Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE AMBULANCE PAYMENTS

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1997
OEI-05-95-00300

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EXECUTIVE SUMMARY

PURPOSE

To determine whether Medicare reimbursement policies and levels of payment for ambulance services are prudent.

BACKGROUND

From 1987 through 1995, Medicare expenditures for ambulance services have more than tripled. In 1987, Medicare allowed charges for ambulance services amounted to slightly more than $600 million. In 1995, carriers paid nearly $2 billion to ambulance providers.

Medicare pays for medically necessary ambulance services when the use of other methods of transportation would endanger the patient's health. Two levels of service, advanced life support (ALS) and basic life support (BLS), are covered by Medicare. Reimbursement is based on the type of vehicle and personnel used (ALS or BLS) and the service status (emergency or non-emergency).

FINDINGS

Medicare payments for ambulance services appear to lack common sense.

In 26 States, Medicare pays more for routine, non-emergency basic life support transportation than it does for advance life support emergency transportation. The difference, in some areas, is more than $200. In 18 States, Medicare pays more for BLS emergency transports without supplies than with supplies. Similar anomalies exist in ALS base rates. In 1995, the modal allowed charge for basic life support mileage was $9.25 a mile, more than twice the allowed charge for advance life support vehicles and seven times greater than the cost of a gallon of fuel.

Ambulance payment policies are vulnerable to fraud and abuse.

Carriers police a significant number of ambulance claims. The complexity of the current system enables transportation suppliers to bill for ALS services when BLS services are provided; misrepresent the patient's true medical condition; and, avoid carrier program safeguards. Carriers report wide spread abusive situations involving unnecessary transports, oxygen, EKGs and other services. Over the past 5 years, the Office of Inspector General has had more than 100 convictions involving ambulance suppliers.

Problems are the result of extremely complex payment methods and inconsistent policies.

A complex payment system encourages fraud and abuse and thwarts efforts to control expenditures. This complexity stems from a payment system that uses four different billing methods, recognizes BLS and ALS vehicles, distinguishes emergency and non-

emergency transports, employs more than 240 different procedure codes and uses more than 35 fiscal agents. Payment levels to ambulance providers are not based on the actual cost of providing services within geographic areas.

Carrier interpretations of policy contribute to variance in payments and coverage. In 16 States the carrier considers payment for oxygen included in the BLS base rate. Other carriers consider oxygen to be a prescription drug and allow ambulance suppliers to bill using a separate procedure code. Policy differences also exist with regard to EKGs, supplies, injections and other services provided during transport.

RECOMMENDATIONS

The Health Care Financing Administration's (HCFA's) well-intentioned efforts to limit ambulance companies to four billing methods using 37 procedure codes has been circumvented by idiosyncrasies of the current reasonable charge payment methodology and the fee-for-service system. At a time when most Medicare Part B services are being paid on a fee schedule, ambulance services are among the few services the Medicare program still reimburses on a reasonable charge basis.

Tremendous variation in payments indicates that Medicare reimbursement in many areas may be too high. The reasonable charge payment mechanism has resulted in inflated charges for ambulance services and does not accurately reflect the real cost of doing business in an area. More importantly, the reasonable charge payment method and the fee-for-service system provide little or no incentive for providers to control costs. Efforts to control expenditures in the fee-for-service system often results in fragmentation of services and increased utilization. Extensive carrier reviews of ambulance claims adds to program costs. Fraud and abuse in this area has also been well documented.

We believe that the vulnerabilities we found need to be addressed as soon as possible. We recommend that HCFA:

- seek legislative authority to develop a fee schedule for ambulance transportation.

In doing so, HCFA should take into consideration the competitive prices available in an area including the negotiated rates that exist between managed care entities/hospitals and ambulance providers. A fee schedule could also take into account the cost of doing business in an area, economies of scale available to providers, adjustments for local subsidies and other considerations that may affect the cost of doing business.

The following interim steps should be taken to help develop the fee schedule:

- Instruct carriers to examine the inherent reasonableness of current allowable charges and adjust them as necessary.

- Work with the ambulance industry to develop clearer guidelines as to what is or is not included in the base rate and what mileage is intended to cover.

- Eliminate separate payments for oxygen, supplies, injectables and other services such as EKGs. These items should be included in the base rate.

- Limit the number of procedure codes available to ambulance suppliers for billing. At a minimum, restrict use of procedure codes to the 37 specific codes designated for ambulance transportation.

We believe that Medicare ambulance policies could be simplified and that unreasonable base rate and mileage payment levels could be reduced. Consistent coverage policies should be developed and the number of billing methods and procedure codes currently in use reduced. Elimination of many procedure codes would discourage unbundling and the routine use of some supplies and services designed simply to enhance payment. Items considered essential for life support should be included in base rate reimbursement and should not be paid as separate items or services.

Actual savings from simplification and more uniform policies would depend on how base rate and mileage are defined and the fee schedule allowances for these services. If implemented, as we have suggested, we project that Medicare could save at least $242 million annually. Fifty million dollars of these projected savings could be derived solely from elimination of separate payments for oxygen, supplies, injectables and other services such as EKGs. At least $192 million could be saved annually by limiting the allowed charge for mileage to the lower of actual charge or $1 per mile.

Our savings projections are predicated on the current base rate levels remaining unchanged except for increases due to the inflation index charge or changes in customary and prevailing charges. Actual savings could be higher if the base rate allowed charge for non-emergency transportation is adjusted to ensure that Medicare pays the same or less for this service than it does for the base rate for emergency transportation. Structuring payments to take into account average miles per gallon, bulk purchasing discounts, State and local taxes and other factors could also impact projected savings. Savings may be lower if some base rates are increased or policies developed that permit unbundling of some services.

AGENCY COMMENTS

Since issuing our draft report, Congress passed the Balanced Budget Act of 1997. This legislation implements our recommendation and requires that HCFA establish a fee schedule for Medicare ambulance payments. We look forward to HCFA's regulation that will carry out the legislation.

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INTRODUCTION

PURPOSE

To determine whether Medicare reimbursement policies and levels of payment for ambulance services are prudent.

BACKGROUND

Ambulance services provided to Medicare beneficiaries are covered by Part B of the Medicare program, commonly called Supplemental Medical Insurance. Medicare pays for medically necessary ambulance services when "...the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations."[1] The Health Care Financing Administration (HCFA) regulations state that ambulance services are covered only if other forms of transportation would endanger the Medicare beneficiary's health.

Ambulance providers must satisfy State and local requirements to operate within a State and must comply with HCFA regulations to qualify for Medicare reimbursement. The HCFA defines an ambulance vehicle as one that must: (1) be designed specifically for transporting the sick or injured; (2) contain a stretcher, linens, first aid supplies, oxygen equipment, and other lifesaving equipment required by State or local ordinances; and, (3) be staffed with personnel trained to provide first aid treatment.

Two distinct levels of service, advanced life support (ALS) and basic life support (BLS), are furnished by ambulance providers. To be considered an ALS ambulance, the vehicle must: be equipped with specialized equipment and medications, such as defibrillators and pulmonary/cardiac monitors; and, maintain radio-telephone contact with physicians or hospitals. In most States, the more intensive ALS services are rendered by *paramedic* emergency medical technicians (EMTs), while BLS services are usually rendered by *basic* or *intermediate* EMTs. Types of ALS services include:

- administering intravenous medications;
- defibrillating the patient; and,
- performing other advanced life support services, such as electrocardiogram monitoring and airway monitoring.

Currently, ambulance reimbursement is based on the type of vehicle and personnel used (BLS or ALS) and the service status (emergency or non-emergency). Ambulance providers submit itemized bills for the services they provide to the Medicare carrier serving their area. According to HCFA, approximately 10 percent of the Medicare Part B patient population uses ambulance services each year.

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[1] Section 1861(s)(7) of *The Social Security Act*.

Carriers process and pay claims based on the information provided by the ambulance companies. From 1987 through 1995, Medicare expenditures for ambulance services more than tripled. In 1987, Medicare allowed charges for ambulance services amounted to slightly more than $600 million. In 1994, carriers paid $1.8 billion for 21 million ambulance services. In 1995, carriers approved nearly 52 million ambulance services and paid nearly $2 billion to ambulance providers. The average annual rate of increase in ambulance expenses (16 percent) exceeds the average Part B (Supplemental Insurance) rate of growth of 9.9 percent. This annual rate of growth for ambulance services is comparable to the growth in expenditures Medicare has seen in home health, cataract surgery, medical supplies and other problematic areas.

Medicare pays ambulances using customary and prevailing charge criteria. Concerns about the inflationary nature of this payment method led to the introduction of an additional fee screen in 1985 called the "Inflation Indexed Charge." The aim of the Inflation Indexed Charge was to limit annual increases in Medicare allowable charges for certain services, including ambulance services, by restricting the rate of increase. More simply put, the Inflation Index Charge became the base rate on which future increases in allowed charges would be based. When determining the allowable charge for a procedure code billed by an ambulance supplier Medicare carriers pay the lower of the:

- actual charge billed,
- provider's customary charge,
- prevailing charge, or
- Inflation Indexed Charge.

In 1994, HCFA undertook a comprehensive revision to the procedure codes used by ambulance providers to bill Medicare. They instructed carriers to eliminate all local codes and to begin using standardized coding for all ambulance services. The new standardized coding attempted to accommodate all billing patterns in use by ambulance providers at that time, while eliminating local codes.

That same year, HCFA asked carriers to assign one of four billing methods to each ambulance provider based on the carrier's past experience with that ambulance company. The four billing methodologies are summarized as follows:

Method 1: A single, all inclusive charge reflecting all services, supplies and mileage.

Method 2: One charge reflecting all services and supplies and a separate charge for mileage.

Method 3: One charge reflecting all services and mileage and a separate charge for supplies.

Method 4: Separate charges for service, mileage and supplies.

Effective January 1, 1995 ambulance providers were to begin using only revised procedure codes and the billing method(s) they elected or were assigned by the carrier. Most ambulance providers bill Medicare using Methods 2 and 4.

Previous studies by the Office of Inspector General (OIG) have contended that Medicare pays unreasonably high amounts for ambulance services. *Ambulance Services for Medicare End-Stage Renal Disease Patients: Payment Practices, (OEI-03-90-02131)*, and other studies conducted by carriers, reveal a high incidence of ambulance transports that do not meet coverage guidelines. In addition to medically unnecessary transports, OIG and other researchers have noted significant variance in payments to ambulance providers often within the same geographical areas.

METHODOLOGY

We selected a 1 percent random sample from all Medicare claims billed by ambulance companies in 1995 and 1996. The 1 percent sample for 1995 was arrayed by allowed charges per claim and used to obtain statistical information about the universe of Medicare expenditures for ambulance services. Our sample contained 189,340 claims.

The sample was refined by merging it with HCFA's zip code file. This enabled us to analyze information by State, county and, in some cases, city. We determined the minimum and maximum allowable charge for each procedure code billed by ambulance providers in 1995. The mean, mode and median allowable charge for each ambulance procedure code billed was determined and arrayed by quartile. The number of services provided and the number of miles billed was also taken into consideration when deriving data about the allowed charge per mile.

Thirty-seven carriers participated in this study. We visited 5 carriers and contacted 32 carriers by mail. We also contacted the American Ambulance Association and three HCFA regional offices. The contacts were made to obtain information that might help us determine why variance in ambulance payments and policies exists. Respondents were asked for information about ambulance policies in each State, system inequities and vulnerabilities. Information on industry trends and their potential impact on the Medicare program was also solicited from respondents.

The Internet was used to obtain national and regional diesel fuel costs for 1995. Additional information was obtained from the Bureau of Labor Statistics, Department of Transportation and U.S. Census Department web sites. Information from previously issued reports concerning the ambulance industry was also reviewed.

FINDINGS

Medicare payments for ambulance services appear to lack common sense.

Medicare pays for an equal number of non-emergency transports and emergency transports each year. In 1995, base rate charges for emergency and non-emergency transports each accounted for approximately 20 percent of the ambulance services paid for by Medicare. Mileage procedure codes accounted for a third of the services paid. Oxygen, supplies, injections and other services make up the remaining 27 percent of the services billed by ambulance suppliers and paid by carriers.

Medicare allowed charges differ widely from State to State, within States and within counties. We analyzed the variance in payment that exists for the 37 ambulance transportation procedure codes listed in the HCFA Common Procedure Coding System (HCPCS). We found tremendous variation in payments for ALS and BLS base rates, mileage, supplies, oxygen and other services paid by Medicare. We compared the differences in allowed charges to the average hourly wage, housing costs, fuel costs and other indicators that reflect the cost of doing business in an area. There was no logical correlation between Medicare allowed charges and these economic indicators.

Base Rate Variation

In 26 States, Medicare pays more for routine, non-emergency basic life support transportation than it does for advance life support emergency transportation. In some areas, the amount Medicare pays for basic life support, non-emergency transportation exceeds the advance life support emergency base rate by more than $200. In some areas there is no difference in the allowable charge for ALS emergency and BLS non-emergency transportation.

Differences Between Ambulance Charges: Supplies Included vs. Supplies Billed Separately

State	BLS Emergency Base Rate With Supplies	BLS Emergency Base Rate Without Supplies
DE	$93.93	$199.44
LA	$85.00	$169.46
MA	$110.79	$206.81
	ALS Emergency Base Rate with Supplies	ALS Emergency Base Rate Without Supplies
CA	$230.02	$436.94
MA	$210.00	$272.12
NJ	$135.00	$309.55

In 18 States the carriers allow, on average, more for the BLS emergency base rate without supplies (A0362) than they do for BLS emergency base rate with supplies (A0322). In 10 States, the ALS base rate without supplies is greater than the ALS base rate with supplies. The ALS base rate without supplies in New Jersey is $175 greater than the ALS base rate with supplies. In Arkansas the difference in ALS base rates with and without supplies is only $15. In Texas and Illinois there is no difference in the payment for these two procedure codes.

The allowed charge for base rate procedure codes that include supplies frequently exceeds the average allowance for supplies billed separately. In 1995, the median allowed charge for supplies billed under procedure code A0398 was approximately $10. At the same time, we found that in many States carriers allowed significantly more than $10 for supplies included in the base rate. In South Dakota Medicare's allowed charge for ALS base rates with supplies was nearly $232 more than the allowed charge for base rate without supplies. This charge is more than 23 times greater than the national median allowed charge ($10) for ALS disposable supplies.

In most States, Medicare pays more for supplies when they are included in the base rate. The difference in the allowed amounts when supplies are included in the BLS base rate ranges from less than $2 in South Dakota to $88 in Idaho. In 22 States, the allowed amount for ALS with supplies (A0328) differs from ALS without supplies (A0368) anywhere from $4 in Tennessee to nearly $232 in South Dakota. The amount allowed for supplies included in the base rate, in some cases, appears unreasonable.

Mileage Reimbursement Variation

Mileage accounts for nearly 1 out of every 3 services paid and nearly 15 cents out of every dollar. In 90 percent of the 3,844 counties in our sample, the allowed charge for ambulance mileage was $2 or more per mile.[2] In 1995, differences in the average allowed charge for mileage varied by as much as $26.23 a mile.

Medicare pays more for basic life support mileage than it does for advance life support mileage. The modal allowed charge for advance life support mileage was $4.35 a mile. The modal allowed charge for basic life support mileage was $9.25 a mile, more than twice the allowed charge for advance life support vehicles. The allowed charge for advance life support mileage (procedure code A0390) ranged from 19 cents to $11.93 per mile.

The average allowed charge per mile for a basic life support vehicle ranged from a high of $11.19 a mile to a low of 27 cents a mile. When the mode was used for this analysis, carrier allowances for basic life support mileage ranged from $11.46 to 20 cents a mile. Payments by one carrier for BLS mileage varied by more than $22.14. This carrier paid $4.10 per mile on one ambulance claim and $26.24 per mile on another claim. While these claims represent the extremes, the average payment per mile to ambulance providers by this carrier was $6.81.

In 1995, Medicare paid more per mile than the cost of a gallon of diesel fuel. During 1995, the average cost of diesel fuel was about $1.20 per gallon.[3] One carrier's average allowed charge was $6.81 a mile, five times more than the cost of a gallon of fuel. If

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[2] Some counties pay both ALS and BLS mileage. If the allowed charge exceeded $2 for both ALS and BLS mileage, the county was counted twice. The number of unique counties in our sample was 3,144.

[3] On-highway diesel prices, self service cash price in cents per gallon, including taxes. Department of Energy data.

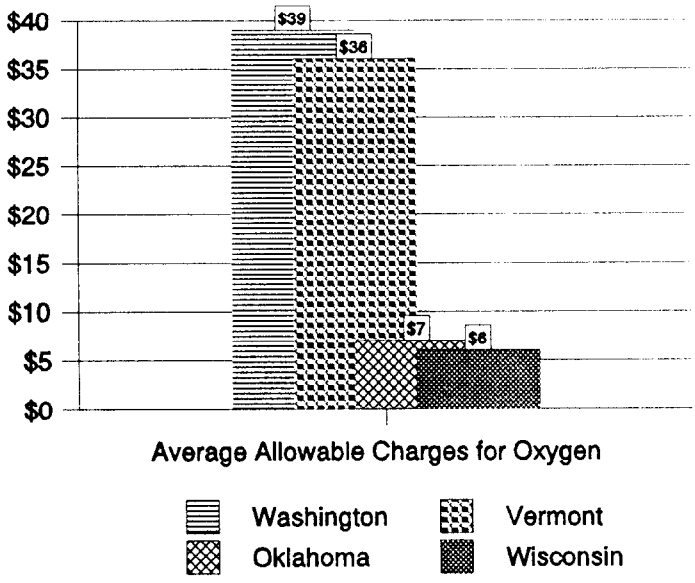
ambulance fuel economy were three miles per gallon, this carrier would be paying at least 1,250 percent more than the cost to replace the fuel used.

It appears that Medicare's reimbursement for mileage is unreasonable. The Internal Revenue Service (IRS) tax code and Federal travel regulations permit recovery of fuel and depreciation expenses related to privately owned vehicles at a rate of 31 cents a mile or actual costs. Medicare pays more than six times the IRS allowable rate for fuel cost and considerably more than actual fuel replacement cost. Medicare mileage payments exceeding $1 per mile cost the program nearly $192 million in 1995.

Other Illogical Variation

Suppliers with high base rates usually had high mileage rates and high rates for other procedure codes they billed. Besides base rate and mileage variance, we found considerable variation in virtually all of the procedure codes used by ambulance providers to bill Medicare.

Allowable charges for BLS routine disposable supplies (procedure code A0382) range from just under $2 to more than $50 with a median allowed charge of $6.50. Disposable supply codes used by ALS ambulance providers have differences in payments ranging from 25 cents to $95.40 with a median allowed charge of $10. Some carriers consider supplies to be part of the base rate and do not reimburse ambulance providers for supplies billed separately.



Allowable charges for oxygen vary by over 550 percent. In the State of Wisconsin allowable charges for oxygen average less than $6 and in Oklahoma they are just under $7. In Washington allowed charges average nearly $39 and in Vermont they average over $36. The median allowed charge for oxygen was determined to be $18. In addition to the wide variance in allowed charges for oxygen we also found that in 21 States carriers do not pay for oxygen charges submitted by ALS providers. In an equal number of States, carriers do not pay for oxygen charges submitted by BLS providers.

Supplies, injectables and other services (e.g., EKGs) are not always payable when billed by ambulance providers. The circumstances under which payment maybe made varies from carrier to carrier, locality to locality, and by the type of vehicle used to transport the

patient. Some carriers consider supplies, injectables and other ambulance services that are required by law to licensing requirements as not payable. These carriers do not recognize separate charges for these services. In 1995, Medicare allowed charges for supplies, injectables and other services provided by during ambulance transports totaled approximately $50 million.

Ambulance payment policies are vulnerable to fraud and abuse.

Carriers find it necessary to review a significant number of ambulance claims. Their experiences in processing and paying claims has shown them that vulnerabilities in Medicare's policies and procedures for paying for transportation services are pervasive. Carriers report manually reviewing all claims submitted by ambulance providers in 23 States. A significant number of claims submitted by providers in the remaining States are also suspended for manual review.

Many carriers reported problems with claims that lack origin or destination modifier codes. These codes help carriers identify transports that may not be medically necessary. Despite carrier efforts to obtain complete claim information, HCFA data shows that more than 500,000 base rate services were processed without modifiers indicating pick up and destination points. Allowed charges for these services totaled more than $30 million.

Manual intervention by the carriers in claims processing is costly. Carriers report spending inordinate amounts of time and money developing missing information and verifying the accuracy of information provided on ambulance claims. In 22 States, carriers report problems with providers who misrepresent the bed confinement status of patients being transported.

Another problem reported by at least one carrier involved providers who bill for supplies when the ambulance was restocked free of charge by local hospitals. Since the provider incurred no expense in securing the supplies, the carrier will not pay for supplies when they are billed by providers in this area. Other carriers are aware of this practice in some of their jurisdictions, but they have not conducted any studies to determine if duplicate payments may have resulted from the practice.

Another problem reported by carriers involves medically unnecessary transportation to dialysis centers (8 States). This problem was also documented in an earlier OIG report entitled, *Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices, (OEI-03-90-02131)*. In 19 States the carrier reported problems with non-approved or suspect destinations. In 14 States carriers have problems with providers not properly disclosing non-emergency transports. These claims may violate Federal statutes when ambulance suppliers falsify destination information in order to obtain payment.

In 10 States, carriers report problems with provider billings for oxygen, mileage, supplies and other services. In these 10 States the carriers question medical necessity for oxygen that some ambulance providers routinely provided patients. They also find abusive

situations involving unnecessary EKGs and other services provided during transportation to maximize payments from Medicare.

Over the past 5 years, the Office of Inspector General has had more than 100 convictions and civil judgements involving ambulance suppliers. The convictions and civil judgements involve issues reported by carriers in this study as ongoing problems with ambulance claims and providers. Appendix A provides brief summaries of several cases illustrating problems the Office of Inspector General has uncovered concerning ambulance services.

The complexity of the current system enables transportation suppliers to bill for ALS services when BLS services are provided; misrepresent the patient's true medical condition; and, avoid carrier program safeguards.

Furthermore, the current appeals system works against carrier efforts to ensure payments are made only for medically indicated transportation. All carriers expressed concern about the incidence of medically unnecessary ambulance transports. One carrier mentioned a tactic that could be used by other ambulance suppliers. This carrier revealed that one ambulance provider refuses to provide information concerning medical necessity. A substantial number of claims are denied for failure to provide the information needed to determine medical necessity. The ambulance provider routinely appeals the carrier denials and provides the information originally requested at the appeal. This tactic avoids scrutiny for medical necessity by trained carrier staff and, more often than not, results in claims that do not meet criteria for payment being paid at the hearing level. While this particular practice is unique and adds to program administrative costs, many carriers expressed frustration with an appeal system that they claim disenfranchises them from the process.

Problems are the result of extremely complex payment methods and inconsistent policies.

A complex payment system encourages fraud and abuse and thwarts efforts to control expenditures. This complexity stems from a payment system that uses four different billing methods, recognizes BLS and ALS vehicles, distinguishes emergency and non-emergency transports, employs more than 240 different procedure codes and uses more than 35 fiscal agents to propagate different coverage policies in nearly all 50 States.

Contributing to the lack of simplicity in the current payment system are 180 different geographical areas and more than 8,000 individual providers. Using charges submitted during the prior year, carriers annually calculate a prevailing charge and a customary charge for each provider in each geographical area. They also calculate an inflation index charge for each geographical area and each provider.

Complex Payment System

Medicare payment levels to ambulance providers are not based on the actual cost of providing services within geographic areas. They were originally based on the procedure code and the charges submitted to the program by providers doing business within a specific geographic location. Charges submitted during the previous year for each procedure code determined the amount carriers would pay. Higher charges in a year meant higher Medicare payments the following year.

In 1995, carriers were processing claims from ambulance companies using approximately 180 different procedure codes. These codes included uniform national codes defined in the HCFA Common Procedure Coding System and local codes deemed necessary by the carrier. In 1996, the number of procedure codes billed by ambulance providers and paid by carriers had increased nearly 35 percent to 240 codes. In addition to the 37 ambulance transportation codes, carriers were paying for medical supplies, injections and a number of unknown procedures under local codes in 1996. At this rate, the number of different procedure codes being billed by ambulance suppliers could approach 300 by the end of 1997.

The fee-for-service payment system encourages providers to unbundle the services they provide and to bill for individual components often using procedure codes outside the 37 transportation codes provided by HCFA. This, in effect, defeats controls, such as the inflation indexed charge, designed to control program costs. Since October 1985, payments for ambulance services have been based on the lower of customary, prevailing, inflation indexed or actual charge submitted on a claim. In areas where reimbursement rates were high, the resulting inflation indexed charges were high; conversely, in areas where reimbursement rates were low, the resulting inflation indexed charges were low. The inflation index charge may control the growth rate in expenditures for specific procedure codes, however, this control is easily circumvented when services are unbundled and when new procedure codes added. The net result is that the payment for the original procedure is inflated.

Inherent in fee-for-service reimbursement is the temptation to accommodate every detail of the services provided to patients. Fee-for-service perpetuates the need to create more and more procedure codes and to develop policies to address services provided by outlier providers. More procedure codes means new sources for increasing revenue. Overtime, providers begin to use these new procedure codes not only to bill for new services but also to unbundle the services previously included in their base rate payment. Availability of procedure codes for billing encourages suppliers to provide services to patients, whether medically indicated or not, and bill the services to Medicare. These practices result in increased expenditures for the Medicare program.

Lack of Uniform Policies

Policy differences exist concerning current billing methodologies. Carriers were instructed by HCFA to assign 1 of 4 methodologies to each ambulance provider based on

that provider's past billing practice. This policy was not uniformly implemented and in 12 States providers can use more than one billing methodology. Allowing providers to choose more than one method can potentially affect payment levels to the detriment of the program.

Carrier interpretations of policy contribute to variance in payments and coverage. This has resulted in fragmentation of services and disparity in coverage policy. In 16 States the carrier considers payment for oxygen included in the BLS base rate. In 21 States it is included in the ALS base rate. These carriers consider a portion of the BLS or ALS base rate payment as reimbursement for oxygen. Other carriers consider oxygen to be a prescription drug and allow ambulance suppliers in their area to bill for oxygen in addition to the base rate.

Policy differences also exist with regard to EKGs, supplies, injections and other services provided during transport. In 30 States ambulances are paid additional amounts for EKG services provided to patients. In 37 States additional amounts are paid for disposable supplies and in 18 States additional payments are made for reusable supplies. In areas where providers historically itemized charges for medical supplies, injections, night differential and other codes, carrier policies have evolved that perpetuate this fragmentation.

The average amount paid per ambulance trip ($500) does not have a consistent and direct relationship to the cost of doing business in a State, county or municipality. Medicare's current payment rates do not take into consideration the cost savings that have taken place in the industry.

In many parts of the country the industry is dominated by a few players. In these areas providers can operate more economically because they bulk purchase fuel and supplies and are in a better position to negotiate discounts favorable to them. They also purchase new technology that enables them to use satellite tracking to monitor all of their vehicles and to make the most efficient use of manpower. The rise of managed care has also created more aggressive competition among ambulance providers for a share of the managed care marketplace.

Local practice and the reasonable charge payment system have permitted the industry to establish a reimbursement environment that favors them financially. One would expect, Medicare to pay more for ambulance services in States such as California, Illinois, New York and other States where the cost of doing business is higher. Conversely, one would expect that Medicare would pay less in Louisiana, Mississippi and other States where the cost of doing business is lower.

Using average hourly wage, housing costs, fuels costs and other measures indicative of the cost of doing business, we found that Medicare's allowed charge has little or no relationship to the cost of doing business in an area. For example, Mississippi consistently ranks in the top 10 States for base rate reimbursement; yet, the average

hourly wage paid in Mississippi ranks 47 out the 50 States. Montana ranks in the top 20 States for these same services, while it ranks 46 out of the 50 States in per capita personal income for 1996.

We asked the carriers what they believed was included in Medicare's reimbursement for mileage. In 24 States, the carrier responsible for processing claims believed the payment was intended to cover only the cost of replacing fuel during a covered transport by ambulance. In 10 States, the carrier believed mileage reimbursement was intended to cover vehicle depreciation as well as fuel replacement costs. An equal number believed the amount was intended to cover insurance cost, fuel replacement and depreciation.

As with base rates, Medicare's allowed charge for mileage is derived from charges submitted by the providers. This encourages providers to raise charges each year. The actual cost to secure fuel is not currently taken into account when determining Medicare allowable reimbursement.

RECOMMENDATIONS

The HCFA's well-intentioned efforts to limit ambulance companies to four billing methods using 37 procedure codes has been circumvented by idiosyncrasies of the current fee-for-service payment system. At a time when most Medicare Part B services are being paid on a fee schedule, ambulance services are among the few services the Medicare program still reimburses on a reasonable charge basis.

Tremendous variation in payments indicates that Medicare reimbursement in many areas may be too high. The reasonable charge payment mechanism has resulted in inflated charges for ambulance services and does not accurately reflect the real cost of doing business in an area. More importantly, the fee-for-service system provides little or no incentive for providers to control costs. Efforts to control expenditure levels in the fee-for-service system result in fragmentation of services and increased utilization. Extensive carrier reviews of ambulance claims adds to program costs. Fraud and abuse in this area has also been well documented.

We believe that the vulnerabilities we found need to be addressed as soon as possible. We recommend that HCFA:

- seek legislative authority to develop a fee schedule for ambulance transportation.

In doing so, HCFA should take into consideration the competitive prices available in an area including the negotiated rate that exist between managed care entities/hospitals and ambulance providers. A fee schedule could also take into account the cost of doing business in an area, economies of scale available to some providers, adjustments for local subsidies and other consideration that may affect the cost of doing business.

The following interim teps should be taken to help develop the fee schedule:

- Instruct carriers to examine the inherent reasonableness of current allowable charges and adjust them as necessary.

- Work with the ambulance industry to develop clearer guidelines as to what is or is not included in the base rate and what mileage is intended to cover.

- Eliminate separate payments for oxygen, supplies, injectables and other services such as EKGs. These items should be included in the base rate.

- Limit the number of procedure codes available to ambulance suppliers for billing. At a minimum, restrict use of procedure codes to the 37 specific codes designated for ambulance transportation.

We believe that Medicare ambulance policies could be simplified and unreasonable base rate and mileage payment levels reduced. Consistent coverage policies should be

developed and the number of billing methods and procedure codes currently in use reduced. Elimination of many procedure codes would discourage unbundling and the routine use of some supplies and services designed simply to enhance payment. Items considered essential for life support should be included in base rate reimbursement and should not be paid as separate items or services.

Actual savings from simplification and more uniform policies would depend on how base rate and mileage are defined and the fee schedule allowances for these services. If implemented as we have suggested we project that Medicare could save at least $242 million annually. Fifty million dollars of these projected savings could be derived solely from elimination of separate payments for oxygen, supplies, injectables and other services such as EKGs. At least $192 million could be saved annually by limiting the allowed charge for mileage to the lower of actual charge or $1 per mile.

Our savings projections are predicated on the current base rate levels remaining unchanged except for increases due to the inflation index charge or changes in customary and prevailing charges. Actual savings could be higher if the base rate allowed charge for non-emergency transportation is adjusted to ensure that Medicare pays the same or less for this service than it does for the base rate for emergency transportation. Structuring payments to take into account average miles per gallon, bulk purchasing discounts, State and local taxes and other factors could also impact projected savings. Savings may be lower if some base rates are increased or policies developed that permit unbundling of some services.

AGENCY COMMENTS

Since issuing our draft report, Congress passed the Balanced Budget Act of 1997. This legislation implements our recommendation and requires that HCFA establish a fee schedule for Medicare ambulance payments. We look forward to HCFA's regulation that will carry out the legislation.

APPENDIX A

Examples of Ambulance Cases Investigated By

The Office of Inspector General

- Three related ambulance companies in Connecticut submitted false claims to the Medicare program from 1991 to 1994. The companies falsified claims to obtain payments for noncovered services. The false claims concealed routine transportation of ambulatory patients from their residences or nonskilled nursing homes to renal dialysis clinics in order to obtain Medicare payments.

- An ambulance provider convicted and sanctioned for Medicaid Fraud in 1986 used "front men" to form transportation companies so she could get Medicare payments for ambulance service without anyone detecting she was a sanctioned provider. Using the fronts, the provider obtained various vehicle licenses for special need transportation and then billed Medicare and Medicaid for individual services when multiple patients were transported in unlicensed personal vehicles.

- A St. Paul, MN based company billed Medicaid and Medicare for basic life support ambulance transportation, claiming the rides were medically necessary, when a lesser form of transportation would have been appropriate. Consumers, too, lost money when they were billed for copayments on the unnecessary ambulance rides when a simple van ride would have been appropriate.

- In Illinois, an ambulance company was convicted of targeting nursing home patients and billing for ambulance services when the patients did not need an ambulance. The defendants falsified medical and trip records and back dated them in an effort to establish the medical necessity of the ambulance transports.

- A case in Indiana found an ambulance provider guilty of transporting nursing home residents to scheduled medical appointments at doctors' offices, clinics and hospitals. Most of the patients transported were ambulatory or in wheelchairs but the provider indicated on claims submitted for payment that the patients were bed confined. The provider also routinely billed for oxygen which was not administered.

- In Ohio, an ambulance provider falsified destinations, medical necessity information and ordering physician information. For 7 years the owner altered trip tickets submitted by his drivers to reflect that patients were transported to covered destinations when in fact patients were transported to doctors' offices. The owner would also change the trip tickets to show that patient's were bedridden when in fact the patients were in wheelchairs and in some instances could walk. There were occasions when the company billed for ambulance transports when the patients were transported in a company station wagon.