MEDICARE PART B AMBULANCE SERVICES

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MEDICARE PART B

AMBULANCE SERVICES

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I. EXECUTIVE SUMMARY

Medicare Part B covers ambulance services to a hospital, nursing home or the patient's home "...only if other means of transportation would endanger the beneficiary's health" [42 CFR 405.232 (i)(2)]. Payment is based on customary and prevailing rates in an area. A base rate is paid for each trip. Additional charges may be allowed for mileage, oxygen, waiting time, and night or emergency trips.

During 1986, the Office of Inspector General, Office of Analysis and Inspections, conducted a national inspection of Medicare Part B ambulance services. The inspection was conducted in response to concerns that Medicare may be paying unreasonably high amounts for ambulance services.

The purposes of the inspection were to determine: 1) why Medicare costs have grown so rapidly; 2) how to control costs; 3) whether public entities can be expected to shift additional costs to Medicare in the future; and 4) the impact of Advanced Life Support (ALS) coverage on Medicare costs.

The inspection found that Part B ambulance costs have risen at an average rate of over 20 percent annually since 1974. Data on the extent to which the increase has resulted from increased utilization is not available. However, we identified several other major reasons for this rapid cost escalation: 1) inability of the reasonable charge methodology to control increases in supplier charges; 2) higher State and local emergency medical services (EMS) standards, resulting in part from Federal legislation; 3) a shift of public provider costs for emergency ambulance services to Medicare; and 4) lack of an economic index cap on reimbursement increases for ambulance services prior to October 1, 1985.

We found that most of the shift of public provider expenses for ALS services to Medicare has already occurred. In addition, local regulation of EMS has helped control Medicare costs in some areas. Where local governments set ambulance rates, Medicare prevailings remain low. Local subsidies for emergency (911) services reduce Medicare ALS costs in some areas. Overall, the extension of Medicare coverage to ALS in 1982 has not had a significant effect on costs.

The inspection found dramatic variation among carriers in prevailing charge rates and coverage for ambulance services. For example, 1984 basic life support (BLS) prevailings ranged from $60 to $115, while ALS prevailings ranged from $90 to $275. Some carriers pay extra for every mile the patient is transported, while others do not allow mileage within defined local limits. Mileage allowances range from

$2 to $6.50 per mile. While most carriers pay extra for emergency and night trips, a few do not. Oxygen rates range from $7 to $25.

The inspection found that Medicare is paying too much for ambulance services. Medicare pays more than the Veterans Administration (VA), health maintenance organizations (HMOs), and hospitals for BLS services. These purchasers use competitive bidding to obtain low rates for BLS ambulance transportation. VA hospitals contract with ambulance suppliers for BLS services at rates approximately 25 percent lower than comparable Medicare rates.

One Medicare carrier has applied its inherent reasonableness authority, achieving annual savings of 15.8 percent. If all carriers were to reduce rates by 15.8 percent, Medicare could save $69 million annually.

We identified 18 major American cities which provide emergency ambulance transportation through competitively awarded contracts with private companies. Some of these arrangements have been in effect for five years or more, with no reduction in the quality of care provided to patients.

Our draft report contained two recommendations: to require carriers to use their inherent reasonableness authority to limit ambulance charges, and to seek legislative authority to allow carriers to use competitive bidding to set ambulance reimbursement rates (the VA approach).

Comments on the draft were received from the Health Care Financing Administration (HCFA) and the American Ambulance Association (AAA). Both respondents generally supported the concept of inherent reasonableness but were concerned about the specific method and factors to be used in determining the reasonableness of ambulance charges. The AAA offered to assist HCFA in arriving at the specific factors to apply.

Neither HCFA nor the AAA agreed with our recommendation on competitive bidding. Both respondents indicated that while this approach would be appropriate for non-emergency BLS transportation, competitive bidding by Medicare might reduce the timeliness, availability and quality of care provided to Medicare beneficiaries in emergency situations. We recognize that more research may be needed to insure continued high quality and timeliness of emergency medical transportation received by Medicare beneficiaries. Therefore, we have revised our recommendations to include seeking competitive bidding authority for BLS transportation, followed by consideration of a similar approach for ALS transportation.

II. INTRODUCTION

Medicare Part B covers ambulance services to a hospital, nursing home or the patient's home, and "...only if other means of transportation would endanger the beneficiary's health" [42 CFR 405.232(i)(2)]. Payment is based on customary and prevailing rates in an area. A base rate is paid for each trip. Additional charges may be allowed for mileage, oxygen, waiting time, and night or emergency trips.

Most of Medicare's ambulance costs are for "basic life support (BLS)" ambulances, which perform scheduled or nonscheduled transfers of nonambulatory patients to or from their homes, hospital or nursing home, at the time of hospital admission or discharge, or for scheduled therapy. BLS ambulances are staffed by emergency medical technicians (EMTs). Most BLS services are provided by private ambulance companies.

In 1982, Medicare extended coverage to include "advanced life support (ALS)" ambulance service. ALS ambulances are actually mobile intensive care units, staffed with highly trained paramedic personnel and equipped with specialized equipment for use in life-threatening situations, such as highway accidents or cardiac arrests. ALS units respond to 911 emergency calls and are typically associated with local fire departments or rescue squads. A detailed description of different levels of medical transportation appears at Appendix A.

Part B reimbursement for ambulance services has increased dramatically over the past decade. Total 1974 expenditures of $34 million grew to over $350 million in 1985. At an average annual increase of more than 20 percent, ambulance costs have grown faster than most other Part B services, and far faster than the rate of inflation.

Reimbursement rates vary widely across the country. In 1984, the average cost per claim ranged from $55 in Tennessee to $175 in northern California, with a mean of $106.

This inspection was conducted in response to concerns that Medicare may be paying unreasonably high amounts for ALS and routine short-distance BLS ambulance trips. In addition, rapid cost escalation has called into question the appropriateness of the reasonable charge methodology in determining ambulance reimbursement.

The purpose of this inspection was to determine: 1) why Medicare costs have grown so rapidly; 2) how to control costs; 3) whether public entities can be expected to shift additional costs to Medicare in the future; and 4) the impact of ALS coverage on Medicare costs.

The inspection was conducted in California, Florida, New York, Pennsylvania, Michigan, Ohio, Texas and Massachusetts, where more than half of Medicare's total ambulance costs are incurred. Contacts included 9 Medicare carriers, 15 State and local emergency medical services agencies, 51 ambulance suppliers (city fire and rescue services, private companies, and volunteer fire departments), 50 purchasers of ambulance transportation (VA hospitals, health maintenance organizations and hospitals), and the American Ambulance Association.

III. FINDINGS

WHY HAVE AMBULANCE COSTS RISEN SO DRAMATICALLY?

Part B ambulance costs have risen at an average annual rate of over 20 percent since 1974. Data are not available on the extent to which the increase is attributable to increased utilization. However, the inspection identified four other major factors which have contributed to the rapid rise in Medicare ambulance costs: 1) inability of the reasonable charge methodology to control increases in supplier charges; 2) higher EMS standards at every level, in large part a response to Federal legislation; 3) a shift of public provider costs for emergency ambulance services to Medicare; and 4) no inflationary cap on Medicare ambulance increases prior to October 1, 1985.

1. REASONABLE CHARGE METHODOLOGY HAS RESULTED IN UNCONTROLLED RATE INCREASES

The Medicare Part B reasonable charge methodology is based upon the customary and prevailing charges of suppliers within a particular locality. The prevailing charge is intended to limit individual provider increases, but over a period of years, the reasonable charge methodology has resulted in nationwide annual increases in ambulance costs greater than increases in most other Part B services, and far in excess of the rate of inflation. The following chart shows estimated annual increases in Part B ambulance costs since 1974.

MEDICARE PART B AMBULANCE EXPENDITURES

Year	Estimated Cost (in millions)	Percentage Increase
1974	$ 34	----
1975	45	32.4%
1976	56	24.4
1977	71	26.8
1978	87	22.5
1979	no est. available	56.3 (2-year period)
1980	136	
1981	165	21.3
1982	188	13.9
1983	231	22.9
1984	248	7.4
1985	305	23.0
1986	385	26.2
1987	435	13.0
1988	495	13.8

Source: Figures for 1974-83 provided by Bureau of Data Management Systems, HCFA, based on 5 percent carrier sample of claims. Figures for 1984-85 based on HCFA Payment Record Tables, 100 percent sample. Estimates for 1986-88 provided by Office of the Actuary, HCFA.

While these figures illustrate the dramatic rise in ambulance costs, we believe that actual Part B expenditures may have been underreported. Approximately $31 million in Part B expenditures made by one carrier in our sample were not included in the 1985 estimate.

In addition, EMS systems in some areas are hospital-based, with ambulance costs billed to Medicare through the cost report. In three of our sample areas, we discovered over $4 million in ambulance costs reimbursed through cost reports on a reasonable cost basis. Other city or county EMS systems may also be claiming ambulance reimbursement through hospital cost reports which are not reflected in the chart above.

2. FEDERAL LEGISLATION HAS RAISED COSTS AS WELL AS STANDARDS

Federal legislation and standards have had a direct impact on the development of emergency medical services, including ambulance services, throughout the United States.

The National Highway Safety Act of 1966, administered by the Department of Transportation, supports State programs to reduce traffic accidents, deaths and injuries. It has led to upgraded emergency medical services at the local level, through ambulance purchase, training of ambulance attendants and drivers, and improved ambulance medical equipment.

The Emergency Medical Services Systems Act of 1973 provided a mechanism for communities to establish regular EMS delivery systems. Administered by the Public Health Service, the Act required that federally-funded emergency care programs use a systems approach to providing emergency response and medical care. The approach centered around 15 systems components, such as manpower, training, communications and transportation, and seven critical patient groups, including acute cardiac victims. Now a part of the Preventive Health Services Block Grant, these funds are used by States for planning, establishing and expanding their EMS systems.

The General Services Administration (GSA) has published specifications for the design, performance, and equipping of ambulances used by Federal agencies. About half of the States have adopted the GSA standards (Federal Specification KKK-A-1822A) as a requirement for State licensure. Many others have established their own vehicle standards.

Today, every State has an EMS office and some type of statewide EMS system. Thirty-seven States have passed EMS laws. In addition to vehicle standards, many States

have adopted minimum personnel requirements. Some 39 States are divided into multiple EMS regions served by local councils.

The actual delivery of emergency services is usually the responsibility of local governments, which may provide services directly through fire or rescue departments or contract with private ambulance companies for emergency medical transport. In some areas, local units of government have the authority to set maximum rates for ambulance services. Where this has occurred, ambulance rates tend to be somewhat lower than in areas where rate setting systems are not in effect.

Since passage of the EMS Services Act, every aspect of emergency medical services has been upgraded and improved. Emergency medical services are available in virtually every part of the U.S. Highly trained staff using state of the art vehicles and equipment can respond to any type of medical emergency, providing on-site treatment and stabilization, then rapid transport to the hospital, following established medical protocols and in constant radio communication with a physician trained in emergency medicine. A new level of service, advanced life support (ALS), has been created to provide emergency life-saving treatment during transit.

The rise in standards has not been limited to ALS emergency vehicles and personnel. Basic ambulances are constantly being improved and upgraded, and staffing qualifications are higher than ever before.

Improved response times, better equipped vehicles, and highly trained staff have all resulted in improved services to the public. They have also resulted in higher costs for public agencies, private suppliers, third party payers, and consumers.

3. LOCAL GOVERNMENTS HAVE SHIFTED EMERGENCY AMBULANCE COSTS TO MEDICARE

Emergency ambulance services have traditionally been provided by local fire departments or volunteer fire and rescue squads. Historically, these services were fully financed by local taxes and contributions.

Declining local revenues coupled with rising operational costs have caused most public agencies to begin billing individuals and third party payers for emergency ambulance transportation. Since public agencies are largely supported by local tax revenues, fees are usually set at a low rate designed to help defray costs, rather than to cover the actual cost of providing the service.

To save money, a growing number of cities and counties contract out their entire EMS systems to the private sector. Several cities visited during this inspection had begun submitting bills in the last few years. Contractors collect fees from individuals and all available third party sources. In addition, local governments may provide subsidies to defray the cost of transporting uninsured individuals who are unable to pay a fee.

The inspection found that much of this shift has already occurred. In a survey of the 100 largest U.S. cities, 86 indicated that Medicare is being charged for emergency ambulance services. Of the remaining 14 who do not charge, 3 are considering charging for transport in the near future. Some volunteer ambulance companies, traditionally providing free ambulance transport, now charge for the service. Others can be expected to begin charging in the future.

4. NEW REGULATION WILL LIMIT FUTURE REIMBURSEMENT INCREASES

Historically, reimbursement increases in nonphysician Part B services have been exempt from economic index limitations previously applied to physician services. Over the years, increased ambulance supplier charges were fully reflected in higher prevailing charge screens established by carriers.

In a final regulation which became effective October 1, 1985, such increases are limited by a new factor, the "inflation-indexed charge," representing the reasonable charge from the preceding fee screen year plus an inflation adjustment factor. This regulation will control the rate of future increases for ambulance and other Part B nonphysician services. However, it does not affect increases which took place in prior years.

ARE MEDICARE AMBULANCE COSTS REASONABLE?

To determine the reasonableness of Medicare payments, we compared BLS base rates paid by Medicare, private hospitals and Veterans Administration hospitals in the States we visited.

1. MEDICARE COMPARED WITH HOSPITALS

Under the Prospective Payment System (PPS), Part B no longer covers the transfer of a Medicare beneficiary between one hospital and another (for treatment or tests) if the patient remains an inpatient of the first hospital. These costs are included in the Part A hospital payment.

Hospitals have begun contracting with private ambulance companies to transport these patients, often at a cost substantially lower than the Medicare prevailing. Here are several examples:

- In a major southwestern city, a private company transports patients between a hospital and a local testing center for $35 each way. When that patient is discharged to home or nursing home, the supplier charges Medicare $110.

- In a major city in the northeast, an ambulance company transports inpatients for diagnostic tests under contract for $55 per trip. The Medicare prevailing is $106.

- A company in a west coast city contracts with a hospital and an HMO for $64.50 per trip. Medicare allows $90.

These examples illustrate that at least in some areas, Medicare is paying more for ambulance services than other large purchasers that have been able to negotiate contracts with ambulance companies.

2. ONE CARRIER'S EXPERIENCE

The Medicare Carriers Manual (HIM 5246) provides that when the use of customary and prevailing charge data results in payment rates that are not "inherently reasonable," the carrier should consider other factors in determining payment. HIM 5246 cites several types of situations where charges might not meet the inherent reasonableness standard. Among those which could apply to ambulance services are:

- charges in a particular locality may be substantially out of line with charges in other localities or other carriers' service areas, and the differences in prices cannot be justified solely on the basis of economic factors;

- sudden increases in charges that cannot be readily explained by the normal rate of inflation or by other economic factors or technology; and

- charges do not reflect the influence of a competitive marketplace, i.e., the market is "dominated" by one or a few suppliers.

Empire Blue Shield, the carrier serving greater New York City, has used its inherent reasonableness authority to limit expenditures for ambulance services.

The following chart summarizes the savings achieved by Empire Blue Shield. A detailed breakdown of savings is provided at Appendix B.

AMBULANCE SAVINGS BASED ON INHERENT REASONABLENESS
Empire Blue Shield (Greater New York City)
April 1984 - March 1985

Procedure	Number of Services	Allowed Amounts		Savings	
		75th Percentile	Inherent Reasonable.	Allowed	%
BLS Base Rate	285,472	$39,150,148	$32,736,713	$6,413,435	16.4
ALS Base Rate	5,788	1,260,365	1,180,325	80,040	6.4
Mileage	1,591,437	4,959,107	4,296,880	662,227	13.4
Oxygen	35,793	1,145,970	966,411	179,559	15.7
Other Services	4,725	111,628	96,193	15,435	13.8
TOTALS		$46,627,218	$39,276,522	$7,350,696	15.8%

In the one-year period ending March 31, 1985, Empire Blue Shield saved $7.4 million in allowed charges, and $5.9 million in actual payments for ambulance services. This represents 15.8 percent of what would have been paid under the reasonable charge methodology. Over $5 million (87.2 percent) of the savings resulted from lower rates for BLS.

To arrive at an estimate of potential national savings, we applied the percentage of savings achieved by Empire Blue Shield (15.8 percent) to the Office of the Actuary estimate of Part B expenditures for FY 1987 ($435 million). Based on these calculations, potential nationwide annual savings of $69 million could be realized if all carriers saved 15.8 percent through use of their inherent reasonableness authority.

We surveyed all other Medicare carriers to learn whether they use any means other than the reasonable charge methodology to set ambulance allowances. Carrier responses revealed the following:

- Empire Blue Shield is the only carrier which has used its inherent reasonableness authority to limit costs for ambulance services.

- One carrier, in a northwestern State, limits its allowance for disposable supplies.
- All other carriers use the reasonable charge mthodology exclusively to determine ambulance reimbursement rates.
- Carriers are not aware of rates paid by the VA, hospitals or other major purchasers of ambulance transportation.

It is apparent from the Empire Blue Shield experience that a real opportunity exists for substantial program savings through application of carriers' inherent reasonableness authority.

3. MEDICARE COMPARED WITH THE VETERANS ADMINISTRATION

Most Veterans Administration (VA) hospitals contract for BLS ambulance services to transport non-ambulatory patients between their homes and the hospital for admission or discharge. As with Medicare patients, VA trips are usually scheduled in advance, and patients, although in need of basic medical attention, are not at high risk.

The following chart summarizes our findings for six sample States where VA hospitals contract with private companies and Medicare pays according to prevailing charges.

MEDICARE AND VETERANS ADMINISTRATION BASE RATES FOR BASIC LIFE SUPPORT
SIX SAMPLE STATES, FY 85

STATE	MEDICARE Allowed Per Claim (a)	MEDICARE Paid Per Claim (b)	VETERANS ADMIN. Negotiated Base Rate (c)	Average Savings Per Claim (d)	MEDICARE Total Paid Claims (e)	POTENTIAL ESTIMATED SAVINGS (d x e) Amount	%
California	$ 99.44	$79.55	$66.31	$13.24	284,232	$ 3,763,232	16.6%
Ohio	91.02	72.82	44.82	28.00	165,661	4,638,508	38.5%
Texas	82.83	66.27	53.02	13.25	84,343	1,117,545	20.0%
Michigan	93.00	74.40	47.72	26.68	193,241	5,155,670	35.9%
Pennsylvania	106.31	85.05	56.68	28.37	284,752	8,078,414	33.4%
Massachusetts	119.29	95.43	85.65	9.78	230,614	2,255,405	10.2%
TOTAL POTENTIAL SAVINGS						$25,009,978	24.8%

VA base rate payments ranged from an average of 10.2 percent to 38.4 percent lower than Medicare payments for the same service. If Medicare BLS base rates were the same as the VA, annual savings in these six States could amount to as much as $25 million for this one procedure. State by State comparisons of BLS base rates appear at Appendix C.

The one exception identified was Florida, where VA rates approximate Medicare rates; this is because in Florida VA hospitals pay on the basis of reasonable and customary charges, i.e., they use the Medicare approach.

As discussed earlier, the one carrier which has used the inherent reasonableness authority has demonstrated overall savings of 15.8 percent over what would have been paid using the reasonable charge methodology. A comparison of VA rates with the carrier's savings based on inherent reasonableness indicate that even greater savings could be achieved through use of the VA competitive bidding approach.

As shown below, Empire Blue Shield saved 16.4 percent in BLS base rate expenditures through using inherent reasonableness rather than the reasonable charge methodology. The rates obtained by VA hospitals for BLS base rate services averaged 42.5 percent lower than the Medicare reasonable charge rates, and 31.3 percent lower than the carrier paid through use of inherent reasonableness.

MEDICARE AND VETERANS ADMINISTRATION BASE RATES
EMPIRE BLUE SHIELD, APRIL 1984 - MARCH 1985

	MEDICARE		VETERANS
	REAS. CHARGE	INHERENT REAS.	ADMIN.
AVG. PAID PER CLAIM	$ 109.71	$ 91.74	$ 63.07
SAVINGS OVER REASONABLE CHARGE METHOD.	----	$ 17.97 (16.4%)	$ 46.64 (42.5%)
SAVINGS OVER INHERENT REASONABLENESS	----	----	$ 28.67 (31.3%)

See Appendix D for additional detail.

We also compared mileage, oxygen and waiting time rates paid by VA hospitals and Medicare in two sample States. The range of payment rates is summarized below, and shown in detail at Appendix E.

MEDICARE AND VA RATES FOR MILEAGE, OXYGEN AND WAITING TIMES
CALIFORNIA AND TEXAS, FY 85

Item	CALIFORNIA		TEXAS	
	Medicare Pays*	VA Pays	Medicare Pays*	VA Pays
Mileage	$ 4.40-$ 5.20	$1.00-$ 5.25	$ 0.80-$ 2.80	$1.10-$ 2.50
Oxygen	$11.20-$23.20	$0.00-$ 25.00	$ 6.40-$20.00	$0.00-$25.00
Waiting Time (per hr.)	$22.40-$70.40	$0.00-$100.00	$16.00-$20.00	$0.00-$60.00

*80 percent of allowed amount

This chart illustrates the dramatic disparity in payments, within and between two Federal programs, for items and services which are essentially identical across the country.

The preceding data and discussion clearly demonstrate that Medicare could achieve annual savings of up to 25 percent over current ambulance expenditures by adopting a competitive bidding approach for BLS transportation similar to the VA system. Legislation would be required to provide carriers with the authority to negotiate reimbursement rates with suppliers.

4. COMPETITIVE BIDDING FOR EMERGENCY TRANSPORTATION

Emergency medical services (EMS) transportation has been contracted out through competitive bidding in a number of large cities around the country.

The majority of large cities provide EMS through city fire or rescue departments. As early as 1981, however, 18 of the nation's most populous cities were contracting with private ambulance companies to provide EMS transportation or had established their EMS transportation systems as "public utilities," utilizing private contractors as the primary provider of emergency ambulance transportation.

While operational details of these systems differ, they are generally characterized by centralized dispatch in response to 911 calls, no call screening or refusals to transport, and no on-scene collections. Contract providers must be financially stable, meet State requirements for equipment, staffing and adherence to medical protocols, as well as locally established response times.

A 1985 survey by the Journal of Emergency Medical Services indicates that 18 of the nation's most populous cities still use private contractors to provide EMS transportation. This would appear to indicate that EMS transportation can be contracted out successfully, without a reduction in timeliness of response or the quality of patient care.

WHAT HAS BEEN THE FISCAL IMPACT OF ALS?

In 1982, Medicare recognized Advanced Life Support (ALS) as a new covered service. Carriers were instructed to establish separate prevailing charge screens for ALS and BLS base rates. ALS rates are higher than BLS rates, and the differences in rates vary greatly.

In one area visited, where EMS is tax supported and rates are set by local government, the ALS rate was $90 and the BLS base rate $70. In another, with no subsidies and no local rate setting, the ALS base rate is $275, compared with a BLS base rate of $115.

In the States we visited, we identified several factors which appear to affect billings for ALS services.

- Most private ambulance suppliers provide BLS transportation exclusively.
- Public and private suppliers who have the equipment and staff needed to provide ALS transportation bill for ALS only when this level of service is actually provided.
- A substantial portion of ALS services is provided by local public agencies (usually fire and rescue services). These agencies often set low rates which represent only a portion of their costs to deliver the service.
- Some volunteer and public agencies which provide ALS services do not bill for the service.

We reviewed carrier data to determine the portion of Medicare Part B ambulance trips being billed as ALS. The following chart shows the percentage of trips and Medicare costs attributed to ALS for those carrier areas for which figures were readily available.

ADVANCED LIFE SUPPORT TRIPS
AS PERCENTAGE OF ALL AMBULANCE TRIPS

Area	Period Covered	ALS as % of Total Trips Allowed	ALS as % of Total Base Rate Dollars Paid
Greater New York City	04/84-05/85	2.0%	3.0%
Pennsylvania	01/84-12/84	4.3%	5.6%
Florida	01/84-12/84	3.4%	8.8% *
Washington, D.C. and Arlington, Virginia	01/84-12/84	5.6%	6.5%
Iowa	10/84-12/84	0.4%	0.8%

* Represents billed amounts.

These figures tend to confirm our field finding that, despite higher ALS rates, the overall fiscal impact on Medicare has been minor, because ALS represents only a small portion of total Medicare ambulance services.

OTHER OIG ACTIVITIES

Both other OIG components, the Office of Audit (OA) and the Office of Investigations (OI), have been involved in activities related to Medicare ambulance payments.

In a report issued in October 1985, the Office of Audit (OA) found that one carrier had been improperly reimbursing ambulance suppliers for round-trip transportation between patients' homes and freestanding renal dialysis centers. This is not a covered service. OA recommended that the carrier establish procedures to ensure denial of such claims.

In a separate review completed June 1986, OA found that based on one carrier's experience, Medicare carriers can increase the efficiency and effectiveness of their ambulance claims processing by adopting a place-of-service coding system. By requiring ambulance suppliers to annotate place-of-service codes in the origin and destination blocks of ambulance claims, carriers could use prepayment computer edit screens to determine whether each claim meets the destination and level of service requirements of the regulations.

Since 1983, the Office of Investigations has pursued 46 investigations of ambulance suppliers. The two most prevalent abuses involved transporting patients in vans rather than ambulances and billing for medically unnecessary ambulance services.

To date, convictions or pleas have been obtained in eight instances, and civil and administrative penalties in four cases. Twenty-two ambulance suppliers and their owners have been excluded from Medicare participation. Of the remaining 24 cases, 7 are before Grand Juries, indictments have been returned in 2, and 4 civil monetary penalty actions are in process. Appendix G provides further detail on the investigations in process at this time.

IV. RECOMMENDATIONS

ISSUE:

Carrier use of the reasonable charge methodology to determine ambulance reimbursement rates has allowed rate increases far in excess of the rate of inflation. Medicare payments are substantially higher than the amounts paid by other purchasers for comparable services. One Medicare carrier, which has applied its inherent reasonableness authority to ambulance expenditures, has achieved annual savings of 15.8 percent as compared with rates determined by the reasonable charge methodology. The Veterans Administration, through competitive bidding, has obtained BLS rates averaging 25 percent lower than Medicare allowed charges in six sample States.

RECOMMENDATIONS:

1. Require carriers to use their inherent reasonableness authority to limit excessive charges for ambulance services.

2. Seek legislative authority to allow carriers to establish ambulance reimbursement rates through competitive bidding (the VA approach) for BLS ambulance transportation.

3. Consider the feasibility of seeking a legislative change to allow competitive bidding for ALS ambulance transportation.

ESTIMATED SAVINGS

Recommendation	Potential Saving
° Apply inherent reasonableness	$69 million
° Legislative change to allow competitive bidding to establish lower BLS rates	$513 million ($102.5 m. x 5 yrs)
° Legislative change to allow competitive bidding to establishing lower ALS rates.	No Estimate

COMMENTS RECEIVED AND OIG RESPONSE

Comments on the draft report were received from the Health Care Financing Administration (HCFA) and the American Ambulance Association (AAA).

Both respondents recognize that changes are needed in the way ambulance services are reimbursed. While generally supportive of the concept of inherent reasonableness, they are concerned about the specific method and factors which should be applied to determine the reasonableness of ambulance charges. In addition, the Department is actively considering the use of inherent reasonableness for physician services under Part B, following guidance provided in the Omnibus Reconciliation Act. The AAA has offered to assist HCFA in determining the specific factors which should be applied to insure that charges will, in fact, be reasonable.

The OIG strongly supports HCFA's decision to review ambulance reimbursement methodologies, and urges HCFA to take action to develop inherent reasonableness criteria.

Neither HCFA nor the AAA agreed with our second recommendation, which called for HCFA to seek legislative authority to permit competitive bidding for ambulance services. Both respondents indicated that while this approach would be appropriate for non-emergency BLS transportation, competitive bidding by Medicare might reduce the timeliness, availability and quality of care provided to Medicare beneficiaries in emergency situations.

While the OIG is aware of at least 18 major American cities which provide 911 emergency ambulance transportation through competitively awarded contracts with private companies, we recognize that more research may be needed to insure continued high quality and timeliness of emergency medical transportation received by Medicare beneficiaries. Therefore, we have revised this recommendation to include seeking competitive bidding authority for BLS transportation, followed by consideration of a similar approach for ALS transportation.

V. APPENDICES

LEVELS OF MEDICAL TRANSPORTATION

Advanced Life Support (ALS)

An ALS ambulance has complex specialized life sustaining equipment and radio contact with a physician or hospital. ALS ambulances are mobile intensive care units, used in true emergencies for life-threatening conditions. These ambulances are staffed with paramedics equipped to provide intravenous therapy, anti-shock trousers, airway maintenance, defibrillation of the heart, and other advanced procedures such as cardiac (EKG) monitoring. ALS transportation represents only a small portion of Medicare ambulance expenditures.

Basic Life Support (BLS)

A BLS ambulance provides transportation plus equipment and staff for such basic services as control of bleeding, splinting fractures, treatment for shock, and cardiopulmonary resuscitation (CPR). Medicare patients are typically transported in BLS ambulances for scheduled hospital admission or discharge, outpatient therapy, transfers between hospitals, and to or from a home or nursing home. BLS ambulances are staffed with emergency medical technicians. Most Medicare ambulance expenditures are for BLS ambulances.

Wheelchair Van

The third level of transportation, litter or wheelchair vans, provides non-emergency medical transportation for medically stable individuals with severe mobility problems. These vehicles are not equipped with medical equipment or personnel. Typically, patients are transported to medical appointments or physical therapy. Medicare does not cover this level of service.

AMBULANCE SAVINGS BASED ON INHERENT REASONABLENESS

Empire Blue Shield (Greater New York City)
April 1984 - March 1985

Procedure Code	Number of Services	75th Percentile Prevailing*	75th Percentile Allowed	Inherent Reasonableness Prevailing	Inherent Reasonableness Allowed	Savings Allowed	Savings Paid	Savings Percent
BASIC LIFE SUPPORT								
W0630 & W0640 (Base Rate, trips originating within New York City)	148,673	$ 140.00	$ 20,814,220	$ 118.00	$ 17,543,414	$ 3,270,806	$ 2,616,645	15.7
A0010 & A0022 (Base Rate, trips originating outside New York City)	82,047	127.95	10,497,740	102.00	8,368,794	2,128,946	1,703,156	20.3
W0540 & W0550 (Base Rate, night, trips originating within New York City)	44,829	148.22	6,644,384	127.00	5,693,283	951,101	760,881	14.3
W0560 & W0570 (Base rate, night, trips originating outside New York City)	9,923	120.29	1,193,804	114.00	1,131,222	62,582	50,066	5.2
BLS Subtotals			$ 39,150,148		$ 32,736,713	$ 6,413,435	$ 5,130,748	16.4
ADVANCED LIFE SUPPORT								
A0220 & W0590 (Base rate, trips originating within New York City, day or night)	1,761	180.00	316,980	180.00	316,980	- 0 -	- 0 -	- 0 -
W0600 (Day base rate, trips originating outside New York City)	2,116	220.05	465,635	203.00	429,548	36,087	28,870	6.2
W0610 (Night base rate, trips originating outside New York City)	1,911	250.00	477,750	227.00	433,797	43,953	35,162	9.2
ALS Subtotals			$ 1,260,365		$ 1,180,325	$ 80,040	$ 64,032	6.4
MISCELLANEOUS								
A0020 (Mileage)	1,591,437	3.12	4,959,107	2.70	4,296,880	662,227	529,782	13.4
A0060 (Waiting Time)	4,124	20.05	82,668	19.00	78,456	4,212	3,370	5.1
A0070 (Oxygen)	35,793	32.02	1,145,970	27.00	966,411	179,559	143,647	15.7
W0620 (Additional attendant)	492	50.00	24,600	31.00	15,252	9,348	7,478	38.0
W0625 (EKG)	109	40.00	4,360	22.80	2,485	1,875	1,500	43.0
Miscellaneous Subtotals			$ 6,216,705		$ 5,359,484	$ 857,221	$ 685,777	13.8%
GRAND TOTALS			$ 46,627,218		$ 39,276,522	$ 7,350,696	$ 5,880,557	15.8%

Appendix B

POTENTIAL ESTIMATED SAVINGS BY STATE, BLS BASE RATES
(Medicare payments compared to VA rates, FY 85)

STATE	ESTIMATED MEDICARE PAYMENT (80% of Allowed Amount)	ESTIMATE PAYMENT USING VA RATES	POTENTIAL ESTIMATED SAVINGS*	
			Amount	Percent
California	$ 22,611,804	$18,847,423	$ 3,764,381	16.6%
Ohio	12,063,156	7,424,926	4,638,230	38.4
Texas	5,589,132	4,471,866	1,117,266	20.0
Michigan	14,377,130	9,221,461	5,155,669	35.9
Pennsylvania	24,217,484	16,139,743	8,077,741	33.4
Massachusetts	22,008,780	19,752,089	2,256,691	10.2
TOTALS	$100,867,486	$75,857,508	$25,009,978	24.8%

* Slight discrepancies between potential estimated savings on this page and individual State calculation pages are due to rounding.

1. Florida is not included in summary because VA hospitals in that State have not negotiated any contracts for ambulance services, and pay more than Medicare pays for this service.

2. New York City is not included because the Medicare carrier already uses inherent reasonableness authority to limit ambulance reimbursement rates. (Detail on New York City rates appears at Appendix D).

STATE: CALIFORNIA

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL PAID (ESTIMATE)
Los Angeles	YES	2,800	$ 58	$ 162,400
Martinez	YES	437	75*	32,775
Palo Alto	YES	1,871	58*	108,518
San Diego	YES	1,320	31	40,920
San Francisco	YES	2,300	90*	207,000
Sepulveda	YES	382	69	26,358
Loma Linda	YES	1,800	40	72,000
Long Beach	YES	300	60*	18,000
Fresno	YES	900	150*	135,000
	TOTAL	12,110		$ 802,971

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $66.31

* includes mileage within defined local area.

II. MEDICARE ALLOWABLES, FSY 1985

(a) CARRIER AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
BLUE SHIELD OF CALIFORNIA			
A	$ 105.	27,713	$ 2,909,865
B	115.	54,851	6,307,865
C	115.	34,186	3,931,390
D	87.50	23,495	2,055,813
TRANSAMERICA-OCCIDENTAL			
A	$ 106.	6,312	669,072
B	90.	94,459	8,501,310
C	90.	43,216	3,889,440
	TOTAL	284,232	$ 28,264,755

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $99.44

AVERAGE PAID PER CLAIM (80% of $99.44) = $79.55

POTENTIAL SAVINGS PER CLAIM IF MEDICARE PAID SAME RATE AS THE VETERANS ADMINISTRATION ($79.55 minus $66.31) = $13.24 or 16.6%.

POTENTIAL ANNUAL SAVINGS ($13.24 per trip x 284,232 trips) = $ 3,763,232

STATE: OHIO

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT (yes or no)	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Cincinnati	YES	125	$ 45	$ 5,625
Dayton	YES	1,500	40	60,000
Cleveland	YES	6,116	46	281,336
	TOTAL	7,741		$ 346,961

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $44.82

II. MEDICARE ALLOWABLES, FSY 1985

(a) AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
A	$ 180	13,960	$ 2,512,800
B	70	21,469	1,502,830
C	90	39,164	3,524,760
D	80	12,761	1,020,880
E	50	6,096	304,800
F	65	4,914	319,410
G	80	2,513	201,040
H	45	5,862	263,790
I	100	7,256	725,600
J	90	17,551	1,579,500
K	145	12,473	1,808,585
L	65	3,268	212,420
M	60	5,970	358,200
N	60	3,109	186,540
O	60	9,295	557,700
	TOTAL	165,661	$15,078,945

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $91.02

AVERAGE PAID PER CLAIM (80% of $ 91.02) = $72.82

POTENTIAL SAVINGS PER CLAIM IF MEDICARE PAID SAME RATE AS THE VETERANS ADMINISTRATION ($72.82 minus $44.82) = $28.00 or 38.5%.

POTENTIAL ANNUAL SAVINGS ($28.00 per trip x 165,661 trips) = $4,638,508.

STATE: TEXAS

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT (yes or no)	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Big Spring	YES	550	$ 70	$ 38,500
Dallas	YES	2,400	51	122,400
San Antonio	YES	2,700	55	148,500
Marlin	YES	312	40	12,480
Temple	YES	999	35	34,965
Houston	YES	1,750	60	105,000
(No contracts in remaining areas of the State)				
	TOTAL	8,711		$ 461,845

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $53.02

II. MEDICARE ALLOWABLES, FSY 1985

(a) AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
A	$ 65	15,664	$ 1,018,160
B	65	11,995	779,675
C	75	13,171	987,825
D	65	16,052	1,043,380
E	75	5,505	412,875
F	125	21,956	2,744,500
	TOTAL	84,343	$ 6,986,415

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $82.83

AVERAGE PAID PER CLAIM (80% of $ 82.83) = $66.27

POTENTIAL SAVINGS PER CLAIM IF MEDICARE PAID SAME RATE AS THE VETERANS ADMINISTRATION ($66.27 minus $53.02) = $13.25 or 20.0%.

POTENTIAL ANNUAL SAVINGS ($13.25 per trip x 84,343 trips) = $1,117,545.

STATE: MICHIGAN

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT (yes or no)	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Allen Park	YES	850	$ 49	$ 41,650
Ann Arbor	YES	100	30	3,000
Saginaw	YES	300	50	15,000
	TOTAL	1,250		$ 59,650

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $47.72

II. MEDICARE ALLOWABLES, FSY 1985

(a) AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
Statewide	$ 93	193,241	$ 17,971,413
	TOTAL	193,241	$ 17,971,413

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $93.00

AVERAGE PAID PER CLAIM (80% of $ 93.00) = $74.40

POTENTIAL SAVINGS PER CLAIM IF MEDICARE PAID SAME RATE AS THE VETERANS ADMINISTRATION ($74.40 minus $47.72) = $26.68 or 35.9%.

POTENTIAL ANNUAL SAVINGS ($26.68 per trip x 193,241 trips) = $5,155,670.

STATE: PENNSYLVANIA

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT (yes or no)	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Pittsburgh	YES	1,100	$ 55	$ 60,500
Philadelphia	YES	1,400	58	81,200
(No contracts in remaining areas of the State)				
	TOTAL	2,500		$ 141,700

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $56.68

II. MEDICARE ALLOWABLES, FSY 1985

(a) AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
A	$ 120	48,802	$ 5,856,240
B	106	188,786	20,011,316
C	75	32,714	2,453,550
D	135	14,450	1,950,750
	TOTAL	284,752	$ 30,271,856

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $106.31

AVERAGE PAID PER CLAIM (80% of $106.31) = $85.05

POTENTIAL SAVINGS PER CLAIM IF MEDICARE PAID SAME RATE AS THE VETERANS ADMINISTRATION ($85.05 minus $56.68) = $28.37 or 33.4%.

POTENTIAL ANNUAL SAVINGS ($28.37 per trip x 284,752 trips) = $8,078,414

STATE: MASSACHUSETTS

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT (yes or no)	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Jamaica Plains	YES	1,725	$ 82	$ 141,450
West Roxbury	YES	1,200	68	81,600
Brockton	YES	800	120	96,000
	TOTAL	3,725		$ 319,050

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $85.65

II. MEDICARE ALLOWABLES, FSY 1985

(a) AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
Urban	$ 125	177,983	$ 22,247,875
Suburban	100	52,631	5,263,100
	TOTAL	230,614	$ 27,510,975

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $119.29

AVERAGE PAID PER CLAIM (80% of $119.29) = $95.43

POTENTIAL SAVINGS PER CLAIM IF MEDICARE PAID SAME RATE AS THE VETERANS ADMINISTRATION ($95.43 minus $85.65) = $9.78 or 10.2%

POTENTIAL ANNUAL SAVINGS ($9.78 per trip x 230,614 trips) = $2,255,405

STATE: FLORIDA

I. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Bay Pines	NO	1,200	$ 77	$ 92,400
Gainesville	NO	2,000	70	140,000
Lake City	NO	300	57	17,100
Miami	NO	700	95	66,500
Tampa	NO	1,500	80	120,000
	TOTAL	5,700		$ 436,000

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $ 76.49

II. MEDICARE ALLOWABLES, FSY 1985

(a) AREA	(b) BLS BASE RATE PREVAILING	(c) # TRIPS PAID	(d) TOTAL $ ALLOWED
A	$ 70.	16,766	$ 1,173,620
B	70.	77,953	5,456,710
C	82.50	42,405	3,498,413
D	75.	31,068	2,330,100
	TOTAL	168,192	$ 12,458,843

AVERAGE ALLOWED PER CLAIM [(d) divided by (c)] = $ 74.08

AVERAGE PAID PER CLAIM (80% of $ 74.08) = $ 59.26

Florida VA hospitals do not have contracts for ambulance services. Instead, the full amount billed by an ambulance company is paid from VA medical administration funds.

The VA paid an average BLS base rate of $17.23 more per trip than Medicare. If the VA had paid the same as Medicare, BLS base rate savings could have amounted to as much as $98,211 during FY 1985.

COMPARISON OF MEDICARE AND VETERANS ADMINISTRATION BASE RATES
EMPIRE BLUE SHIELD, APRIL 1984 - MARCH 1985

I. MEDICARE ALLOWABLES BASED ON REASONABLE CHARGE METHODOLOGY

TOTAL PAID SERVICES	AVERAGE BLS BASE RATE	TOTAL $ ALLOWED	TOTAL $ PAID (ESTIMATE)	PAID PER CLAIM
285,472	$ 137.14	$ 39,150,148	$ 31,320,118	$109.71

II. MEDICARE ALLOWABLES BASED ON INHERENT REASONABLENESS

TOTAL PAID SERVICES	AVERAGE BLS BASE RATE	TOTAL $ ALLOWED	TOTAL $ PAID (ESTIMATE)	PAID PER CLAIM
285,472	$ 114.68	$ 32,736,713	$ 26,189,370	$91.74

III. VETERANS ADMINISTRATION HOSPITAL BASE RATES FOR AMBULANCE SERVICES

(a) VA HOSPITAL	(b) CONTRACT (yes or no)	(c) EST. # TRIPS FY 1985	(d) AVERAGE BLS BASE RATE	(e) TOTAL $ PAID (ESTIMATE)
Manhattan	YES	4,000	$ 62.00	$ 248,000
Bronx	YES	600	65.00	39,000
Long Island	YES	293	73.65	21,579
	TOTAL	4,893		$ 308,579

WEIGHTED AVERAGE BASE RATE [(e) divided by (c)] = $63.07

IV. RATE COMPARISON

	MEDICARE		VETERANS ADMINISTRATION
	REAS. CHARGE	INHERENT REAS.	
AVERAGE PAID PER CLAIM	$ 109.71	$ 91.74	$ 63.07
SAVINGS OVER REASONABLE CHARGE METHOD.	----	$ 17.97 (16.4%)	$ 46.64 (42.5%)
SAVINGS OVER INHERENT REASONABLENESS	----	-----	$ 28.67 (31.3%)

MEDICARE AND VETERANS ADMINISTRATION MILEAGE, OXYGEN AND WAITING TIME RATES STATE OF CALIFORNIA, FY 85

I. VETERANS ADMINISTRATION

Hospital	Mileage		Oxygen	Waiting Time (per hour)
	Included In Base Rate	Rate Per Mile		
San Diego	-0-	$1.90	$25	$ 90
Long Beach	city limits	2.00	0	48
Sepulveda	39	3.00	4	0
West Los Angeles	20	1.00	0	15
Loma Linda	0	1.60	0	20
Fresno	50	5.25	0	0
Palo Alto	30	1.50	5	20
San Francisco	7	5.25	20	100
Martinez	local area	3.75	15	15

II. MEDICARE

Area	Mileage		Oxygen	Waiting Time (per hour)
	Included In Base Rate	Rate Per Mile		
Northern California	0	4.40-5.20*	$16.00-$20.00	$48.00-$70.40
Southern California	0	4.40	$11.20-$23.30	$22.40-$48.00

*All figures are 80% of Medicare allowable.

MEDICARE AND VETERANS ADMINISTRATION MILEAGE, OXYGEN AND WAITING TIME RATES STATE OF TEXAS, FY 85

I. VETERANS ADMINISTRATION

Hospital*	Mileage	Oxygen	Waiting Time (per hour)
San Antonio	$1.25-$2.50	$5.00-$25.00	up to $60.00
Marlin	1.10	10	0
Kerrville	2.00	0	0
Temple	1.25	0	$10
Houston	1.35	0	$60
Dallas	1.40	0	0
Big Spring	2.10	20	$30

*Two hospitals do not have contracts and are not included.

II. MEDICARE

Mileage	Oxygen	Waiting Time (per hour)
$0.80-$2.80*	$6.40-$20.00	$16.00-$20.00

*All figures are 80% of Medicare allowable.

ALS AND BLS BASE RATE PREVAILINGS BY CARRIER AREA, FY 84

Carrier Area	ALS Prevailing	BLS Prevailing
Arkansas	$102	$65
California		
Northern	$275	$ 87.50-$115.00
Southern	$210	$ 70.00-$113.00
Connecticut	$142.60-$146.90	$ 87.60-$ 91.90
Florida	$ 90	$ 68.00-$ 75.00
Hawaii	$130.00-$234.00	$107.00-$208.00
Illinois	$120.00-$150.00	$ 50.00-$ 96.00
Indiana	$140.00-$150.00	$ 60.00-$ 85.00
Michigan	$140	$97.20
North Dakota	$180	$95
Ohio	$265	$ 40.00-$180.00
South Dakota	$120	$60
Washington	$245	$125

APPENDIX G

ACTIVE INVESTIGATIONS OF AMBULANCE SUPPLIERS
(as of October 1986)

NATURE OF ACTIVITY	NUMBER OF ACTIVE INVESTIGATIONS
Transporting beneficiaries absent medical necessity and overstating the medical need of the beneficiary to obtain payment.	7
Transporting beneficiaries to and from non-covered locations and concealing the true origin and destination of the trips to obtain payment.	3
Claiming payment for services not provided, e.g., actual trips, medical supplies.	2
Overstating the level of service provided, e.g., van service provided; BLS ambulance service provided, ALS claimed.	4
Overstating actual miles traveled and waiting time to obtain payment.	3
Misrepresenting the true location of the business to take advantage of higher reimbursement rates at a fictitious address.	1
Submitting claims for service in an area other than the place of service to obtain higher payment.	1
Violating assignment agreements.	1
Transporting multiple patients and submitting claims for singular trips.	1
Knowingly providing noncovered service and bribing carrier employees to authorize payment for the noncovered care.	1