related ambulance transport claims did not meet Medicare's coverage requirements. A 1998 report found that two-thirds of sampled ambulance transports did not meet Medicare's coverage requirements; the majority of the claims found in error were nonemergency transports. We conducted this study because of the extent of problems found in the past with specific kinds of ambulance transports and to determine if the ambulance benefit was being used appropriately. We based our review on a sample of 720 ambulance claims from 2002 stratified by three categories of ambulance transports: transports to and from dialysis facilities, nonemergency transports, and emergency transports.

FINDINGS

Twenty-five percent of ambulance transports did not meet Medicare's program requirements, resulting in an estimated \$402 million of improper payments. In CY 2002, 13 percent of transports did not meet coverage criteria because the patient's condition did not warrant transport by ambulance, resulting in an estimated \$220 million in improper payments. Nine percent of covered transports did not meet level of service criteria because a lower level of ambulance transport was indicated, resulting in an estimated \$31 million paid improperly. Five percent of transports were found to be in error because the ambulance supplier, though contacted, did not respond to

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our request for documentation, resulting in an estimated \$150 million in improper payments.

We found statistically significant differences in coverage error rates when we compared either dialysis (27 percent) or nonemergency transports (20 percent) to emergency transports (7 percent). We did not find a statistically significant difference when we compared dialysis transports to nonemergency transports. Level of service error rates varied little across these categories.

Contractor safeguards are insufficient to identify and prevent improper payments for ambulance transports. The Medicare program mandates very few specific program safeguards to detect and prevent payment for improper ambulance transports. Under existing safeguards, contractors may choose the prepayment edits they use to screen claims for ambulance transports and the extent of postpayment activities they conduct. We found that contractors use few prepayment edits consistently. Less than half of the contractors we surveyed conducted postpayment review of ambulance claims. Of those contractors that conducted postpayment reviews of ambulance claims, most conducted only one or two postpayment reviews in CYs 2001 and 2002.

There are no uniform requirements regarding the kind of documentation contractors review to determine the appropriateness of ambulance transports. We were informed by contractors that contractor medical reviewers are allowed to and often do determine the appropriateness of the transport without obtaining additional documentation from the ambulance supplier or third-party providers, which include dialysis facilities, hospitals, and nursing homes. Our medical reviewers reported that making a determination of coverage required synthesizing information from various sources, particularly from third parties.

Our findings indicate that third-party providers that request ambulance transports may not be aware of Medicare's requirements for nonemergency ambulance transports. We found that almost two out of three noncovered transports originated at third-party facilities where it is unlikely that the patient initiated the ambulance transport. We found that contractors made minimal effort to educate these health care providers regarding coverage and level of service criteria for ambulance transports.

RECOMMENDATIONS

The Centers for Medicare & Medicaid Services should implement program integrity activities designed to reduce improper payments for ambulance transports at greatest risk for error.

The Centers for Medicare & Medicaid Services (CMS) should:

- (1) Consider instructing all Medicare contractors to implement prepayment edits that target dialysis and nonemergency ambulance transport claims;
- (2) Instruct Medicare contractors, when conducting postpayment medical reviews, to obtain documentation from ambulance suppliers and third-party providers to determine that ambulance transports meet program requirements; and
- (3) Direct Medicare contractors to educate third-party providers who initiate ambulance transports about the appropriate use of Medicare's nonemergency ambulance transport benefit. Once education has occurred, CMS may want to revisit the issue of noncovered ambulance transports ordered by third-party providers. If a problem still exists, CMS may want to determine if it can take administrative action and refer any potentially fraudulent or abusive providers to OIG.

In addition to these recommendations, we have forwarded information on noncovered, miscoded, and undocumented services we identified in our sample to CMS for appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS's comments are summarized below and included in their entirety as Appendix D.

CMS concurred with our recommendations. CMS indicated that it will advise all contractors to consider implementing prepayment edits for trips with an origin or destination modifier for a dialysis facility, as well as nonemergency transports to and from a hospital, nursing home, or physician's office. In addition, CMS noted that it will encourage contractors to consider obtaining documentation from ambulance suppliers and third-party providers to determine that ambulance transports meet program requirements on postpayment review. CMS also stated that it plans to encourage Medicare contractors to consider educating suppliers and third-party providers who initiate ambulance

transports about the appropriate use of Medicare's nonemergency ambulance transport benefit. If education proves ineffective, contractors should then determine if they can take administrative action and refer any potentially fraudulent or abusive providers to OIG.

CMS's comments did not warrant any revisions to the results of our review or our recommendations.

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OBJECTIVE

To determine whether ambulance transports met Medicare's coverage and level of service criteria and to evaluate the safeguards in place to identify improper payments.

BACKGROUND

Previous Office of Inspector General (OIG) studies indicated that Medicare's ambulance transport benefit was highly vulnerable to abuse. A 1994 report found that 70 percent of sampled dialysis-related transport claims were paid in error. A 1998 report found that two-thirds of sampled ambulance transports were paid in error. Nonemergency transports made up 70 percent of these transports paid in error.¹ OIG recommendations to address these issues included implementing prepayment edits designed to identify specific kinds of ambulance transports (e.g., dialysis transports) and education efforts targeted at Medicare ambulance suppliers, dialysis facilities, and beneficiaries. This OIG work also contributed to changes in ambulance policy and reimbursement practices as part of the Balanced Budget Act (BBA) of 1997.²

In calendar year (CY) 2002, Medicare paid approximately \$3 billion for ambulance transports.³ Ambulance transports in emergency and nonemergency situations are payable when these transports meet Medicare's program requirements as set forth in section 1861(s)(7) of the Social Security Act (the Act) and implementing regulations found in 42 CFR §§ 410.40 and 410.41. An ambulance transport is considered covered when transportation by means other than ambulance would jeopardize the patient's health. Once coverage requirements are met, requirements regarding medical necessity (e.g., the appropriate level of service necessary for the diagnosis or treatment of the patient's illness or injury) must be met.

Medicare Coverage of Ambulance Transports

Medicare pays for emergency and nonemergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation, such as taxi, private car, wheelchair van, or other type of vehicle, is contraindicated (i.e., would endanger the beneficiary's medical condition).⁴ Medicare does not cover means of transport other than ambulance.

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Emergency ambulance transport. An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- Place the patient's health in serious jeopardy,
- Result in serious impairment of bodily functions, or
- Result in serious dysfunction of any bodily organ.

Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:

- Severe pain or hemorrhage,
- Unconsciousness or shock,
- Injuries requiring immobilization of the patient,
- Patient needs to be restrained to keep from hurting himself or others,
- Patient requires oxygen or other skilled medical treatment during transportation, and
- Suspicion that the patient is experiencing a stroke or myocardial infarction.⁵

Nonemergency ambulance transports. Nonemergency transportation by ambulance is appropriate when a patient is bed-confined AND his/her condition is such that other methods of transportation are contraindicated; OR if the patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (e.g., the patient is combative and a danger to himself or others). While bed-confinement is an important factor to determine the appropriateness of nonemergency ambulance transports, bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare's ambulance benefits.

To be considered bed-confined, the patient must meet all three of the following criteria:

- Be unable to get up from bed without assistance,
- Be unable to ambulate, and
- Be unable to sit in a chair or wheelchair.⁶

Nonemergency transports are often scheduled in advance and are repetitive in nature, such as for patients with end-stage renal disease requiring maintenance treatments three times a week.

In these circumstances, ambulance suppliers must obtain or document all attempts to obtain a Physician Certification Statement (PCS) stating the reasons a patient requires nonemergency transportation by ambulance. The PCS or proof of the supplier's attempt to obtain it is required within 48 hours after providing the service. The PCS is effective for 60 days from the date it is signed.⁷

Level of Service

While program requirements determine whether Medicare will pay for an ambulance transport, the level of service required by the patient's condition determines the amount paid for a transport. Medicare only pays for the level of service deemed medically necessary. A transport denied due to level of service under section 1862(a)(1) of the Act, is usually reimbursed at a lower rate reflecting the lower level of service judged appropriate, rather than denied outright.⁸

Medicare pays for different levels of ambulance services. These service levels include Basic Life Support (BLS), Advanced Life Support (ALS), Specialty Care Transport (SCT), and air transport (fixed-wing and rotary-wing transport).⁹ These levels of service are differentiated by the qualifications and training of the crew and the equipment and supplies available on a vehicle that allows for treatment of more complex medical conditions. For example, to provide an ALS-level service, an ambulance must be equipped with specialized equipment, such as defibrillators and pulmonary/cardiac monitors and certain medications. Another distinction between ALS and BLS is the personnel that staff the ambulance. In most States, BLS services are rendered by basic and intermediate emergency medical technicians (EMT), while more intensive ALS services are provided by paramedic EMTs. The SCT transports require a level of service beyond what a paramedic can provide, such as care that must be provided by a medical professional—for example, a nurse or a respiratory therapist.¹⁰

Payments for Ambulance Transports

Providers of ambulance services submit claims for payment to carriers or fiscal intermediaries (FIs). Independent ambulance suppliers bill carriers on the uniform Medicare billing form, the Centers for Medicare & Medicaid Services (CMS) 1500. Provider-based ambulance suppliers (owned by or affiliated with a Medicare Part A provider such as a

hospital) bill the FIs on the uniform billing form known as the UB-82 (form CMS-1450). Ambulance suppliers are not required to submit additional documentation for billing purposes. However, Medicare rules require ambulance suppliers to retain appropriate documentation that contains information about the personnel involved in the transport and the patient's condition, and to obtain a PCS for nonemergency transports. These documents must be kept on file and made available for contractor review if requested.¹¹

Historically, ambulance payment was based solely on "reasonable charges" for independent suppliers or "reasonable cost" for hospital-based ambulance companies. The BBA required the Secretary of the Department of Health and Human Services to replace these methods with a national fee schedule.¹² Transition to the fee schedule began April 1, 2002. During the transition period, payment is based on a blend of a provider's old method and the fee schedule rates, with the fee schedule portion increasing to 100 percent beginning in 2006.¹³ The amount Medicare pays for covered ambulance transports is determined by the level of service required by the patient's condition.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) contains provisions affecting ambulance payments. The MMA establishes a regional ambulance fee schedule payment rate for services furnished between July 1, 2004, and December 31, 2009. For this same period, it increases the fee schedule payment amount for transports originating in the least-populated rural areas. It also adjusts ground mileage payments for transports greater than 50 miles provided between July 1, 2004, and December 31, 2008. For the period July 1, 2004, through December 31, 2006, reimbursement under the fee schedule for ambulance transports that originate in rural and urban areas increase by 2 percent and 1 percent, respectively.¹⁴

Contractor Program Safeguards

Carriers and FIs that process and pay Medicare claims, play a vital role in ensuring the integrity of Medicare payments through their program safeguard activities. Program safeguards include activities aimed at detecting and preventing improper Medicare payments. Ambulance program safeguards can include prepayment and postpayment activities, as well as educational efforts aimed at the ambulance suppliers, health care providers, and beneficiaries to inform them of program requirements for ambulance transports.

To assist contractors in program safeguard efforts, CMS has contracted with entities to promote the integrity of the Medicare program. These entities, known as program safeguard contractors (PSC), perform some or all of the activities currently done by FIs and carriers with the exception of processing and paying claims. PSC activities can include provider activity reviews, including medical, utilization, and fraud reviews; cost report audits; Medicare secondary payer determinations; provider and beneficiary education regarding program integrity; and developing and updating a list of durable medical equipment that is frequently subject to unnecessary utilization.¹⁵

Prepayment edits and reviews. Prepayment edits are automated procedures that identify claims that require further manual review by claims processing clerks or medical professionals (e.g., nurse practitioners or registered nurses). CMS requires few prepayment edits specifically for ambulance claims. Both the carriers and the FIs are required to edit zip codes for validity.¹⁶ FIs must edit ambulance claims to ensure proper reporting.¹⁷

If a claim is rejected due to an edit, it is subjected to a medical review, which consists of examining the information contained on the claim itself. Usually, the contractor reviews the claim, any other documents submitted with the claim, and the patient claim history files. For a small percentage of claims, the contractor requests additional records from the suppliers/providers that document the service that was billed to determine if it meets coverage and level of service criteria.¹⁸

In the case of an ambulance claim review, the contractor requests records on file with the ambulance supplier. These records vary by ambulance supplier in the amount of detail and information they contain. Generally, this additional documentation consists of a “trip ticket” and, for nonemergency transports, a PCS documenting why the patient requires transport by ambulance. The trip ticket is created by the ambulance supplier and contains information regarding the date, mileage, crew, origin, destination, and type and level of ambulance service provided. It also contains, to varying degrees, descriptive information regarding the condition of the patient and the type of service and supplies provided to the patient while in transport.¹⁹

Reviewing a medical record or other documentation on file to make a claim payment determination can be resource intensive for the Medicare program, providers, suppliers, and physicians. While medical review activities are important to ensure that claims are paid correctly,

CMS's policy is to weigh the relative benefit of appropriate payments with the expense of conducting medical reviews.²⁰

Postpayment reviews. CMS does not specifically require contractors to conduct postpayment reviews of ambulance claims. Apart from the general Medicare requirement that contractors conduct audits necessary to ensure that proper payments are made, there is no specific requirement to regularly review claims for specific services, such as ambulance services.²¹ Generally, postpayment activities involve analysis of claims data after payment has been made to identify aberrant billing patterns by service or provider type. Postpayment review can be done on an individual claim, but typically is done on a statistically valid sample of claims. As in prepayment review, a postpayment review typically consists of examining the claim and any other documents submitted with it. On occasion, contractors request more documentation for these reviews. The findings of these postpayment analyses are often the basis for implementing prepayment edits or for targeting specific providers for corrective actions or education.²²

Educational efforts. Contractor and CMS educational efforts are aimed at the health care community to inform them of program requirements and provide other useful information. Educational activities for Medicare services as well as ambulance services encompass a broad range of activities that include: (1) issuing bulletins or memorandums to the supplier community, (2) corresponding with a supplier who has consistently submitted claims in error, (3) conducting periodic conferences or conference calls with all interested parties regarding questions or clarifications of current or new policy, (4) making contractor personnel available to answer individual provider questions, (5) presenting information at public meetings where Medicare issues are discussed, and (6) maintaining Web sites that convey information regarding ambulance policies and billing procedures.

Liability for Ambulance Transports That Do Not Meet Program Requirements

Liability for any overpayment resulting from a denied ambulance transport claim depends on the type of denial. When a claim is denied for coverage reasons (such as when other forms of transportation are not contraindicated), the beneficiary is liable for any overpayment unless he or she lacks constructive knowledge that the service is not covered, or is otherwise without fault.²³

If the claim is denied due to level of service requirements (section 1862(a)(1) of the Act), it is usually not denied in total. Generally, these types of denials result in the claim being down-coded to a lower level of ambulance service. If an overpayment results, the ambulance supplier is liable unless the beneficiary signs an Advanced Beneficiary Notice that shifts liability to the beneficiary.²⁴ The Advanced Beneficiary Notice is rarely used and is only appropriate in limited, nonemergency situations.²⁵

METHODOLOGY

We used multiple methodologies to determine the appropriateness of Medicare payments for ambulance transports. To compare error rates for different kinds of claims, we used a stratified random sampling methodology to select claims for review. For our sampled claims, we compared the error rates for transports occurring before implementation of the fee schedule (April 1, 2002) and after. Our analysis revealed no difference in error rates between the two periods.

We conducted a medical review of ambulance supplier and third-party provider records associated with the patient for the date of transport on the selected claim. To determine what payment safeguards were in place to prevent and detect improper payments for ambulance transports, we interviewed officials from carriers and FIs. We did not verify contractor statements or written information provided about program safeguards.

Sample Selection

We defined our population as all Part A and Part B final action claims for ground ambulance transports occurring in CY 2002. The population consisted of 8,729,183 claims with a total allowed amount of \$2,966,104,982.

To detect statistical differences in error rates among categories of ambulance transports (dialysis, nonemergency, and emergency), we selected a representative sample of ambulance claims using a stratified random sampling strategy.

The sample size was 720 claims submitted to and paid by carriers and FIs for ambulance transports in CY 2002. We selected the sample from CMS's National Claims History database. We grouped the claims into strata according to the origin/destination of the transport (dialysis facility) and the type of transport (emergency and nonemergency). We selected 240 claims for each of 3 strata consisting of: (1) transports

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to/from dialysis facilities, (2) nonemergency transports (excluding dialysis transports), and (3) emergency transports (also excluding dialysis transports).

We excluded 69 claims from our original sample for the following reasons: ongoing investigations by OIG (17 claims), unable to contact the ambulance supplier (19 claims), the ambulance supplier was out of business (12 claims), contractors did not provide us with claim information (11 claims), and claims were used as part of the medical review pretest (10 claims). A description of the population and sample for each stratum appear in Table 1.

Transport Type	Stratum Number	Population	Original Sample Size	Excluded Claims	Revised Sample Size	Undocumented Claims	Documented Claims
Dialysis	1	866,379	240	38	202	12	190
Nonemergency	2	2,870,482	240	17	223	14	209
Emergency	3	4,992,322	240	14	226	9	217
Totals		8,729,183	720	69	651	35	616

Source: OIG analysis of CY 2002 ambulance claims data from the National Claims History Database, 2005.

Response to OIG Request for Documentation

For the sampled claims, we requested records from Medicare’s contractors, ambulance suppliers, and third-party providers associated with the transport. Table 2 contains a list of documents we requested from each source.

Table 2: Documents Requested by Source				
1 st Tier Documentation	2 nd Tier Documentation	3 rd Tier Documentation		
Medicare Contractors	Ambulance Suppliers	Dialysis Facilities	Hospitals	Nursing Facilities
-CMS 1500/UB 82 or printout of electronic claim -Ambulance supplier contact information	-Trip report -Dispatch record -Physician certification statement -CMS 1500/UB 82 or printout of electronic claim	-Treatment record -Social worker notes -Any documents containing information about patient's condition at the time of transport	-Admit/discharge records -Order sheet(s) -Patient history & physical exam -Rx/treatment records -Nurse notes -Progress notes -Consultation notes -Therapy notes -Dialysis records -Behavioral management monitoring records	-Admit/discharge records -Order sheet(s) -Most recent care plans -Most recent patient history & physical exam -Rx/treatment records -Nurse notes -Consultation or ancillary notes -Behavioral management monitoring records

We made a minimum of three attempts to obtain documentation from the contractors and the ambulance suppliers. To avoid putting an unnecessary burden on third-party providers, we made two attempts to obtain documentation from them. We used mail, phone, fax, or a combination of these methods to request documentation.

Of the 651 sampled claims, we received ambulance supplier documentation for 616 claims and no documentation for 35 claims. Of the 616 claims, we received third-party provider documentation for 547 claims. Table 3 illustrates the number of claims for which we received documentation. This documentation was then forwarded to our medical review contractor.

Table 3: Claims Documented and Reviewed by Transport Type				
Transport Type	Contractor Documentation Received (1st Tier Medical Review)	Ambulance Supplier Documentation Received (2nd Tier Medical Review)	Third-party Provider Documentation Received (3rd Tier Medical Review)	Undocumented Claims (Not Reviewed)
Dialysis Transports	190	190	158	12
Nonemergency Transports	209	209	194	14
Emergency Transports	217	217	195	9
Totals	616	616	547	35

Source: OIG analysis of CY 2002 ambulance claims data from the National Claims History Database, 2005.

OIG Medical Review

We contracted for the services of a medical review company that provided registered nurses to review the records and determine whether the ambulance transports met Medicare’s program requirements. Reviewers had several years of nursing, quality management, or claims review experience. They also had prior experience applying CMS’s coverage policies and guidelines. Reviewers completed a medical review instrument for each ambulance trip billed on the sampled claims.

Our medical reviewers conducted a three-tier review. The first tier consisted of reviewing only the claim form provided by the carriers and FIs. The second tier involved reviewing the claim form as well as documentation we obtained from the ambulance supplier. The third tier involved a review of all documents including medical records submitted by the third-party providers. Table 3 provides details regarding the number of claims reviewed in each of the three tiers.

Claims Analysis

Of the 616 claims for which we received ambulance supplier documentation, 547 also had documentation from at least one third-party provider (either the origin or the destination of the transport). The 35 undocumented claims were assumed not to have met coverage requirements at any of the 3 tiers of medical review and are counted as errors. We conducted our analysis on a final sample of 582 claims (547 third-tier reviewed claims and 35 undocumented claims considered in error) except for our analysis of the levels of documentation. Table 4 illustrates the number of claims we analyzed for this report.

Table 4: Claims Analysis		
Claim Type	Stratum Number	Claims Analyzed
Dialysis Transports	1	158
Nonemergency Transports	2	194
Emergency Transports	3	195
Subtotal of Claims		547
Undocumented Claims (Automatic Errors)		35
Total Claims Analyzed		582

Source: OIG analysis of CY 2002 ambulance claims data from the National Claims History Database, 2004.

We analyzed the medical reviewers’ determinations using SAS, SUDAAN, and Nud*IST software. We tested for statistical differences in error rates between the strata at the 0.05 significance level. We also estimated the dollar amounts paid in error in each stratum. All results are weighted appropriately and are reported based on the third-tier medical review determinations except where noted. Details of significance tests and confidence intervals for selected statistics are included in Appendixes A and B. For details about medical review determinations and documentation levels, see Appendix C.

Structured Interviews

In addition to the medical review, we contacted 23 contractors who hold 73 contracts to process and pay Medicare’s ambulance claims. For purposes of this report, we refer to each Medicare contract as a contract jurisdiction. These 23 contractors processed over 80 percent of all ambulance claims submitted in CY 2002. We conducted structured interviews with officials from these Medicare contractors to identify the safeguards in place to prevent improper payments for ambulance transports. Table 5 contains a description of the types of contractors we contacted for structured interviews. Contractors provided the information verbally and in written form, e.g., manuals, guidelines, etc.

Table 5: Structured Interviews with Contractor Representatives	
Type of Contractor	Number of Contractors Interviewed
Carrier - Process Medicare Part B Claims	7
Fiscal Intermediary – Process Medicare Part A Claims	5
Carrier and Fiscal Intermediary Process Both Medicare Part A and B Claims	11
Total	23

We also conducted interviews with staff at the following organizations: CMS headquarters, two CMS regional offices, one PSC , the American Ambulance Association, the American Kidney Association, and two major ambulance suppliers.

Scope

In addition to the previous and current OIG work examining ambulance transports, CMS, as part of its Comprehensive Error Rate Testing (CERT) program, measures errors in ambulance transports. The goal of CERT is to measure the performance of CMS's contractors by calculating a paid claims error rate. CMS bases the rate on the dollars paid after the contractor makes its payment decision on a claim. The paid claims error rate is a percentage of dollars that contractors erroneously allowed to be paid. In addition to the paid claims error rate, CMS calculates a provider compliance error rate and a services processed error rate.

In comparison, OIG's objective was to estimate a national paid claims error rate for ambulance transports, as well as to compare error rates among emergency, nonemergency, and dialysis transports. The OIG study was not designed to reproduce, or to review the CERT paid claims error rate.

Because the goals of the OIG review and CERT differ, the respective methodologies used to calculate the error rates differ. The OIG review included the following factors, differentiating it from CMS's CERT:

- A stratified sample by type of ambulance transport;
- Part A and Part B ambulance claims; and
- A multitiered review with increasing levels of documentation including information provided by third-party sources such as hospitals, nursing homes, and dialysis facilities.

The CERT program includes a random sample by contractor; includes only Part B claims; and reviews documentation provided by the ambulance supplier, which may not include third-party documentation for all claims.

In addition, there are differences in how the CERT and OIG report the calculated error rates. As mentioned previously, CMS calculates three different error rates. For the paid claims error rate and provider compliance error rate, CMS bases the rate on dollars. For the services processed error rate, CMS bases the error rate on the number of services. The OIG review bases the error rate on the number of claims. In addition to the overall fee-for-service error rate, CMS calculates error rates for individual contractors. The OIG review calculates error rates for the different types of ambulance transports and projects the error rate nationally, as well as dollars associated with claims paid in error.

I N T R O D U C T I O N

Our review was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

Twenty-five percent of ambulance transports did not meet Medicare program requirements, resulting in an estimated \$402 million of improper payments

We found that one in four ambulance transports in CY 2002 did not meet Medicare program requirements. There were three types of errors: (1) transports that did not meet Medicare’s coverage requirements, (2) covered transports that did not meet level of service requirements, and (3) transports for which the ambulance supplier did not submit documentation to substantiate the ambulance transport claim.

Table 6: Coverage, Level of Service, and Documentation Errors for Ambulance Transports

Type of Error	Sample (N=582 Claims)		Projected	
	Claims	Allowed Amounts	Claims (Proportion)	Allowed Amounts
Coverage	94	\$22,262.70	12.84%	\$220,305,387.22
Level of Service	38	\$2,352.18	8.72%	\$31,499,974.86
Undocumented	35	\$11,648.83	5.44%	\$149,886,464.66
- Nonresponse	34	\$11,283.59	5.39%	\$148,319,948.49
- Missing documentation	1	\$365.24	0.05%	\$1,566,516.17
Total Errors	167	\$36,263.71	24.77%	\$401,691,826.73

Source: OIG analysis of CY 2002 ambulance claims data from the National Claims History Database, 2004.

Thirteen percent of ambulance transports did not meet Medicare’s coverage criteria, resulting in an estimated \$220 million in improper payments

More than one in eight claims did not meet Medicare’s coverage criteria for ambulance transport. In these instances, failure to meet coverage criteria means that the patient’s condition did not warrant transport by ambulance; rather, the patient could have been transported by other means such as taxi, private car, wheelchair van, or another type of vehicle. Pursuant to section 1861(s)(1) of the Act, when other means of transport can be utilized without endangering the individual’s health (whether or not such other transportation is actually available), no payment may be made for ambulance service.

F I N D I N G S

Typical examples of transports determined by medical reviewers to be in error included the following:

- Although the patient required continuous oxygen to sit up and to transfer from bed to a chair, a wheelchair van would have been more appropriate, particularly when the trip was only a distance of 1 mile.
- The patient was very active at the skilled nursing facility. The patient sat up in a wheelchair while working at the gift shop. The patient also served on the nursing home patient council. In this case, use of a wheelchair van would have been more appropriate.
- The patient was able to get around in a wheelchair, although the patient needed assistance getting into the wheelchair. Transport to the dialysis facility via ambulance was inappropriate. A wheelchair van would have been more appropriate since the driver, skilled nursing facility staff, or dialysis staff could provide assistance.

Statistically significant differences in coverage error rates were found when comparing different categories of ambulance transports

Dialysis transports (27 percent) and nonemergency transports (20 percent) had a statistically significant higher coverage error rate than emergency transports (7 percent). The difference between dialysis and nonemergency transports was not statistically significant. Table 7 illustrates the error rates and the estimate of dollars paid in error. Refer to Appendix B for confidence intervals.

Table 7: Coverage Point Estimates (Percent and Dollars) by Stratum

Transport Type (Stratum)	Point Estimate (Percent in Error)	Point Estimate (Dollars in Error in Millions)
Dialysis Transports (N=158 claims)	27.22 %	\$ 47.93
Nonemergency Transports (N=194 claims)	19.59 %	\$101.33
Emergency Transports (N=195 claims)	6.67 %	\$71.05*
All Transports (N=547 claims)	12.84 %	\$220.31

Source: OIG Analysis of CY 2002 ambulance claims data from the National Claims History Database, 2004.

* Relative precision exceeds 50 percent. See Appendix A for confidence intervals for select statistics.

F I N D I N G S

Dialysis transports had a 27-percent coverage error rate. Our medical reviewers determined that 27 percent of ambulance transports to or from dialysis facilities did not meet Medicare’s coverage criteria, resulting in an estimated \$48 million in improper payments.

The ongoing and repetitive nature of dialysis treatment makes transports to and from such treatment vulnerable to abuse. For instance, physicians or other health care providers may sign a PSC initiating a standing order for ambulance transport valid for 60 days. This ensures that persons with end-stage renal failure requiring dialysis treatments (usually three times a week), and whose condition warrants ambulance transport receive the service. While the condition of some patients warrants repetitive, scheduled ambulance transports for dialysis treatment, many dialysis transports do not meet coverage criteria.

Nonemergency transports had a coverage error rate of 20 percent.

Nonemergency ambulance transports (not including dialysis trips) had a coverage error rate of 20 percent resulting in an estimated \$101 million in erroneous payments. These transports accounted for most of the money we estimate was paid due to coverage errors. Nonemergency transports have a lower error rate than dialysis transports, but account for the higher estimate of erroneous payments because of their higher volume.

Our medical reviewers expressed concern that ambulance vehicles are being misused as taxis or to facilitate transfers into and out of vehicles. Here is an example of this misuse of ambulance services recounted by our medical reviewers:

Pt [patient] had no ongoing assessment requirements during transport. Assist available at hospital & SNF [skilled nursing facility] to transfer patient. Stretcher van would have been adequate based on patient’s ability to self-propel wheelchair and the trip being only 1 mile.

This patient could have been transported in an alternative vehicle, but because he or she required assistance getting into and out of the vehicle, an ambulance was used to provide the necessary “lift” service. The coverage criteria, pursuant to section 1861(s)(1) of the Act, are clear that the need for transfer does not warrant an ambulance.

F I N D I N G S

Emergency transports had a coverage error rate of 7 percent. Emergency transports had the lowest coverage error rate and accounted for an estimated \$71 million* paid due to coverage error. The estimate of dollars paid in error for emergency transports is higher than the estimate for dialysis transports due to the higher volume of emergency transports and the higher reimbursement for emergency transports. Almost 60 percent of all ambulance claims processed in CY 2002 were for emergency transports.

Emergency transport coverage errors were typically due to discrepancies between ambulance supplier documentation and third-party provider documentation. One example, noted by our medical reviewers, involved a situation in which the ambulance supplier documentation listed a “slip and fall,” but the third-party provider documentation (emergency room records) made no mention of such an incident. This discrepancy led our reviewers to conclude that the ambulance transport was not warranted.

Beyond discrepancies in documentation, our reviewers found few problems with the Medicare contractors’ decisions to pay the emergency ambulance claims in our sample. The definition of an emergency is based on the response phase of the call (e.g., from firehouse to scene). These runs (911 calls) are generally considered emergencies. In some cases the ambulance supplier understood the call to be an emergency, although the actual ambulance trip (from scene to hospital) was not. An example of this situation is reflected in the following scenario recounted by our medical reviewers:

. . . an elderly woman notified her daughter she bumped her head on the bathtub and had a headache, the daughter suspects a head injury and calls an ambulance. On evaluation at the emergency department, the patient is found to have no significant problems and is referred to her primary care physician.

In such cases, our medical reviewers applied Medicare’s policy and did not overturn the decision to cover the transport.

* Relative precision exceeds 50 percent. See Appendix A for confidence intervals for selected statistics.

F I N D I N G S

Of all transports that met Medicare’s coverage criteria, 9 percent did not meet the level of service billed, resulting in an additional estimated \$31 million in improper payments

Nine percent of the transports that met coverage criteria were billed at a more intense level of service than was medically necessary. Pursuant to section 1862(a)(1) of the Act, Medicare pays only for the category of service provided and then only when the category of service is medically necessary.

One example, noted by our medical reviewers, involved a patient transferred from a skilled nursing facility to a hospital. The ambulance crew noted that the patient was combative at the scene and had other conditions that warranted an ambulance transport. However, vitals were not taken, no interventions were required, and the transport was documented as uneventful. This transport should have been paid at the BLS level but was paid at an ALS level.

Level of service error rates varied little across dialysis, nonemergency, and emergency transports. While differences in coverage error rates for the various types of ambulance transports were statistically significant, there was little difference between them concerning level of service. Despite little difference in level of service error rates, almost \$21 million of the overpayments resulting from such errors was for emergency transports because these types of transports are paid at a higher rate.

Five percent of transports lacked documentation, representing an estimated \$150 million in improper payments

Transports for which ambulance suppliers did not submit documentation to our office accounted for 5 percent of the overall errors. In all but one of these instances, ambulance suppliers did not respond to our multiple requests for documentation. In that one instance, an ambulance supplier had no record of conducting the transport in our sample and could not locate documentation for it.

Contractor safeguards are insufficient to identify and prevent improper payments for ambulance transports

Despite prior OIG recommendations to address ambulance program safeguard issues, Medicare mandates very few specific safeguards to prevent improper ambulance payments.

F I N D I N G S

Contractors use few prepayment edits consistently

Four of the twenty-three contractors we interviewed screened 100 percent of their ambulance claims before they were paid. These four contractors held a total of eight jurisdictional contracts (contracts representing different areas or States). Five of these contracts were for Part A contract jurisdictions with relatively low ambulance claim volume, and three were for Part B contract jurisdictions. One contract jurisdiction had no prepayment edits in place specifically for ambulance claims and another had edits in place only for paper claims.

Most of the prepayment edits reported by contractors are automated and result in a suspended or an automatically denied claim. Some of the suspended claims are subjected to further manual review, as discussed later in this report.

Table 8 lists prepayment edits that contractors reported using in CYs 2001 and 2002 specifically for ambulance claims. The edits are listed by the number of contract jurisdictions (n=73) with the specific edit in place rather than by the number of contractors (n=23) that used the edit. Contractors may hold more than one contract with CMS to process Medicare claims, and not every contract has the same edits in place.

Types of Edits Used	Number of Contracts With Edits (N=73)
Origin/Destination (i.e., hospital to hospital, nursing home to physician's office, dialysis facility to emergency room, all dialysis transports)	37
Mileage	27
Other (e.g., all ALS transports, all nonemergency transports, certain modifiers, condition codes, valid contracts between ambulance suppliers and hospitals)	19
Air Ambulance Transports	13
Zip Code	12
Certain HCPCS and Revenue Codes	10
Missing Information	8
Certain ICD-9 Codes/Diagnoses	8
Frequency of Transports	4
Specialty Transports	5
Multiple Patient Transports	4
Round-Trip Transports	3

Source: OIG analysis of contractor interview data, 2004.

Fewer than half of the contractors interviewed reported conducting postpayment reviews of ambulance claims

Medicare does not specifically require postpayment reviews of ambulance claims. Contractors decide the degree to which postpayment reviews are conducted and which services or providers/suppliers to target. Only 11 of 23 contractors reported conducting postpayment review of ambulance claims. One contractor reported conducting 53 such reviews. Another small contractor was instructed by CMS to conduct postpayment reviews of ambulance transports to dialysis facilities due to widespread problems identified. This contractor conducted 70 reviews during our review period. The majority of contractors reported conducting only one or two reviews in CYs 2001 and 2002.

There are no uniform requirements regarding documentation that should be reviewed when conducting prepayment or postpayment review of ambulance transports

Medicare requires ambulance suppliers, as most other billers, to submit only the claim form (CMS-1500 or UB-82) for payment. The claim form contains general billing information needed for all types of claims (e.g., patient identifier information), the origin and destination of the ambulance transport, mileage, the general condition of the patient, and the type of service provided (ALS, BLS, etc.).²⁶

Ambulance suppliers are not required to submit the trip ticket or the PCS with the claim. While the trip ticket varies by ambulance supplier, it describes in more detail the circumstances of the trip and the condition of the patient. Contractors do not consistently request this documentation when conducting prepayment or postpayment reviews of ambulance transport claims.

In only 13 of 73 contract jurisdictions did contractors report requesting third-party medical records to determine whether the transport met coverage and level of service guidelines. In nine of these instances, contractors report “rarely” or “sometimes, but usually not” requesting the third-party medical record.

Of those requesting third-party medical records, contractors reported that they were not always successful in obtaining them. Contractors also reported problems with the sufficiency of documentation provided by ambulance suppliers and third parties. Our medical reviewers, as well as two contractors, noted concerns regarding the insufficient amount of documentation submitted by dialysis facilities. Our

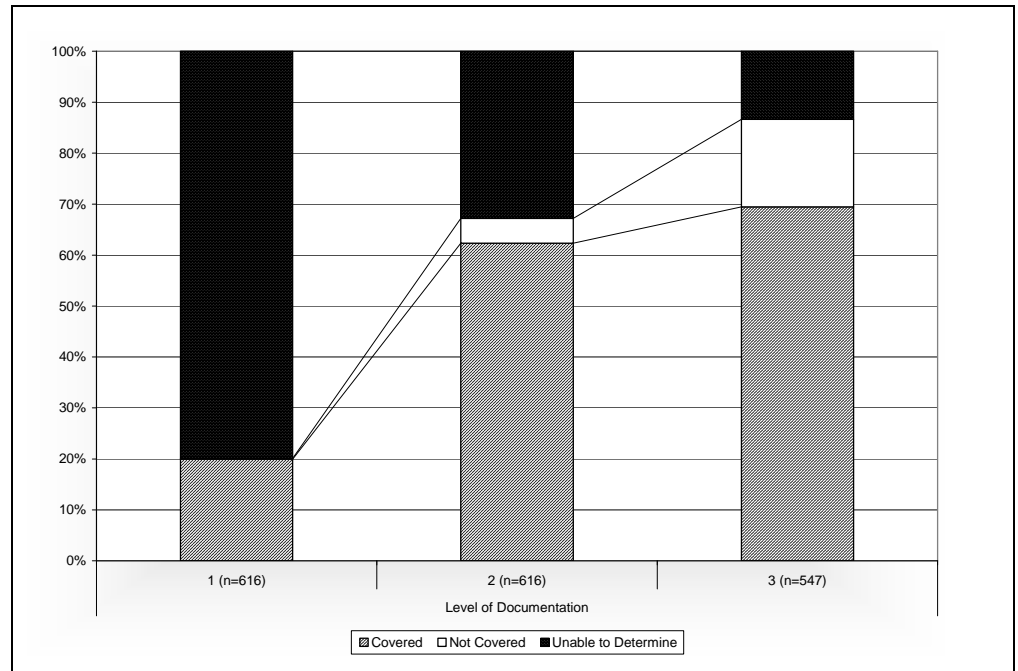
FINDINGS

reviewers noted that information provided was very brief and did not adequately describe the condition of the patient. Dialysis facilities generally maintain progress notes or social worker notes that describe the condition of the patient in detail, but these were often missing.

Our medical reviewers found it essential to obtain third-party documentation to determine the appropriateness of ambulance transports. They found that the additional amount of documentation reviewed, particularly that from third parties, increased their ability to determine whether ambulance transports met coverage criteria. Our medical reviewers reported that making a determination of coverage depended on a synthesis of information from various sources. A review based on a single source could result in an inaccurate determination or no determination at all.

Chart 1 illustrates the effect documentation has on determining coverage of ambulance transports.

Chart 1:
Medical Review
Determinations by
Level of
Documentation
Reviewed.



Source: OIG analysis of medical reviewer determinations, 2004.

The trend shows that, as the amount of documentation increased, the number of claims for which our reviewers were unable to determine whether the claim met coverage criteria decreased and the number of noncovered claims increased. Most of the transports reviewed at Level 1 (based solely on contractor documentation) resulted in an

inability to make a coverage determination. Based on a Level 2 review (contractor and ambulance supplier documentation), the number of claims the reviewers were unable to make a determination about decreased and reviewers began to identify more noncovered transports. The Level 3 review (contractor, ambulance supplier, and third-party provider documentation) resulted in even fewer claims for which our reviewers were unable to make a coverage determination and still more noncovered transports.

Obtaining records from third-party providers could help expose cases of document tampering by ambulance suppliers that could uncover cases of fraud or abuse. For example, on March 17, 2005, an ambulance company was sentenced to 5 years' probation and was ordered to provide community service following its conviction in a Federal fraud case.²⁷ Earlier this ambulance company had agreed to pay \$1.6 million to settle allegations that the company submitted false claims to Medicare and entered into a corporate integrity agreement to settle charges that it instructed its EMT and paramedic staff to omit information from ambulance records regarding patients' ambulatory status. The claims were for noncovered, nonemergency transports for dialysis treatment.²⁸ Also in October 2004, a hospital company, three of its hospitals, and an ambulance company agreed to pay \$20 million to settle allegations that they falsified PSCs to obtain reimbursement from Medicare for ambulance transports that did not meet Medicare's program requirements.²⁹

Beneficiaries, third-party providers, and physicians, unlike ambulance suppliers, receive little or no information regarding Medicare requirements for ambulance transports

In anticipation of the new ambulance fee schedule implemented in April 2002, contractors issued numerous program memorandums to the ambulance supplier community. To date, contractors have issued more than 600 such memorandums to the ambulance supplier community. These provider bulletins cover a wide variety of subjects ranging from policy changes, billing instructions, and clarifications, to other types of educational information.

However, little or no effort has been made to educate beneficiaries, physicians, or medical facilities about coverage and level of service issues affecting ambulance transports. Eleven of seventy-three contract jurisdictions reported conducting training for hospitals, seven reported training physicians, two reported offering training to dialysis facilities,

F I N D I N G S

and none reported providing information to nursing homes. In seven contract jurisdictions, contractors reported making educational contacts with beneficiary groups regarding ambulance coverage issues.

The majority of contractors reported that educational activities targeted at Medicare beneficiaries were limited due to reductions in outreach and education budgets. Two contractors further commented that CMS believed that information regarding coverage of ambulance services contained in the “Medicare and You Handbook” (the beneficiary handbook issued each year) was sufficient and further beneficiary education was not needed.

Lack of education may contribute to initiation of improper ambulance transports by third-party providers

Third parties who request nonemergency ambulance transports may not be aware of Medicare requirements for nonemergency ambulance transport. When a health care facility is the origin of the ambulance trip, it is unlikely that the beneficiary called for the ambulance transport. In these situations, a clinical judgment must be made to determine whether the patient’s condition meets the requirements for nonemergency transport. This decision is usually made, out of necessity, by the health care facility staff rather than the patient.

Our analysis of noncovered transports found that 63 percent of them originated from a third-party facility such as a hospital, nursing home, dialysis facility, or physician’s office. The remaining 37 percent originated from a residence or the scene of an accident. This is in contrast with covered transports, of which roughly 50 percent originated from a third-party facility and 50 percent from a residence or scene of accident. Of all transports, 57 percent originated at a third-party facility.

The lack of education afforded third-party providers regarding ambulance coverage guidelines may contribute to improper use of nonemergency transports. Our medical reviewers expressed concern that ambulances were being used as taxis or to facilitate transfers of patients into and out of vehicles as a convenience rather than out of medical necessity. Medicare’s guidelines for coverage of nonemergency ambulance transports are clear. The benefit should not be used for convenience, nor is availability of other types of transportation options a criterion for coverage.³⁰

► R E C O M M E N D A T I O N S

Since our previous work in this area, ambulance transport error rates have fallen, although nonemergency transports and transports to or from dialysis facilities continue to be problematic. Based on our current findings and the estimated \$402 million paid in error in CY 2002, we believe there continues to be a need for increased efforts to prevent improper payment of ambulance claims, particularly the dialysis and nonemergency transports that are at the greatest risk for error. Currently, contractors have inadequate safeguards to detect and prevent improper payments for specific types of ambulance transports, and neither CMS nor the contractors are adequately educating staff of third-party providers about Medicare's coverage rules for ambulance transports. Based on these findings, we offer the following recommendations. CMS should:

Implement Program Integrity Activities Designed to Reduce Improper Payments for Ambulance Transports at Greatest Risk for Error

Consider instructing all Medicare contractors to implement prepayment edits that target dialysis and nonemergency ambulance transport claims. We are sensitive to the fact that contractors must work within claims processing budgets and must be judicious in conducting additional reviews of claims. Therefore, we are not recommending prepayment review of all ambulance claims, although some contractors are currently doing this. Rather, we urge CMS to instruct contractors to consider adding prepayment edits that would scrutinize more closely claims where the trip origin or destination was a dialysis facility, or other nonemergency transports involving a hospital, nursing home, or physician's office.

Instruct contractors, when conducting a postpayment medical review, to obtain documentation from ambulance suppliers and third-party providers to determine if the transport meets program requirements. As indicated in our findings, contractors do not consistently obtain documentation from the ambulance supplier and from at least one provider associated with the transport (the origin or destination facility). We found this information to be necessary to determine the appropriateness of the transport.

Direct contractors to educate medical facilities that initiate ambulance transports about the appropriate use of Medicare's nonemergency ambulance transport benefit. Information similar to that sent to ambulance suppliers should be sent to nursing homes, dialysis facilities, hospitals, and

R E C O M M E N D A T I O N S

physicians instructing them on when it is appropriate to use an ambulance for nonemergency transports. The issue of beneficiary liability (i.e., the fact that should the transport be paid, and later denied, the beneficiary is liable for any overpayment unless he or she lacks constructive knowledge that the service is not covered) should also be discussed in these informational documents.

Once education of third-parties has been completed, CMS may want to examine whether third-party providers continue ordering noncovered ambulance transports. There is no incentive for third-party providers not to call an ambulance in nonemergency situations, especially when other suitable transportation options (e.g., stretcher or wheelchair van) are not available or difficult to arrange. If a problem still exists after educating third parties, we suggest that CMS examine existing departmental authorities that may permit CMS to take appropriate administrative actions against providers that demonstrate a pattern of improper use of the nonemergency ambulance benefit. If appropriate, suspected fraudulent and abusive providers should be referred to OIG.

In addition to these recommendations, we have forwarded information on noncovered, miscoded, and undocumented services identified in our sample to CMS for appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS's comments are summarized below and included in their entirety as Appendix D.

CMS concurred with our recommendations. CMS indicated that it will advise all contractors to consider implementing prepayment edits for trips with an origin or destination modifier for a dialysis facility, as well as nonemergency transports to and from a hospital, nursing home, or physician's office. In addition, CMS noted that it will encourage contractors to consider obtaining documentation from ambulance suppliers and third-party providers to determine that ambulance transports meet program requirements on postpayment review. CMS also stated that it plans to encourage Medicare contractors to consider educating suppliers and third-party providers who initiate ambulance transports about the appropriate use of Medicare's nonemergency ambulance transport benefit. If education proves ineffective, contractors should then determine if they can take administrative action and refer any potentially fraudulent or abusive providers to OIG.

CMS's comments did not warrant any revisions to the results of our review or our recommendations.

▶ E N D N O T E S

- ¹ Medicare Ambulance Payments: A Framework for Change. U.S. Department of Health and Human Services, Office of Inspector General, April 1999.
- ² BBA § 4531(b)(2) added § 1834(l) of the Social Security Act.
- ³ CMS Parts A and B ambulance claim files for CY 2002.
- ⁴ Social Security Act § 1861(s)(7) and 42 CFR §§ 410.40 and 410.41.
- ⁵ Medicare Part B Reference Manual, September 2001, Appendix F: Ambulance Billing Guide.
- ⁶ 42 CFR § 410.40(d)(1).
- ⁷ 42 CFR § 410.40(d)(2)(3).
- ⁸ The Medicare Ambulance Benefit - Statutory Bases for Denial of Claims, prepared by CMS, July 10, 2003.
- ⁹ 42 CFR § 410.40(b).
- ¹⁰ Medicare Part B Reference Manual, September 2001, Appendix F: Ambulance Billing Guide.
- ¹¹ 42 CFR § 410.40(3)(v) and Medicare Claims Processing Manual, Chapter 26: Completing and Processing Form CMS-1500 Data Set.
- ¹² BBA § 4531(b)(2).
- ¹³ 42 CFR § 414.615.
- ¹⁴ Social Security Act § 1834(l)(10)-(13).
- ¹⁵ Social Security Act § 1893(a)-(b). See also CMS web document at <http://www.cms.hhs.gov/providers/psc/pscwebp2.asp>.

¹⁶ Medicare Claims Processing Manual (Pub. 100-04), Chapter 15: Ambulance, sections 30.1.2 and 30.2.1 F.

¹⁷ Medicare Claims Processing Manual (Pub. 100-04), Chapter 15: Ambulance, section 30.2.1 F.

¹⁸ The Medicare Medical Review Program—Pay It Right, <http://www.cms.hhs.gov/providers/mr/default.asp>, accessed October 18, 2004.

¹⁹ Medicare Claims Processing Manual (Pub.100-04) Chapter 15: Ambulance, Section 30.2.

²⁰ Medicare Medical Review Program, <http://www.cms.hhs.gov/providers/mr/default.asp>, accessed October 18, 2004.

²¹ Social Security Act § 1842(a)(1)(C).

²² Medicare Medical Review Program, <http://www.cms.hhs.gov/providers/mr/default.asp>, accessed October 18, 2004.

²³ According to the document entitled “The Medicare Ambulance Benefit—Statutory Bases for Denial of Claims,”

. . . beneficiaries are liable for denial for ambulance claims under §1861(s)(7). Nevertheless, that fact does not abrogate any other protections from financial liability that the beneficiary may have, e.g., the beneficiary cannot be charged when a provider agreement is violated in some circumstances (see 42 CFR § 489.21(b) regarding failure to submit proper claims) or instances in which a waiver of recovery for overpayments applies (see §§ 1870, 1879, and 1842(l)). There are also protections against fraud, abuse, substandard care, quackery, etc. (See title XI, § 1128A(a)(1)(E).

²⁴ Medicare Claims Processing Manual, Chapter 30: Financial Liability Protections.

²⁵ CMS Program Memorandum AB-03-106, July 25,2003.

- ²⁶ CMS Publication 100-04—Medicare Claims Processing. Transmittal 459, February 4, 2005.
- ²⁷ Norwich Ambulance Company Pleads Guilty to Federal Health Care Fraud Charge. Press Release: United States Attorney's Office, District of Connecticut, October 19, 2004.
- ²⁸ Norwich Ambulance Company Sentenced on Federal Health Care Fraud Case. Press Release: United States Attorney's Office, District of Connecticut, March 18, 2005.
- ²⁹ Hospital, Ambulance Firms Agree to Pay \$20 Million in False Certifications Case. BNA Health Care Daily Report, Volume 9 Number 209, October 29, 2004.
- ³⁰ Medicare Part B Reference Manual, September 2001, Appendix F: Ambulance Billing Guide.

➤ A P P E N D I X ~ A

Confidence Intervals for Selected Statistics

Confidence Intervals for All Errors by Type of Transport						
Transport Type	Error Estimates			Dollar Estimates		
	Point Estimate	Upper 95	Lower 95	Point Estimate	Upper 95	Lower 95
All Transports (N=582)	24.77%	28.57%	20.97%	\$401,691,827	\$483,038,776	\$320,344,878
Dialysis (N=170)	37.65%	44.94%	30.36%	\$ 66,391,695	\$ 83,534,318	\$ 49,249,072
Nonemergency (N=208)	30.77%	37.06%	24.48%	\$172,908,954	\$222,029,291	\$123,788,617
Emergency (N=204)	19.12%	24.53%	13.71%	\$162,391,178	\$224,926,361	\$ 99,855,995

Confidence Intervals for Coverage Errors by Type of Transport						
Transport Type	Coverage Error Estimates			Dollar Estimates		
	Point Estimate	Upper 95	Lower 95	Point Estimate	Upper 95	Lower 95
All Transports (N=547)	12.84%	15.68%	10.00%	\$220,305,387	\$275,437,008	\$165,173,766
Dialysis (N=158)	27.22%	34.18%	20.26%	\$ 47,925,942	\$ 62,716,223	\$ 33,135,661
Nonemergency (N=194)	19.59%	25.20%	13.98%	\$101,334,064	\$134,524,689	\$ 68,143,440
Emergency (N=195)	6.67%	10.18%	3.16%	\$ 71,045,381	\$112,507,721	\$ 29,583,041

Confidence Intervals for Level of Service Errors by Type of Transport						
Transport Type	Level of Service Error Estimates			Dollar Estimates		
	Point Estimate	Upper 95	Lower 95	Point Estimate	Upper 95	Lower 95
All Transports (N=453)	8.72%	12.18%	5.78%	\$31,499,975	\$43,895,645	\$19,104,305
Dialysis (N=115)	7.83%	12.30%	2.91%	\$ 3,707,973	\$ 8,782,333	\$ 0
Nonemergency (N=156)	7.69%	11.79%	3.50%	\$ 7,080,050	\$12,394,118	\$ 1,765,982
Emergency (N=182)	9.34%	13.46%	5.11%	\$20,711,951	\$30,695,147	\$11,728,755

Confidence Intervals for Documentation Errors by Type of Transport						
Documentation Type	Documentation Error Estimates			Dollar Estimates		
	Point Estimate	Upper 95	Lower 95	Point Estimate	Upper 95	Lower 95
All Transports (N=582)	5.44%	7.46%	3.42%	\$149,886,465	\$213,136,543	\$86,636,386

➤ **A P P E N D I X B**

Significance Tests for Selected Statistics

Comparison of Coverage Error Rates by Type of Transport (N=582)				
Transport Type		Error Rates		P value Chi-Square
Target	Comparison	Target Transport Type Point Estimate	Comparison Transport Type Point Estimate	
Dialysis	Nonemergency	27.22%	19.59%	0.1176
Dialysis*	Emergency	27.22%	6.67%	0.0000
Nonemergency*	Emergency	19.59%	6.67%	0.0001
Bonferroni threshold = 0.016667				

* Differences in error rates are statistically significant at the 0.05 level.

➤ A P P E N D I X ~ C

Medical Reviewer Coverage Determinations by Documentation Level

All Transports			
Coverage Determination	Level 3 Documentation (N=547)	Level 2 Documentation (N=616)	Level 1 Documentation (N=616)
Not Covered	12.84%	4.51%	0.16%
Covered	79.71%	73.22%	25.01%
Unable to Determine	7.45%	22.27%	74.84%
Total	100%	100%	100%

Dialysis Transports			
Coverage Determination	Level 3 Documentation (N=158)	Level 2 Documentation (N=190)	Level 1 Documentation (N=190)
Not Covered	27.22%	5.26%	0.00%
Covered	40.51%	37.89%	10.53%
Unable to Determine	32.28%	56.84%	89.47%
Total	100%	100%	100%

Nonemergency Transports			
Coverage Determination	Level 3 Documentation (N=194)	Level 2 Documentation (N=209)	Level 1 Documentation (N=209)
Not Covered	19.59%	5.74%	0.48%
Covered	72.16%	58.37%	14.83%
Unable to Determine	8.25%	35.89%	84.69%
Total	100%	100%	100%

Emergency Transports			
Coverage Determination	Level 3 Documentation (N=195)	Level 2 Documentation (N=217)	Level 1 Documentation (N=217)
Not Covered	6.67%	3.69%	0.00%
Covered	90.26%	87.56%	33.18%
Unable to Determine	3.08%	8.76%	66.12%
Total	100%	100%	100%



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 11 2005

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

FROM: Mark McClellan, M.D., Ph.D. *[Signature]*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: OIG Draft Report, "Medicare Payments for Ambulance Transports"
(OEI--02-00590)

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 GENERAL

The Centers for Medicare & Medicaid Services (CMS) would like to thank the Office of Inspector General (OIG) for their investigation into this program vulnerability. We appreciate the opportunity to provide the following comments on this report.

Medicare covers and pays for emergency and non-emergency ambulance transports when a beneficiary's medical condition, at the time of transport, is such that other means of transportation, such as taxi, private car, wheelchair van, or other type of vehicle, would jeopardize the beneficiary's health.

The OIG contracted with independent reviewers to analyze whether ambulance payments made in calendar year 2002 met Medicare program requirements. They determined that Medicare inappropriately paid 25 percent of ambulance transports, amounting to estimated improper payments of \$402 million. More specifically, dialysis transports had a coverage error rate (error rate based on number of claims, and associated dollars) of 27 percent, other non-emergency transports had a coverage error rate of 20 percent, and emergency transports had a coverage error rate of 7 percent.

The OIG found that few contractors use ambulance-specific prepayment edits consistently, and that half did not perform post pay ambulance review. Of those claims reviewed there were no uniform documentation requirements. The OIG further states that little education was provided to third-party providers regarding Medicare's coverage requirements.

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OIG Recommendations

The OIG recommends that CMS consider instructing all Medicare contractors to implement prepayment edits that target dialysis and non-emergency ambulance transport claims.

CMS Response

The CMS concurs with the OIG's recommendation to consider instructing all Medicare contractors to implement prepayment edits that target dialysis and non-emergency ambulance transport claims. CMS will advise all contractors to consider implementing prepayment edits for trips with an origin or destination modifier for a dialysis facility, as well as non-emergency transports to and from a hospital, nursing home, or physician's office. As with any determination to allocate medical review resources, contractors should implement prepayment edits only where contractor data indicates that aberrant billing practices make this a priority activity.

OIG Recommendations

The OIG recommends that CMS instruct Medicare contractors, when conducting post payment medical reviews, to obtain documentation from ambulance suppliers and third-party providers to determine that ambulance transports meet program requirements.

CMS Response

The CMS concurs with the OIG's recommendation, and will encourage contractors to consider obtaining documentation from ambulance suppliers and third-party providers to determine that ambulance transports meet program requirements on post pay review. We will advise them of the increased accuracy that can be realized as a result of this additional development, as demonstrated by your study.

OIG Recommendations

The OIG recommends that CMS direct Medicare contractors to educate third-party providers who initiate ambulance transports about the appropriate use of Medicare's non-emergency ambulance transport benefit.

CMS Response

The CMS concurs with OIG's recommendation to direct Medicare contractors to educate suppliers and third-party providers who initiate ambulance transports about the appropriate use of Medicare's non-emergency ambulance transport benefit. CMS

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anticipates posting a provider education article on the CMS' Medlearn Web site regarding coverage and level of service requirements. CMS will also encourage contractors to consider educating suppliers and third-party providers on coverage and level of service requirements through local provider education and training (LPET) activities, where they identify aberrancies with a provider or supplier, or a group of providers or suppliers. Should education prove ineffective, contractors will determine if they can take administrative action and refer any potentially fraudulent or abusive providers to the OIG.

OIG Recommendations

Once education has occurred, the OIG recommends that if a problem still exists, CMS may want to determine if they can take administrative action and refer any potentially fraudulent or abusive providers to the OIG.

CMS Response

The CMS will take action on the information you forward on non-covered, miscoded, and undocumented services identified as part of OIG's sample.

Once again CMS would like to thank the OIG for their efforts in identifying ambulance payment vulnerabilities and improper payments. CMS looks forward to continued collaboration with the OIG to reduce the risk of improper billing.



A C K N O W L E D G M E N T S

This report was prepared under the direction of William C. Moran, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Ann Maxwell, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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