

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**AMBULANCE SERVICES FOR  
MEDICARE END-STAGE RENAL  
DISEASE BENEFICIARIES:**

**MEDICAL NECESSITY**



**JUNE GIBBS BROWN  
Inspector General**

**AUGUST 1994  
OEI-03-90-02130**

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# EXECUTIVE SUMMARY

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## PURPOSE

This study determined whether 1991 dialysis-related ambulance claims for beneficiaries with end-stage renal disease (ESRD) met Medicare's Part B coverage criteria for medical necessity.

## BACKGROUND

The Medicare Part B benefit for ambulance service has very strict limits. These are explained by the Health Care Financing Administration (HCFA) in the Medicare Carriers Manual, Section 2120. The transport is not covered if it fails to meet the medical necessity requirement, even if it meets other requirements. The Carriers Manual states that no payment may be made in any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available. Generally, ambulance transport is covered for patients whose condition requires emergency medical attention, or whose condition makes it impossible to sit and requires transfer by stretcher.

A small number of ESRD beneficiaries are associated with extremely high ambulance payments. In 1991, there were 193,883 ESRD beneficiaries with Part B claims, of whom only 21 percent had ambulance claims. The ambulance allowances totalled \$101 million, 75 percent of which was for less than 2 percent (2,573) of the beneficiaries. The high dollars for so few people is related to use of ambulances three times per week for maintenance dialysis.

We conducted a medical review of 1991 dialysis-related ambulance claims to assist HCFA in its continuing efforts to assess coverage and payment policies. The universe for this study was the 16 carriers with the highest Part B ambulance allowances. They represented 87 percent of total Part B ambulance allowances for ESRD beneficiaries (\$85 million out of \$101 million). The claims were selected in a two-stage cluster design. First we selected 8 carriers from the 16 in our universe, and then we selected 35 random claims from each of the 8 carriers. The medical review was conducted by a team of medical professionals from Federal Occupational Health (FOH), a division of the Public Health Service. The FOH has conducted other medical reviews for various Federal agencies including HCFA. We also analyzed data from HCFA, carriers, ambulance providers, dialysis facilities, and the American Ambulance Association.

## FINDINGS

*Seventy percent of dialysis-related ambulance claims across 16 carriers with the highest allowances did not meet Medicare's coverage guidelines for medical necessity. These claims represent \$44 million.*

*While carriers had systems to identify claims that did not meet Medicare guidelines, medically unnecessary claims were paid.*

- Results of systems carriers used to identify inappropriate claims were not clear.
- Carriers may have been misled to believe claims were medically necessary when providers used key phrases on claim forms to give the appearance that transport was medically necessary.
- Carriers do not routinely include ambulance transports for beneficiaries with ESRD in their post-payment reviews.
- Since 1991, three carriers have adopted new systems to identify inappropriate claims.

## RECOMMENDATIONS

After we informally alerted HCFA to our preliminary findings, HCFA took the initiative to collect ESRD ambulance coverage policies from 43 carriers. The HCFA shared this information with us, and our review of it confirmed our findings regarding the eight carriers in our sample. Therefore we recommend:

*The HCFA should ensure that claims meet Medicare coverage guidelines.*

We suggest the following targeted options as ways to address the problems described in this report. For carriers with very high ambulance allowances:

- Alert them that utilization of ambulance service by ESRD beneficiaries is highest for dialysis-related transports, that these claims are for a small number of ESRD beneficiaries, and many of these claims are not medically necessary.
- Alert them it is possible to identify, in a prospective manner, those ESRD beneficiaries with high potential for large expenditures for ambulance services. Two methods for identifying these beneficiaries were described in the Office of Inspector General report, *Ambulance Services for Medicare ESRD Beneficiaries: Payment Practices* (OEI 03-90-02131). One method looks at the number of days between the first and second trip claimed during the year. The second looks at the number of trips for which claims were filed within a fixed time period, e.g., 15 days.
- Identify those with methods which ensure that transport for ESRD beneficiaries is medically necessary, and advise other carriers of these methods. Methods that are practical and cost-effective will vary depending on the carrier's overall volume and other considerations. For example, a carrier with a relatively low volume may effectively pre-authorize ambulance transport for ESRD beneficiaries going to dialysis. A carrier with high volume may prefer to

electronically suspend, for medical review, ESRD-related ambulance claims when there are more than six transports in a month.

- Advise beneficiaries of the limited nature of the ambulance benefit, and encourage them to call the carrier if the supplier misrepresents Medicare coverage. Carriers could send such a message to beneficiaries directly by mail and through national and local senior citizen groups and newspapers.
- Advise ambulance companies of Medicare's limited coverage of ambulance service and the consequences of submitting bills for transports that are not medically necessary. Carriers could distribute notices to providers directly and through national and local trade associations.
- Advise dialysis-facility physicians of the limits of Medicare's coverage for ambulance service as they are often the physicians called upon to sign certifications of medical necessity. Carriers could include this advice in their provider education material.
- Periodically, conduct a medical necessity review of ESRD-related ambulance claims.
- Conduct studies to determine: (1) what percentage of ESRD beneficiaries being transported to dialysis in ambulances could use wheelchair vans or some other non-emergency vehicle; and (2) whether dialysis facilities would cover the cost of ambulance service, for ESRD beneficiaries who need it, for an add-on to the composite rate Medicare pays for dialysis.

We also suggest that HCFA could:

- Advise beneficiaries of the limited coverage for ambulance service through *The Guide to Health Insurance for People with Medicare*.
- *The Medicare Handbook* already has a section which explains the limited ambulance transportation benefit. However, the section on fraud and abuse mentions ambulance providers only indirectly--under the umbrella of health care service provider. Since beneficiaries may not connect the two, perhaps ambulance transport could be identified as an example of a health care service.

We have already referred to our Office of Investigations all cases that involve possible fraud. Details of our medical review of claims are available should HCFA wish to review these claims or take any action.

## COMMENTS FROM HCFA

The HCFA concurs with our recommendation that they ensure that claims meet Medicare guidelines. They have listed steps they are taking to address our recommendation. Appendix C contains the full comments.

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# INTRODUCTION

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## PURPOSE

This study determined whether 1991 dialysis-related ambulance claims for beneficiaries with end-stage renal disease (ESRD)<sup>1</sup> met Medicare's Part B coverage criteria for medical necessity.

## BACKGROUND

The Medicare Part B benefit for ambulance service has very strict limits. These are explained by the Health Care Financing Administration (HCFA) in the Medicare Carriers Manual (see Appendix A). The transport must meet requirements in the areas of medical necessity, destination, vehicle, and crew. It is not covered if it fails to meet the medical necessity requirement, even if it meets the other requirements. The Carriers Manual states that no payment may be made in any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available (section 2120.2.A.). The Manual also states that a person receiving outpatient dialysis is not ordinarily ill enough to require an ambulance (section 2120.3.J.). Generally, transport is covered for patients whose condition requires emergency medical attention, or whose condition makes it impossible to sit and requires transfer by stretcher (section 2125.2).

The limited nature of coverage for ambulance was shown in a complaint dismissed by a U.S. District Court. The court rejected an argument that when a physician finds that other forms of transportation are contraindicated there is a presumption of coverage for ambulance expenses. The case involved an intermediary that had determined the ambulance services were not reasonable and necessary because the patients in question were able to ambulate with the aid of walkers and wheelchairs. The provider argued that Medicare imposed a responsibility on physicians to determine when other means of transportation are unsafe. If physicians certify the need for ambulance, the certifications should ensure payment. The court said physician certification was only one of several conditions of coverage under Part B and that the Secretary had a continuing obligation to review the patient's condition and need for an ambulance.<sup>2</sup>

A small number of ESRD beneficiaries are associated with extremely high ambulance payments. In 1991, there were 193,883 ESRD beneficiaries with Part B claims, of whom only 21 percent had ambulance claims. The ambulance allowances totalled \$101 million, of which 75 percent was for less than 2 percent of the beneficiaries (2,573). The high dollars for so few people is related to use of ambulances three times per week for maintenance dialysis.<sup>3</sup>

Ambulance providers submit claims on behalf on the beneficiaries they transport. Maintenance dialysis transports account for a high volume of services by a small number of providers. In 1991, only 4 percent<sup>4</sup> of all ambulance providers receiving Part B payments (215 out of 5,228) had 72 percent or \$73 million of the total allowances for ESRD beneficiaries.

Medicare carriers process all types of Part B claims. They have a variety of systems to identify inappropriate claims in both pre-payment and post-payment stages of operations. In the pre-payment stage, for example, claims may be suspended for additional development that could lead to paying or denying the claim. Providers have the right to appeal a carrier's decision to deny payment. On the post-payment side, carriers review samples of claims more closely, and might even conduct medical reviews. Claims for post-payment reviews are usually selected on a priority basis from particular provider groups that represent high expenditures or aberrant billing.

Other Office of Inspector General (OIG) reports, issued within the last 10 years, indicated that ambulance policies were vulnerable to abuse, and a Medicare consultant with the American Ambulance Association indicated that many of the dialysis-related transports may not meet Medicare guidelines for medical necessity.

This is the first national study to retrospectively examine the medical necessity of randomly selected ambulance claims for beneficiaries with ESRD. We conducted a medical review of dialysis-related claims and examined carrier policies and procedures for identifying claims for medically unnecessary transports. Our objective is to assist HCFA in its efforts to assess coverage and payment policies for ambulance service.

## **SCOPE AND METHODOLOGY**

This report is focused on transports of ESRD beneficiaries to and from dialysis facilities. It is based on calendar year 1991 data from HCFA, Medicare carriers, ambulance company representatives, and dialysis facility nurses and physicians. We collected the data from November 1992 through December 1993.

To determine the availability of data and to clarify issues, we met with representatives of HCFA, a Medicare carrier, the American Ambulance Association, and dialysis facilities. We also reviewed ambulance studies conducted within the Department (1983-1993) and ambulance-related Management Information Reports (1988-1993) by the OIG's Office of Investigations.

To review ambulance claims for ESRD beneficiaries, we selected a sample of carriers and claims using a two-stage cluster design. Total Part B ambulance allowances for ESRD beneficiaries were \$101 million. Of that amount, \$85.3 million represents 16 carriers whose allowances were the highest. From those top 16 carriers, we randomly selected 8. We then chose a simple random sample of 35 claims from each of the 8 carriers for a total of 280 claims. Of the 280 sampled claims, 180 were dialysis-related.

Our findings regarding the dialysis-related claims are projected from the 8 sampled carriers to the universe of 16 carriers.

A medical team, headed by a physician from Federal Occupational Health (FOH), a division of the Public Health Service, determined whether the dialysis-related claims met Medicare guidelines for medical necessity. The FOH has conducted other medical reviews for various Federal agencies including HCFA. The medical team did not review claims that were not related to dialysis (62 out of 280) or for which data was inaccessible (38 out of 280).

Methodology details regarding sampling, data collection, and analyses are in Appendix B. The confidence levels regarding estimates in this report are also in Appendix B.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

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## **SEVENTY PERCENT OF TRANSPORTS INVOLVING DIALYSIS DID NOT MEET MEDICARE'S GUIDELINES FOR MEDICAL NECESSITY. THESE CLAIMS REPRESENT AN ESTIMATED \$44 MILLION.**

While ESRD beneficiaries used ambulance service in a variety of circumstances, approximately 67 percent of the claims in our universe involved transports to or from dialysis. Our universe was 16 carriers with the highest ESRD ambulance allowances. Of the dialysis-related transports, 70 percent did not meet coverage guidelines for medical necessity. They represent an estimated \$44 million in ambulance allowances. The percentages of medically unnecessary dialysis-related ambulance trips for each of the 8 sampled carriers were 23, 48, 50, 70, 81, 81, 85, and 91 percent (as shown in Table 5, page B-6).

Our medical review had three possible outcomes. The claims either did not meet Medicare guidelines (70 percent), did meet guidelines (29 percent), or conflicting data prevented a determination (1 percent). By conflicting data, we mean that a claim folder had data which contradicted other data in the same folder.

Beneficiaries can obtain immediate ambulance service in emergency situations. In non-emergency situations (e.g., transport for routine dialysis) they can schedule service in advance of the transport date. Virtually all (99 percent) of the dialysis-related transports in our sample were scheduled. According to ambulance company respondents, nearly all of the beneficiaries (97 percent) associated with these claims were transported by the company on a regular basis: three times per week was the average. (See tables on pages B-4 and B-5 for confidence intervals of percentages in this paragraph.)

### *Beneficiaries could have used other forms of transportation.*

Claims did not meet Medicare guidelines because on the date of ambulance service beneficiaries did not have conditions that contraindicated use of another type of transport. Of the claims that were medically necessary, beneficiaries had conditions including--but not limited to--dementia, contractures, hypotension after dialysis, spinal cord compression, and severe obesity. Beneficiaries associated with claims that did not meet medical necessity guidelines did not have these kinds of conditions.

In addition to not having medical conditions requiring an ambulance, almost two-thirds of the beneficiaries (63 percent) were clearly not bed-confined. The claim folders contained evidence that 28 percent of the claims were for ambulatory patients and 35 percent were for beneficiaries in wheelchairs on the date of ambulance service, as observed by dialysis facility staff (see Table 6 on page B-6 for confidence intervals).

A beneficiary's use of a wheelchair or ability to walk did not automatically mean the claim did not meet Medicare guidelines. There were cases where beneficiaries were ambulatory or wheelchair capable but had other destabilizing conditions, such as low blood pressure after dialysis that may have required monitoring, and therefore an ambulance was justified.

Claim folders reviewed by our medical team contained data about the patient's medical history, diagnoses, and ambulatory status. According to Medicare guidelines, a diagnosis of ESRD is not sufficient explanation to warrant an ambulance. The reviewers evaluated the accumulated data and determined that claims did not meet Medicare guidelines if there was no medical condition that confined the patient to bed and/or made travel by other than an ambulance unsafe. "Bed-confined" was a commonly used phrase on claim forms but data regarding the claims did not support it.

**WHILE CARRIERS HAD SYSTEMS TO IDENTIFY CLAIMS THAT DID NOT MEET MEDICARE GUIDELINES, MEDICALLY UNNECESSARY CLAIMS WERE PAID.**

*Results of systems carriers used to identify inappropriate claims were not clear.*

Carriers in our sample were using automated screens, certifications of medical necessity, and specialized processing units through 1991 to identify and prevent inappropriate claims. Regardless of the type of system used, six carriers could not say how many inappropriate claims had been identified in 1991 or the total dollar amount they represented. The carriers either did not have mechanisms or procedures to capture that information, were not equipped to sort information about ambulance trips for ESRD beneficiaries from aggregated claims data, or the information was extremely time-consuming and labor intensive to produce.

Two carriers did give us the number of inappropriate claims they identified in 1991 and the dollar amount associated with those claims. However, even these carriers did not say whether the figures were related to ambulance claims for ESRD beneficiaries or whether they related directly to the use of a particular system for identifying inappropriate claims.

Automated screens had different functions and were used inconsistently by most of the carriers that had them. In 1991, three carriers had screens. The first of these three had a screen which suspended all ambulance claims for ESRD beneficiaries. The second suspended any claims for non-emergency transports, and the third suspended claims when there were more than six transports for the same beneficiary within 30 days. One of these three carriers said its screen is on whenever the HCFA mandated workload permits. For example, its screen was on in 1991, off for part of 1992, and back on in 1993. A fourth carrier had screens for ambulance claims, operating until late 1990, which identified transports for ESRD beneficiaries and repetitive billing. The ambulance screens were deactivated with HCFA's knowledge so that the carrier

could screen other types of Medicare claims. This carrier said the ambulance screens saved an average of \$291,000 per month.

Two carriers required certifications of medical necessity for non-emergency transports to dialysis. Certifications have a variety of formats. Some, for example, are checklists printed by the ambulance company while others are letters to carriers on dialysis facility stationery. What they have in common is the signature of a physician or other medical provider and statements indicating that the patient needs an ambulance.

Two carriers had claims processing units specializing in ambulance claims. These carriers felt that specialized processors become familiar with the beneficiaries and can spot irregularities or cloning. Cloning is the process of using a claim that has been paid as a model for filling out subsequent claims regardless of whether the circumstances of the transports were the same. One of the two carriers said if the processors believe a beneficiary is not bed-confined, even though the claim says so, they will call someone to verify the patient's condition. Since most of their beneficiaries are in nursing homes, a call to the nursing home settles the question. Nursing homes have, at times, contradicted what was on the claim form.

While we did not perform cause and effect analyses, the carrier with the lowest percentage (23) of medically unnecessary claims was the only one with a screen to suspend ambulance bills if there were more than six transports for the same beneficiary in one month. The carrier with the lowest percentage of dialysis-related transports was the only one with a screen to suspend all claims for ESRD beneficiaries. (The distribution, by carrier, of claims that did not meet Medicare guidelines is on page B-6.)

*Carriers may have been misled to believe claims were medically necessary when providers used key phrases on claim forms to give the appearance that transport was medically necessary.*

If statements providers use to fill out the claim form fit Medicare guidelines, the claim will be paid. All carriers said they consider provider statements on the claim form regarding patient condition and diagnosis proof that transport is medically necessary. One carrier, for example, considers a transport medically necessary if the claim says the patient has ESRD and is bed-confined. Other carriers said claims appear to be medically necessary depending on the description of the patient's medical condition.

Four of the eight carriers said they do not verify the providers' claim-form statements. Two others consider certifications of medical necessity a verification of claim statements. The two remaining carriers believe its processors know the beneficiaries well enough to spot irregularities in claims, and they may make telephone calls to verify unusual data.

While providers need Medicare coverage information if they are to submit claims for covered service, some may be using key phrases directly from the Medicare Carriers

Manual to ensure payment regardless of the beneficiary's condition. Most carriers advise providers of the Medicare requirements for medical necessity through periodic newsletters or special notices. One carrier said it refrains from giving out wording from the Carriers Manual. This carrier advises ambulance crew members to describe on the trip report exactly what they see when they pick up a patient. Information from the trip report can then be transferred to the claim form. Providers, however, can learn the phrases in the Carriers Manual from trade associations as well as from carriers.

In 1991, a carrier conducted a special ambulance project because providers had been submitting claims without sufficient data. A significant number of ambulance claims were denied that year because they were incomplete. The special effort to get thorough information on ambulance claims has resulted in cleaner claims, according to the carrier. But the carrier is also aware that this could mean they taught the ambulance providers the right things to say to get paid. A fraud investigator with this carrier said the need for ambulance service to dialysis is rare, but the claim form can fool the claims processor and fraud investigator alike.

While carriers rely on providers' claim form statements, there is no guarantee that the statements are truthful. One carrier described a claim that met medical necessity guidelines for an ambulance because the provider listed the patient's multiple medical conditions. After the claim was paid, the beneficiary called to complain that the provider, which was certified for basic and advanced life support ambulances, had transported the beneficiary in a wheelchair van. Without the complaint, the provider's statements would not have been questioned and payment for a false claim would not have been detected.

Various respondents expressed the opinion that once in a while everyone--patients, doctors, nurses, social workers, and ambulance providers--will bend a story to fit Medicare requirements for convenience or for a needy patient. Beneficiaries may use ambulance transport for reasons that are financial, logistical, or for lack of an alternative. Patients may be ambulatory or wheelchair capable but may not be able to afford the cost of a taxi or wheelchair van service, especially if they have to travel long distances. Some patients may be so debilitated that they cannot lift their own weight and require two people to make the transfer to a chair safely, or once in a wheelchair they cannot get down a flight of stairs. These situations are not covered under Medicare guidelines.

***Post-payment reviews by carriers do not routinely include ambulance transports for beneficiaries with ESRD.***

Carriers do not routinely target ambulance claims for post-payment reviews. Most carriers use their post-payment resources to review other types of claims that represent higher Medicare expenditures. One carrier that did an ambulance utilization review in 1991 found 15 cases representing over \$3 million in overpayments. Unless carriers target ambulance providers for special post-payment audits or target

ambulance claims for medical reviews, inappropriate ambulance claims for ESRD beneficiaries can slip through the system.

It appears that carriers do not review ambulance claims for ESRD beneficiaries for two major reasons: either payments for ambulance transports are far less than payments for other services, or carriers do not have a system for isolating and examining ESRD-related ambulance claims.

In the post-payment stage, beneficiary complaints have helped five carriers discover inappropriate ambulance claims. As mentioned previously, complaints from beneficiaries have revealed that providers will sometimes transport the beneficiary in a non-emergency vehicle and charge Medicare for an ambulance.

Other mechanisms that help carriers identify inappropriate claims include quality assurance audits of staff's workload. One carrier, for example, audits 5 percent of the workload weekly, while another carrier audits 400 claims per month. However, unless the workload is strictly ambulance claims, there is little likelihood that ambulance claims for ESRD beneficiaries will surface in significant numbers. Carrier respondents who mentioned workload audits did not specify what an audit entails and whether the medical necessity issue is examined.

Seven carriers were of the opinion that more post-payment reviews would help in the identification of inappropriate payments of ambulance transports for ESRD beneficiaries. Without post-payment reviews, medically unnecessary claims can go unnoticed, and the magnitude of the problem will be unknown. The one carrier that did not suggest additional post-payment reviews had recently established a system of pre-approving transports.

Five carriers think focused medical reviews, known as FMRs, should be used for ambulance services. The FMRs are a new type of post-payment review required by HCFA. In this type of review local data about a particular service is compared with national data. However, because other services have priority, carriers do not anticipate doing FMRs on ambulance service in the near future. Carriers said they will need more funding to increase the number of any type of post-payment reviews.

*Since 1991, three carriers have adopted new systems to identify inappropriate claims.*

When we conducted interviews in May of 1993, three out of eight sampled carriers described changes to the systems they had used in 1991. Of the three carriers, one began using automated screens in 1992 to suspend claims for manual review if the transport was within 30 days of an ESRD procedure; and a second carrier expected to have a specialized processing unit by the summer of 1993.

The third carrier adopted a system that was unique among all carriers in the sample. In 1992, it began to pre-approve transport to dialysis for ESRD beneficiaries. According to this carrier, the HCFA regional office had alerted them to abuses in the



area of transports to dialysis. As a result, in 1992, the carrier stopped all payments on these types of claims. It followed with a survey of the medical necessity for transport of ESRD beneficiaries. Telephone calls to beneficiaries revealed that some were truly in need of transfer by stretcher while others rode to dialysis in mini vans or the front seat of pick up trucks. As a result of the survey, ambulance providers are now required to get a medical necessity letter from the beneficiary's treating physician and forward it to the carrier. Medical necessity letters are to include the patients' medical history, diagnosis, current condition, and reasons patients might be bed-confined. The letters are reviewed by the carrier's medical director who decides whether the beneficiary's transport to dialysis is medically necessary. Thereafter, claims for that beneficiary are checked against a pre-approval list.

Of the three carriers who described systems established after 1991, the one with an automated screen identified over 1000 inappropriate claims in 1992. The two other carriers did not say they had a procedure to account for outcomes of the system.

## RECOMMENDATIONS

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Because such a high percentage of Part B dialysis-related ambulance claims for ESRD beneficiaries did not meet Medicare's medical necessity guidelines, we alerted HCFA to our preliminary findings in an informal briefing in February 1994. In response, HCFA took the initiative to contact 43 Medicare carriers and collect their ESRD ambulance coverage policies, which it then shared with us. Our review of the information indicates that systems used by the eight carriers in our sample have not changed since we collected our data in 1993. We therefore recommend:

*The HCFA should ensure that claims meet Medicare coverage guidelines.*

We suggest the following targeted options as ways to address the problems described in this report. For carriers with very high ambulance allowances:

- Alert them that utilization of ambulance service by ESRD beneficiaries is highest for dialysis-related transports, that these claims are for a small number of ESRD beneficiaries, and many of these claims are not medically necessary.
- Alert them it is possible to identify, in a prospective manner, those ESRD beneficiaries with high potential for large expenditures for ambulance services. Two methods for identifying these beneficiaries were described in the Office of Inspector General report, *Ambulance Services for Medicare ESRD Beneficiaries: Payment Practices* (OEI 03-90-02131). One method looks at the number of days between the first and second trip claimed during the year. The second looks at the number of trips for which claims were filed within a fixed time period, e.g., 15 days.
- Identify those with methods which ensure that transport for ESRD beneficiaries is medically necessary, and advise other carriers of these methods. Methods that are practical and cost-effective will vary depending on the carrier's overall volume and other considerations. For example, a carrier with a relatively low volume may effectively pre-authorize ambulance transport for ESRD beneficiaries going to dialysis. A carrier with high volume may prefer to electronically suspend, for medical review, ESRD-related ambulance claims when there are more than six transports in a month.
- Advise beneficiaries of the limited nature of the ambulance benefit, and encourage them to call the carrier if the supplier misrepresents Medicare coverage. Carriers could send such a message to beneficiaries directly by mail and through national and local senior citizen groups and newspapers.
- Advise ambulance companies of Medicare's limited coverage of ambulance service and the consequences of submitting bills for transports that are not

medically necessary. Carriers could distribute notices to providers directly and through national and local trade associations.

- Advise dialysis-facility physicians of the limits of Medicare's coverage for ambulance service as they are often the physicians called upon to sign certifications of medical necessity. Carriers could include this advice in their provider education material.
- Periodically, conduct a medical necessity review of ESRD-related ambulance claims.
- Conduct studies to determine: (1) what percentage of ESRD beneficiaries being transported to dialysis in ambulances could use wheelchair vans or some other non-emergency vehicle; and (2) whether dialysis facilities would cover the cost of ambulance service, for ESRD beneficiaries who need it, for an add-on to the composite rate Medicare pays for dialysis.

We also suggest that HCFA could:

- Advise beneficiaries of the limited coverage for ambulance service through *The Guide to Health Insurance for People with Medicare*.
- *The Medicare Handbook* already has a section which explains the limited ambulance transportation benefit. However, the section on fraud and abuse mentions ambulance providers only indirectly--under the umbrella of health care service provider. Since beneficiaries may not connect the two, perhaps ambulance transport could be identified as an example of a health care service.

We have already referred to our Office of Investigations all cases that involve possible fraud. Details of our medical review of claims are available should HCFA wish to review these claims or take any action.

#### COMMENTS FROM HCFA

The HCFA concurs with our recommendation that they ensure that claims meet Medicare guidelines. They have listed steps they are taking to address our recommendation. Appendix C contains the full comments.

## ENDNOTES

1. Persons with ESRD are entitled to Medicare under 1972 amendments to the Social Security Act.
2. *American Ambulance Service of Pennsylvania, Inc. v. Sullivan* as summarized in *Medicare and Medicaid Guide* (Chicago, IL: Commerce Clearing House, 1991), paragraphs 3,148.56 and 39,250.
3. Office of Inspector General, *Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices*, OEI-03-90-02131 (Washington, D.C.: U.S. Department of Health and Human Services, 1994).
4. This percentage could be lower if, as is often the case, ambulance companies have more than one provider identification number.

# APPENDIX A

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## MEDICARE CARRIERS MANUAL AMBULANCE COVERAGE AND LIMITATIONS

Section 2120. Ambulance Service.....	A-2
Section 2125. Coverage guidelines for claims.....	A-10

**2120. AMBULANCE SERVICE**

Reimbursement may be made for expenses incurred for ambulance service provided the conditions specified in the following subsections are met. (See §§ 4115 and 2125 concerning instructions for processing ambulance service claims.)

**2120.1 Vehicle and Crew Requirements**

A. The Vehicle.--The vehicle must be a specially designed and equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by State or local authorities.

B. The Crew.--The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training, i.e., training at least equivalent to that provided by the standard and advanced Red Cross first aid courses. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

C. Verification of Compliance.--In determining whether the vehicles and personnel of each supplier meet all of the above requirements, carriers may accept the supplier's statement (absent information to the contrary) that its vehicles and personnel meet all of the requirements if (1) the statement describes the first aid, safety, and other patient care items with which the vehicles are equipped, (2) the statement shows the extent of first aid training acquired by the personnel assigned to those vehicles, (3) the statement contains the supplier's agreement to notify the carrier of any change in operation which could affect the coverage of his ambulance services, and (4) the information provided indicates that the requirements are met. The statement must be accompanied by documentary evidence that the ambulance has the equipment required by State and local authorities. Documentary evidence could include a letter

from such authorities, a copy of a license, permit, certificate, etc., issued by the authorities. The statement and supporting documentation would be kept on file by the carrier.

When a supplier does not submit such a statement or whenever there is a question about a supplier's compliance with any of the above requirements for vehicle and crew (including suppliers who have completed the statement), carriers should take appropriate action including, where necessary, on-site inspection of the vehicles and verification of the qualifications of personnel to determine whether the ambulance service qualifies for reimbursement under Medicare. Since the requirements described above for coverage of ambulance services are applicable to the overall operation of the ambulance supplier's service, it is not required that information regarding personnel and vehicles be obtained on an individual trip basis.

**D. Ambulance of Providers of Services.**--The Part A intermediary is responsible for the processing of claims for ambulance service furnished by participating hospitals, skilled nursing facilities and home health agencies and has the responsibility to determine the compliance of provider's ambulance and crew. Since provider ambulance services furnished "under arrangements" with suppliers can be covered only if the supplier meets the above requirements, the Part A intermediary may ask the carrier to identify those suppliers who meet the requirements.

**E. Equipment and Supplies.**--As mentioned above, the ambulance must have customary patient care equipment and first aid supplies. Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance service and would be included in the charge for the trip. On the other hand, a separate reasonable charge based on actual quantities used may be recognized for nonreusable items and disposable supplies such as oxygen, gauze and dressings required in the care of the patient during his trip.

**2120.2 Necessity and Reasonableness.**--To be covered, ambulance service must be medically necessary and reasonable.

**A. Necessity for the Service.**--Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.

**B. Reasonableness of the Ambulance Trip.**--A claim may be denied on the ground that the use of ambulance service was unreasonable in the treatment of the illness or injury involved (§ 2303) notwithstanding the fact that the patient's condition may have contraindicated the use of other means of transportation. The carrier should use discretion when applying this principle. It is expected that generally its application will be limited to those instances where a supplier or provider repeatedly demonstrates a pattern of uneconomical practice and to those individual claims where the excess cost is large.

2120.3 The Destination.--As a general rule, only local transportation by ambulance is covered. This means that the patient must have been transported to a hospital or a skilled nursing home as defined in § 2125 item 3(a) whose locality (see paragraph E below) encompasses the place where the ambulance transportation of the patient began and which would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. In exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, full payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities (see F below). The institution to which a patient is transported need not be a participating institution but must meet at least the requirements of 1861(e)(1) or 1861(j)(1) of the Act. (See § 2100.3 A and B for an explanation of these requirements.) A claim for ambulance service to a participating hospital or skilled nursing facility should not be denied on the grounds that there is a nearer nonparticipating institution having appropriate facilities. (See C below for destination exceptions.)

A. Institution to Beneficiary's Home.--Ambulance service from an institution to the beneficiary's home is covered when the home is within the locality of such institution or where the beneficiary's home is outside of the locality of such institution and the institution, in relation to the home, is the nearest one with appropriate facilities.

B. Institution to Institution.--Occasionally, the institution to which the patient is initially taken is found to have inadequate facilities to provide the required care and the patient is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered provided the institution to which the patient is being transferred is determined to be the nearest one with appropriate facilities. In these cases, transportation from such second institution to the patient's home could be covered if the home is within the locality served by that institution, or by the first institution to which the patient was taken.

C. Round-Trip for Specialized Services.--Round-trip ambulance service is covered for a hospital or participating skilled nursing facility inpatient to the nearest hospital or nonhospital treatment facility, i.e., a clinic, therapy center of physician's office to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) not available at the institution where the beneficiary is an inpatient. (See §4168.)

The round-trip ambulance service benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient.



Carriers will monitor this by performing a periodic postpayment review with appropriate medical staff assistance to determine whether the frequency of such ambulance services for a particular patient, together with the medical condition, indicates there is another preferred medical course of treatment. The carrier should not request transfer of hospital inpatients to another hospital capable of providing the required service but should deny such ambulance service claims in the future. For patients in SNFs and those residing at home, the attending physician should be asked to furnish additional information supporting the need for ambulance service relative to the option of admission to a treatment facility.

**D. Partial Payment.**—Where ambulance service exceeds the limits defined in A, B and C above, refer to §2125 item #5 for instructions on partial payment.

**E. Locality.**—The term "locality" with respect to ambulance service means the service area surrounding the institution from which individuals normally come or are expected to come for hospital or skilled nursing services.

**Example:** Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35 bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community but they regularly provide hospital services to the community's residents. The community is within the "locality" of the metropolitan hospital and direct ambulance service to either of these (as well as to the local community hospital) is covered.

**F. Appropriate Facilities.**—The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest tuberculosis hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is also not considered an appropriate facility if there is no bed available. The carrier, however, will presume that there are beds available at the local institutions unless the claimant furnished evidence that none of these institutions had a bed available at the time the ambulance service was provided.

**EXAMPLE:** Mr. A becomes ill at home and requires ambulance service to the hospital. The hospitals servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis and the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with the equipment is covered since it is the nearest one with appropriate facilities.

**G. Ambulance Service to Physician's Office.**—These trips are covered only under the following circumstances:

- o The trips meet the criteria of §2120.3C, or
- o While transporting a patient to a hospital, the ambulance stops at a physician's office because of a patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the hospital.

**H. Transportation Requested by Home Health Agency.**—Where a home health agency finds it necessary to have a beneficiary transported by ambulance to a hospital or skilled nursing facility to obtain home health services not otherwise available to the individual, the trip is covered as a Part B service only if the above coverage requirements are met. Such transportation is not covered as a home health service.

**I. Coverage of Ambulance Service Furnished Deceased Beneficiary.**—An individual is considered to have expired as of the time he is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician. Therefore, if the beneficiary was pronounced dead by a legally authorized individual before the ambulance was called, no program payment is made. Where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered. If otherwise covered ambulance services were furnished to a beneficiary who was pronounced dead while enroute to or upon arrival at the destination, the entire ambulance services are covered.

**J. Ambulance Transportation to Renal Dialysis Facility Located on Premises of Hospital.**—A renal dialysis facility may be approved to participate in the end-stage renal disease program as a part of a hospital or as a nonprovider. Where the facility has been approved as a part of a hospital, it meets the destination requirements of an institution. Even where the facility has been approved as a nonprovider, it may be determined to meet the destination requirements for purposes of ambulance service coverage under the following circumstances:

- o The facility is located on or adjacent to the premises of a hospital;
- o The facility furnishes services to patients of the hospital, e.g., on an outpatient or emergency basis, even though the facility is primarily in operation to furnish dialysis services to its own patients; and
- o There is an ongoing professional relationship between the two facilities. For example, the hospital and the facility have an agreement that provides for physician staff of the facility to abide by the bylaws and regulations of the hospital's medical staff.

Do not reopen or change a prior determination that the facility is a nonprovider for approval purposes, even though it is found to be sufficiently related to the hospital, to meet the destination requirement for ambulance service coverage, unless there has been a significant change in the relationship between the hospital and the facility since the facility's certification.

A beneficiary receiving maintenance dialysis on an outpatient basis is not ordinarily ill enough to require ambulance transportation for dialysis treatment. This is so whether the facility is an independent enterprise or part of a hospital. Thus, if a claim for ambulance services furnished to a maintenance dialysis patient does not show that the patient's condition requires ambulance services, disallow it. However, if the documentation submitted with the claim shows that ambulance services is required, determine whether the facility meets the destination requirements under the ambulance service benefit described.

**2120.4 Air Ambulance Services.**—Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support land ambulance is not appropriate.

**A. Coverage Requirements.**—Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if—

- o The vehicle and crew requirements described in §2120.1 are met;
- o The beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by land ambulance; and either
  - The point of pick-up is inaccessible by land vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States), or
  - Great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities as described in subsection D.

**B. Medical Appropriateness.**—Medical appropriateness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by land, or the instability of transportation by land, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. Following is an advisory list of examples of cases for which air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

- o Intracranial bleeding - requiring neurosurgical intervention;
- o Cardiogenic shock;
- o Burns requiring treatment in a Burn Center;
- o Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- o Multiple severe injuries; or
- o Life-threatening trauma.

**C. Time Needed for Land Transport.**—Differing Statewide Emergency Medical Services (EMS) systems determine the amount and level of basic and advanced life support land transportation available. However, there are very limited emergency cases where land transportation is available but the time required to transport the patient by land as opposed to air endangers the beneficiary's life or health. As a general guideline, when it would take a land ambulance 30-60 minutes or more to transport an emergency patient, consider air transportation appropriate.

**D. Appropriate Facility.**—It is required that the beneficiary be transported to the nearest hospital with appropriate facilities for treatment. The term "appropriate facilities" refers to units or components of a hospital that are capable of providing the required level and type of care for the patient's illness and that have available the type of physician or physician specialist needed to treat the beneficiary's condition. In determining whether a particular hospital has appropriate facilities, take into account whether there are beds or a specialized treatment unit immediately available and whether the necessary physicians and other relevant medical personnel are available in the hospital at the time the patient is being transported. The fact that a more distant hospital is better equipped does not in and of itself warrant a finding that a closer hospital does not have appropriate facilities. Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital.

E. Hospital to Hospital Transport.—Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria are met, that is, transportation by ground ambulance would endanger the beneficiary's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such services include burn units, cardiac care units, and trauma units. A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or his or her family prefers a specific hospital or physician.

F. Special Coverage Rule.—Air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician's office or a beneficiary's home.

G. Special Payment Limitations.—If a determination is made that transport by ambulance was necessary, but land ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for land transport, if less costly.

If the air transport was medically appropriate (that is, land transportation was contraindicated and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which he or she was transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

H. Documentation.—Obtain adequate documentation of the determination of medical appropriateness for the air ambulance service. All claims for air ambulance services are to be reviewed by your medical staff.

**2125. COVERAGE GUIDELINES FOR AMBULANCE SERVICE CLAIMS**

Reimbursement may be made for expenses incurred by a patient for ambulance service provided conditions 1, 2, and 3 in the left-hand column have been met. The right-hand column indicates the documentation needed to establish that the condition has been met.

<u>Conditions</u>	<u>Review Action</u>
1. Patient was transported by an approved supplier of ambulance service.	1. Ambulance supplier is listed in the carrier's table of approved ambulance companies. (§ 2120.1C)
2. The patient was suffering from an illness or injury which contraindicated transportation by other means. (§ 2120.2A)	2. (a) Presume the requirement was met if file shows the patient: <ul style="list-style-type: none"> <li>(i) Was transported in an emergency situation, e.g., as a result of an accident, injury, or acute illness, or</li> <li>(ii) Needed to be restrained, or</li> <li>(iii) Was unconscious or in shock, or</li> <li>(iv) Required oxygen or other emergency treatment on the way to his destination, or</li> <li>(v) Had to remain immobile because of a fracture that had not been set or the possibility of a fracture, or</li> <li>(vi) Sustained an acute stroke or myocardial infarction, or</li> <li>(vii) Was experiencing severe hemorrhage, or</li> <li>(viii) Was bed confined before and after the ambulance trip, or</li> <li>(ix) Could be moved only by stretcher.</li> </ul>

- (b) In the absence of any of the conditions listed in (a) above additional documentation should be obtained to establish medical need where the evidence indicates the existence of the circumstances listed below:
- (i) Patient's condition would not ordinarily require movement by stretcher, or
  - (ii) The individual was not admitted as a hospital inpatient (except in accident cases), or
  - (iii) The ambulance was used solely because other means of transportation were unavailable, or
  - (iv) The individual merely needed assistance in getting from his room or home to a vehicle.

- (c) Where the information indicates a situation not listed in 2(a) or 2(b) above, refer the case to your supervisor.
3. The patient was transported from and to points listed below. (§ 2120.3)
- (a) From patient's residence (or other place where need arose) to hospital or skilled nursing home.
3. Claims should show points of pickup and destination.
- (a) (i) Condition met if trip began within the institution's service area as shown in the carrier's locality guide.
- (ii) Condition met where the trip began outside the institution's service area if the institution was the nearest one with appropriate facilities. Refer to supervisor for determination.
- NOTE:** A patient's residence is the place where he makes his home and dwells permanently, or for an extended period of time. A skilled nursing home is one which is listed in the Directory of Medical Facilities as a participating SNF or as an institution which meets section 1861(j)(1) of the law.
- NOTE:** A claim for ambulance service to a participating hospital or skilled nursing facility should not be denied on the grounds that there is a nearer nonparticipating institution having appropriate facilities.
- (b) Skilled nursing home to a hospital or hospital to a skilled nursing home.
- (b) (i) Condition met if pickup point is within the service area of the destination as shown in the carrier's locality guide.
- (ii) Condition met where the pickup point is outside the service area of the destination if the destination institution was the nearest one with appropriate facilities. Refer to supervisor for determination.



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| (c) Hospital to hospital or skilled nursing home to skilled nursing home.  | (c) Condition met if the discharging institution was not an appropriate facility and the admitting institution was the nearest one with appropriate facilities.  |
| (d) From a hospital or skilled nursing home to patient's residence.  | (d) (i) Condition met if patient's residence is within the institution's service area as shown in the carrier's locality guide.<br><br>(ii) Condition met where the patient's residence is outside the institution's service area if the institution was the nearest one with appropriate facilities. Refer to supervisor for determination. |
| (e) Round trip for hospital or participating skilled nursing facility inpatients to the nearest hospital or nonhospital treatment facility | (e) Condition met if the medically necessary diagnostic or therapeutic service required by the patient's condition is not available at the institution where the beneficiary is an inpatient.  |

NOTE: Ambulance service to a physician's office or a physician-directed clinic is not covered. (See § 2120.3G where a stop is made at a physician's office enroute to a hospital and 2120.3C for additional exceptions.)

4. Ambulance services involving hospital admissions in Canada or Mexico are covered (§§ 2312 ff.) if the following conditions are met:
- (a) The foreign hospitalization has been determined to be covered; and
  - (b) The ambulance service meets the coverage requirements set forth in §§ 2120-2120.3. If the foreign hospitalization has been determined to be covered on the basis of emergency services (§ 2312.2A) the necessity requirement (§ 2120.2) and the destination requirement (§ 2120.3) are considered met.

5. Make partial payment for otherwise covered ambulance service which exceeded limits defined in item 3. (Claims supervisors are to make all partial payment determinations.) Base the payment on the amount payable had the patient been transported: (1) from the pickup point to the nearest appropriate facility, or (2) from the nearest appropriate facility to his/her residence where he/she is being returned home from a distant institution. (See \$5215.2.)

2130.

# APPENDIX B

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## METHODOLOGY

### SAMPLING

We selected a sample of ambulance claims for ESRD beneficiaries as follows:

- Using the Medicare Status Code, we identified all ESRD beneficiaries with 1991 Part B claims in HCFA's Common Working File (CWF).
- Then all 1991 CWF ambulance claims were selected for these beneficiaries based on eight national ambulance codes (base rate codes A0010, A0220, A0223, A0150, and A0222; mileage codes A0020 and A0221, and a miscellaneous code A0999).
- The ambulance claims were then summarized by Part B carrier, and we arrayed the 56 jurisdictions of all 36 carriers by total allowed payments. Two carriers were then excluded: Maryland Blue Shield (because of a number of active investigations) and the Railroad Retirement Board (because of the large geographical area that it covers). The total allowed amounts for all carriers was \$101,175,828. Without Maryland and Railroad the total was \$97,383,189. From the remaining 54 carrier jurisdictions, we identified the top 16, representing 87 percent of the total ESRD ambulance allowances for 1991 or \$85.3 of \$97.3 million.
- We employed a two-stage Rao-Hartly-Cochran sampling technique to randomly select eight carriers from the top 16 and 35 ESRD ambulance claims within each carrier for a total of 280 claims. At the first stage, we used random numbers to group the top 16 carriers into eight groups. This produced eight groups of two carriers from which we selected a carrier with probability proportional to size. Size was measured by the number of claims corresponding to the eight ambulance codes given above. The eight carriers selected for the sample were California Blue Shield, Florida Blue Shield, Kentucky Blue Shield, Massachusetts Blue Shield, Michigan Blue Shield, New York [Empire] Blue Shield, Pennsylvania Blue Shield, and Texas Blue Shield.
- We selected a simple random sample of 35 ESRD ambulance claims for each of 8 sample carriers for a total of 280 claims representing 277 beneficiaries.

Of the 280 sampled claims, 180 transports were dialysis-related, 62 were non-dialysis (e.g., hospital emergency room), and 38 were unknown (the ambulance providers associated with these 38 claims were either out of business or under review by the OIG's Office of Investigations).

## DATA COLLECTION

We collected information about claims in our sample from a number of sources. These included Medicare carriers, ambulance providers, dialysis facilities and physicians.

We conducted structured interviews with each of the sample carriers regarding coverage policy, claims processing, identification of non-covered transports, detection of overpayments, and provider education. We provided carriers with the interview questions in advance. The carriers sent us documents to support their interview responses and copies of the sample claims with any supplementary documentation. An example of supplementary documentation is a physician's statement that the ambulance trip was medically necessary. In the carrier and ambulance industries these statements are called certifications of medical necessity.

The certifications of medical necessity were either ambulance company forms that were completed and signed by a physician or they were letters written by dialysis facility physicians on the facility's letterhead. Most of the certifications in our sample were signed by physicians. A few were signed by nurses, and one was signed by a social worker.

We collected data from the ambulance providers associated with our sample claims. These respondents answered a questionnaire about the claim and provided us with documentation of the transport, including, but not limited to, its origin and destination, whether it was scheduled in advance, and whether it was round trip or one-way. Ambulance company respondents also sent us certifications of medical necessity if they had them. We did on-site interviews with 16 companies in 3 States. We received a questionnaire for each of the 180 dialysis-related claims. A total of 242 questionnaires were returned out of 280 mailed.

For transports that involved dialysis (180), we sent almost identical questionnaires to the dialysis facility's head nurse and the beneficiary's treating physician. These respondents used written medical records and memory to answer questions about the beneficiary's medical condition and ambulatory status on the date of ambulance service. While the response rate for dialysis facilities was 100 percent, it was only 55 percent for physicians. However, in most cases, the physicians we wrote to were associated with the dialysis facility. Even when physicians did not return a questionnaire their progress notes or discharge summaries were sent to us by the dialysis facility nurses as supporting documents for the dialysis facility questionnaire.

## MEDICAL REVIEW

We contracted with Federal Occupational Health (FOH), a division of the Public Health Service for a medical team to review the dialysis-related claims in our sample. The FOH has conducted other medical reviews for various Federal agencies including HCFA. A physician, board certified in Family Medicine, served as team leader,

reviewer, and liaison with the OIG. The three other reviewers were registered nurses with over 22 years combined experience in critical care.

We focused the medical review on dialysis-related claims since these transports account for very high annual ambulance bills and since they represented almost two-thirds (180 out of 280) of our sample. If a transport was round trip, only one leg of the trip was reviewed by the contractor. The leg was chosen according to the assignment of random numbers (1 or 2) to each round trip. Claims involving a medical service other than dialysis, e.g., hospital emergency room, were not part of the medical review.

The medical team used the documents we collected from various respondents to determine whether the claims met Medicare coverage guidelines. Prior to mailing the dialysis facility and physician questionnaires, the medical team's leader helped the OIG design the instruments so that sufficient data would be collected for determining medical necessity. If claims met the Medicare guidelines they were determined medically necessary; if they did not, they were determined medically unnecessary. In cases where claims had conflicting data, no determination was made.

#### *Documents for Medical Review*

We sent the medical team a folder of documents for each of the 180 dialysis-related claims. The folders contained: claim forms, ambulance providers' trip reports, dialysis facility questionnaires and, when available, certifications of medical necessity and physician questionnaires. The documents in the claim folders that made a determination possible most frequently were those provided by dialysis facilities.

A majority of the dialysis facility questionnaires had supporting documents such as progress notes, flow sheets, and discharge summaries. The physicians sent fewer supporting documents with their questionnaires, and usually they were identical to the ones attached to the facility questionnaire.

#### *Determinations of Medical Reviewer*

Our medical reviewers sought evidence that a patient had a medical condition on the date of ambulance service that made travel by other than an ambulance unsafe. According to Medicare guidelines, a diagnosis of ESRD is not sufficient explanation to warrant an ambulance. Documents reviewed by the medical team contained data about the patient's medical history, diagnoses, and ambulatory status. The reviewers evaluated the accumulated data and determined that claims did not meet Medicare guidelines if there was no medical condition that confined the patient to bed and/or made travel by any means other than ambulance unsafe. They also used evidence that the patient could walk or use a wheelchair to determine the patient was not bed-confined.

## ANALYSIS OF NON-MEDICAL DATA

Information not of a medical nature was analyzed by OIG program analysts. This included responses from the ambulance providers and carriers in our sample.

Based on responses from ambulance providers, we determined three things: 1) whether each transport was dialysis-related or involved an origin and destination other than dialysis; 2) whether dialysis-related transports were scheduled or not; and 3) whether beneficiaries who had scheduled transports were also transported by the ambulance provider on a regular basis. We received 173 responses to our question concerning scheduled transports and 173 responses to our question about beneficiaries who were transported regularly. Percentages of scheduled and regular transports were calculated based on the number of responses only.

Based on the carrier interviews and their supporting documents we determined their pre-payment and post-payment systems for identifying inappropriate claims. We determined what systems were used in 1991 and whether new systems had been established since then. We attempted to ascertain the effect of these systems on the number of inappropriate claims identified and the dollar amounts they represented. However, because most of the carriers did not have this information we could not assess which systems were the most effective. Carrier respondents did tell us what methods they *thought* would be effective in preventing inappropriate payments of ambulance transports for ESRD beneficiaries.

We used carrier responses in two other ways. First we were able to determine how claims processors decided a claim was medically necessary and whether information on the claim form is verified. Second, we determined how carriers educate ambulance providers about coverage and filling out claim forms.

## ESTIMATES AND CONFIDENCE INTERVALS

The statistics presented in the report represent our best estimates and were weighted based on the Rao-Hartly-Cochran method. We also computed 95 percent confidence intervals for each of the estimates.

Table 1.

### PERCENTAGE OF DIALYSIS-RELATED CLAIMS THAT WERE SCHEDULED

Percentage	95% Confidence Interval
98.6	96.5-99.9

Table 2.

**PERCENTAGE OF DIALYSIS-RELATED TRANSPORTS  
THAT WERE REGULAR (3 X PER WEEK)**

Percentage	95% Confidence Interval
96.8	94.4-99.1

Table 3.

**DISTRIBUTION AND ALLOWED AMOUNTS OF CLAIMS  
BY TYPE OF TRANSPORT  
FOR ALL 280 SAMPLED CLAIMS**

	Estimated Percent	95% Conf. Interval for percents	Estimated Allowed Amount*	95% Conf. Interval for amounts
<b>Dialysis Transports</b>	67.1		61.5	
Met Guidelines	19.3	10.8-27.8	16.2	6.2-26.2
Did not meet guidelines	46.9	33.6-60.1	44.4	32.6-56.1
Could not determine (conflicting data)	.9	0-2.2	.9	0-2.5
<b>Non-Dialysis Transports</b>	18.0	10.8-25.2	13.6	5.3-22.0
<b>Unknown**</b>	14.9	6.7-23.1	10.2	3.5-16.9
<b>Totals</b>	<b>100.0</b>		<b>85.3</b>	

\* Dollar amounts in millions

\*\* Data inaccessible for these claims

Table 4.

**DISTRIBUTION OF CLAIMS  
BY DETERMINATION OF MEDICAL NECESSITY  
FOR DIALYSIS-RELATED TRANSPORTS**

	Sample Size	Estimated percent	95% Confidence Interval for Percent
<b>Dialysis Transports</b>	180		
Met guidelines	56	28.8	16.0-41.6
Did not meet guidelines	122	69.9	56.0-83.8
Could not determine	2	1.3	0-3.2

Table 5.

**DISTRIBUTION OF DIALYSIS-RELATED CLAIMS  
THAT DID NOT MEET MEDICARE GUIDELINES  
BY CARRIER**

Carrier	Sample Dialysis- Related Claims	Sample Claims Not Meeting Guidelines	Percent of Claims Not Meeting Guidelines	95% Confidence Interval for percent
A	26	6	23.1	11.5-34.7
B	25	12	48.0	33.9-62.1
C	8	4	50.0	25.2-74.8
D	20	14	70.0	55.6-84.4
E	16	13	81.3	67.6-94.0
F	32	26	81.3	71.6-91.0
G	20	17	85.0	73.8-96.2
H	33	30	90.9	83.9-97.9

Table 6.

**PERCENTAGE OF BENEFICIARIES  
THAT WERE NOT BED-CONFINED  
(OUT OF CLAIMS THAT WERE NOT MEDICALLY NECESSARY)**

	Percentage	95% Confidence Interval
Ambulatory	28.23	16.23-40.23
In wheelchairs	35.31	27.55-43.07
<b>Total</b>	<b>63.54</b>	<b>52.92-74.16</b>



# APPENDIX C

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COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION



**Memorandum**

JUL 28 1994

Date

From

Bruce C. Vladeck  
Administrator

Subject

Office of Inspector General (OIG) Draft Report: "Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity," (OEI-03-90-02130)

To

June Gibbs Brown  
Inspector General

We reviewed the subject draft report which looked at 1991 dialysis-related ambulance claims to determine if Medicare's Part B coverage criteria for medical necessity were met.

The Health Care Financing Administration (HCFA) concurs with the OIG recommendation to ensure that claims meet Medicare coverage guidelines. Attached are the actions HCFA has taken in this regard.

Thank you for the opportunity to review and comment on this report. Please advise us if you would like to discuss our position on the report's recommendation at your earliest convenience.

Attachment

**Comments of the Health Care Financing Administration (HCFA)**  
**on Office of Inspector General (OIG) Draft Report:**  
**"Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries:**  
**Medical Necessity," (OEI-03-90-02130)**

**OIG Recommendation**

OIG recommends that HCFA ensure that claims meet Medicare coverage guidelines.

**HCFA Response**

HCFA concurs and has taken the following actions:

- o Carrier Medical Directors attend and participate in regional and national conferences where they have the opportunity to solicit input from their colleagues on policies such as dialysis-related ambulance transports, as well as systems techniques for identifying and reviewing those claims.

HCFA is developing a local medical review policy retrieval system which will provide carriers with access to each other's policies. They can use this system to gather information to change or improve their own policies.

- o Currently, there are a number of ambulance messages placed on the Explanation of Medicare Benefits form when a beneficiary receives ambulance services. These messages are used to communicate ambulance coverage to beneficiaries. One such message reads: "Medicare does not pay for this (service) because you could have traveled another way."

Additional steps, however, may be needed to communicate the coverage limitations for ambulance services to beneficiaries. HCFA will suggest that carriers add coverage limitations for ambulance services to beneficiaries as part of an outreach topic for the customer service plans they are developing for Fiscal Year 1995.

- o HCFA will request that the carriers include in an upcoming newsletter a reminder to ambulance companies of Medicare's limited coverage of ambulance service and the consequences of submitting bills for transports that are not medically necessary.
- o Many freestanding facilities have some type of direct relationship to a hospital; and those physicians may already be aware of the Medicare

regulations because of that relationship. However, in some cases such a relationship does not exist and we will request that the carriers include the information on limits of Medicare coverage for end-stage renal disease (ESRD) in an upcoming newsletter.

- o HCFA carries out periodic medical necessity reviews of ESRD-related ambulance claims. Using available funding, carriers review claims data and determine if, and when, it may be necessary to conduct intensified medical necessity reviews for ESRD ambulance claims.

Since 1991, many of the carriers have put screens in place or more closely reviewed ESRD ambulance claims to eliminate wrongful Medicare payments. The medical reviews performed by carriers focus on provider-specific problems. If carrier data indicate a given provider submits a significant percentage of incorrect ESRD ambulance claims, the carrier may address the problem through what is called "comprehensive medical," in which 100 percent of the provider's ESRD ambulance claims are reviewed for a certain period of time. In addition, if carrier data indicate an unusually high dollar volume of ESRD ambulance claims are being submitted in its service area, it may develop a screen to conduct a 100 percent review of all ESRD ambulance claims for as long as is necessary to identify and rectify any aberrancies.

- o HCFA will add an explanation of the limited ambulance transportation benefit in The Guide to Health Insurance for People With Medicare.
- o HCFA's Office of Research and Demonstrations is undertaking a study that will (a) identify the detailed characteristics of ESRD ambulance users, and (b) assess the reasons for, and alternatives to, ambulance transport to dialysis.

In addition, we are in the process of developing regulations to address several issues raised by OIG concerning coverage of ambulance services.