

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAID TWICE FOR
AMBULANCE SERVICES SUBJECT TO
SKILLED NURSING FACILITY
CONSOLIDATED BILLING
REQUIREMENTS**

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**February 2019
A-01-17-00506**

Office of Inspector General

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Report in Brief

Date: February 2019

Report No. A-01-17-00506

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Prior OIG reviews identified significant Medicare Part B overpayments, including those to ambulance suppliers, for services they provided to Medicare beneficiaries during skilled nursing facility (SNF) stays covered under Medicare Part A. The Centers for Medicare & Medicaid Services (CMS) generally concurred with recommendations in these reports and implemented them. However, our analysis of recent claim data indicated that overpayments for ambulance transportation might still be occurring.

Our objective was to determine whether Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of consolidated billing requirements.

How OIG Did This Review

We selected a stratified random sample of 100 beneficiary days. Each beneficiary day contained all ambulance claim line items for a given beneficiary having the same date of service. These line items were paid nationwide by Medicare Part B with dates of service from July 1, 2014, to June 30, 2016, for services provided to beneficiaries in Part A SNF stays.

Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements

What OIG Found

Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of consolidated billing requirements. For 78 of the 100 beneficiary days we sampled, Medicare made Part B payments that were incorrect. Medicare overpaid the ambulance suppliers because the Common Working File (CWF) edits were not designed to prevent or detect Part B overpayments for all transportation subject to consolidated billing. In addition, ambulance suppliers did not have the necessary controls to prevent incorrect billing to Medicare Part B.

On the basis of our sample results, we estimated that Medicare made a total of \$19.9 million in Part B overpayments to ambulance suppliers for transportation services for beneficiaries in Part A SNF stays. In addition, we estimated that beneficiaries incurred an estimated \$5.2 million in coinsurance and deductible liabilities related to these incorrect payments.

What OIG Recommends and CMS Comments

We recommend that CMS redesign the CWF edits to prevent Part B overpayments to ambulance suppliers for transportation services provided to beneficiaries in Part A SNF stays. We also recommend that CMS direct the Medicare contractors to recover the incorrectly billed claims related to 78 sampled beneficiary days; notify the ambulance suppliers responsible for potential overpayments estimated at \$19.9 million; and educate ambulance suppliers on Medicare Part B billing requirements, among other recommendations.

CMS concurred with our recommendations and described the actions that it has taken or planned to take to address them.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews identified significant Medicare Part B overpayments, including those to ambulance suppliers, for services they provided to Medicare beneficiaries during skilled nursing facility (SNF) stays covered under Medicare Part A. In those reviews, we recommended that the Centers for Medicare & Medicaid Services (CMS) recover overpayments, ensure that edits to prevent such overpayments were in place and working properly, and educate suppliers on the proper billing of ambulance services provided to beneficiaries in Part A SNF stays. CMS generally concurred with our recommendations and implemented them. (Appendix B contains a list of our related reports.) However, our analysis of recent claim data indicated that overpayments for ambulance transportation might still be occurring.

OBJECTIVE

Our objective was to determine whether Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of consolidated billing requirements.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. Medicare beneficiaries are responsible for out-of-pocket costs, such as deductibles and coinsurance, for both Medicare Part A and Part B services.¹

CMS administers the Medicare program. CMS contracts with Medicare administrative contractors (Medicare contractors) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A and B claims submitted by SNFs, hospitals, ambulance suppliers, and other outside suppliers.

¹ The deductible that beneficiaries pay for Part B coverage can change yearly. Once the deductible is met, beneficiaries generally pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare in excess of the deductible. If the beneficiary also has secondary coverage under a non-Medicare health plan, the secondary payer may pay the Medicare deductible or coinsurance.

Medicare Prospective Payment System for Skilled Nursing Facilities and Consolidated Billing Regulations

SNFs provide post-hospital extended-care services and are paid through the Medicare prospective payment system (PPS) for SNFs. Under the PPS, Medicare Part A pays SNFs through per diem, prospective, case-mix-adjusted payment rates that cover virtually all of the costs of furnishing services to beneficiaries. Medicare Part A prospective payments to SNFs include payment for most of the services that outside suppliers provide to SNF residents (the Social Security Act (the Act) § 1888(e)).

Under the consolidated billing regulations, SNFs are responsible for billing Medicare for most of the services provided to beneficiaries in SNF stays covered under Part A, including services that outside suppliers provide under arrangement (the Act §§ 1862(a)(18) and 1842(b)(6)(E)). The outside suppliers must then bill the SNFs for these services.

Medicare Part A helps pay for up to 100 days of inpatient care in a SNF during a benefit period. After beneficiaries have exhausted their allowed days of inpatient SNF coverage under Part A, they remain eligible for Medicare Part B benefits.

Ambulance Transportation Provided During a Skilled Nursing Facility Stay Covered Under Medicare Part A

Federal regulations state that, with certain exceptions, the SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay (42 CFR § 409.27(c)). Accordingly, when an ambulance supplier erroneously bills Medicare Part B for ambulance services included in the SNF's Part A consolidated billing payment, Medicare pays for the same service twice—once to the SNF and again to the ambulance supplier.

The SNF consolidated billing requirement applies only to those services that are provided to a SNF resident during a covered Part A stay. Accordingly, ambulance transportation that begins or ends beneficiaries' SNF resident status, or that is to receive services that suspend or end their SNF resident status, is excluded from consolidated billing. Federal regulations further define the exceptions to the consolidated billing requirement, which include certain outpatient hospital services. Ambulance transportation to receive dialysis services is statutorily excluded from consolidated billing. Appendix C contains the details of the Medicare requirements.

We believe that this audit report constitutes credible information of potential overpayments. Suppliers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment

amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).²

Payment Edits in the Medicare Claim-Processing System

Before payment, all Medicare contractor claims are sent to CMS's Common Working File (CWF) for verification, validation, and payment authorization. The CWF contains system edits that should prevent or detect overpayments for outside services provided during Part A covered SNF stays, including outpatient claims and the associated ambulance claims. Once the CWF has processed a claim for payment, it electronically transmits information to the contractor about potential errors on the claim.

The edits for ambulance transportation are limited to detecting suppliers' claims for transporting SNF residents to or from a diagnostic or therapeutic site other than a hospital or physician office and claims for transporting SNF residents to or from another skilled nursing facility.³ As a result of our prior review,⁴ CMS issued CMS Transmittal 595, dated November 6, 2009, and related Medicare Learning Network MLN Matters Article Number MM6700, which describe Medicare system checks to ensure that ambulance services that are subject to SNF consolidated billing rules (but that are billed separately as a Part B service) are denied when the date of service on the ambulance claim overlaps outpatient hospital claims that are rejected for SNF consolidated billing.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$25.3 million in Medicare Part B payments to ambulance suppliers for services provided to beneficiaries in Part A SNF stays. We did not include ambulance line items that matched to certain emergency or intensive outpatient hospital services or to dialysis services. Our sample unit was a beneficiary day. Each beneficiary day contained all ambulance claim line items for a given beneficiary on a particular date of service. These ambulance claim line items were paid by Medicare Part B and had dates of service from July 1, 2014, to June 30, 2016 (audit period).⁵ We selected a stratified random sample of 100 beneficiary days from the 58,006 beneficiary days in our sampling frame.

² The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

³ These edits are dependent on the ambulance supplier billing the correct origin and destination modifiers as well as the presence of a denied outpatient hospital claim on file. None of the ambulance claim line items in our sample were associated with a denied outpatient hospital claim. As such, we believe the outpatient hospital edit may not be functioning as intended. We have brought this to the attention of CMS officials.

⁴ *Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006* (A-01-08-00505), issued August 25, 2009. This report is available at <https://oig.hhs.gov>.

⁵ This was the most recent claim data available at the time the audit started.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology. Appendix D contains our statistical sampling methodology. Appendix E contains our sample results and estimates.

FINDINGS

Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of consolidated billing requirements. For 22 of the 100 beneficiary days in our stratified random sample, Medicare made Part B payments to ambulance suppliers that were correct because the transportations (1) ended the beneficiaries' SNF resident status, (2) were for services that suspended their SNF resident status, or (3) were related to dialysis.⁶ However, for the remaining 78 beneficiary days we sampled, Medicare made Part B payments that were incorrect because the ambulance suppliers transported beneficiaries to receive services that did not suspend or end their SNF resident status and were not related to dialysis. As a result, Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs, which resulted in total overpayments of \$41,456.

On the basis of our sample results, we estimated that Medicare made a total of \$19.9 million in Part B overpayments to ambulance suppliers for transportation services for beneficiaries in Part A SNF stays. In addition, we estimated that beneficiaries incurred an estimated \$5.2 million in coinsurance and deductible liabilities related to these incorrect payments.

Medicare overpaid the ambulance suppliers because the CWF edits were not designed to prevent or detect Part B overpayments for all transportation subject to consolidated billing. In addition, ambulance suppliers did not obtain confirmation of the beneficiary's Part A SNF resident status from the SNFs before billing Medicare. Further, ambulance suppliers did not fully understand that some third-party services did not suspend beneficiaries' SNF resident status and were, therefore, subject to consolidated billing.

FEDERAL REQUIREMENTS

SNFs are responsible for billing Medicare for most of the services, including ambulance transportation services, provided to SNF residents during covered Part A stays. The outside

⁶ During our data validation, we found instances where the service the beneficiary received, such as dialysis, would not be identified in the Medicare data owing to factors outside of our control. Our match identified 22 instances of these situations.

suppliers may not separately bill Medicare Part B but must obtain payment from the SNFs (the Act §§ 1862(a)(18) and 1842(b)(6)(E)).

The SNF consolidated billing provision applies only to services provided to SNF residents during covered Part A stays. As a result, ambulance services that begin or end a beneficiary's SNF stay are excluded from consolidated billing (42 CFR § 411.15(p)(2)(x)). Federal regulations also state that receiving certain emergency or intensive outpatient hospital services that are beyond a SNF's scope of care suspends a beneficiary's status as a SNF resident (42 CFR § 411.15(p)(3)(iii)). Accordingly, because the beneficiary receiving those specific emergency or intensive outpatient hospital services is temporarily not a SNF resident, ambulance transportation associated with those services is excluded from consolidated billing and may be billed to Medicare Part B (64 Fed. Reg. 41644, 41673 (July 30, 1999) and the *Medicare Claims Processing Manual*, chapter 6, § 20.1.2).

Ambulance transportation provided in connection with dialysis services is statutorily excluded from consolidated billing (the Act § 1888(e)(2)(A)(iii)(I)).

MEDICARE MADE INCORRECT PART B PAYMENTS TO AMBULANCE SUPPLIERS FOR SERVICES INCLUDED IN MEDICARE PART A PAYMENTS TO SKILLED NURSING FACILITIES

Medicare made incorrect Part B payments to ambulance suppliers for 78 of the 100 beneficiary days we sampled. The incorrect payments were for transportation services that did not suspend or end the beneficiaries' SNF resident status and were not related to dialysis. These services were also included in Medicare Part A payments to SNFs. The services were for transporting beneficiaries, mostly to outpatient hospitals, to receive services that included x-rays, blood testing, and evaluations. The incorrect billing resulted in (1) overpayments to ambulance suppliers totaling \$41,456 and (2) \$10,723 in deductible and coinsurance amounts that may have been incorrectly collected from beneficiaries or from another payer on their behalf.

CAUSES OF OVERPAYMENTS

Inadequate Medicare Payment Controls

Medicare overpaid the ambulance suppliers because the CWF edits were not designed to prevent or detect Part B overpayments for all transportation subject to consolidated billing. Specifically, the CWF did not have edits that were based on applicable Healthcare Common Procedure Coding System (HCPCS) codes.⁷ While CMS Transmittal 595 describes additional Medicare system checks, the edits that CMS implemented were not effective in identifying incorrectly billed ambulance services and were not based on the list of outpatient services (i.e., HCPC codes) that suspend or end beneficiaries' SNF resident status. The edits for ambulance

⁷ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

transportation are limited to detecting suppliers' claims for transporting SNF residents to or from a diagnostic or therapeutic site other than a hospital or physician office. Therefore, the edits cannot detect claims for transporting SNF residents to outpatient hospitals or physician offices to receive nonemergency services that do not suspend or end their SNF resident status and are not related to dialysis services.

Inadequate Controls at Ambulance Suppliers

Ambulance suppliers did not have the necessary controls to prevent the incorrectly billed claims that we identified. Specifically, suppliers did not obtain confirmation of the beneficiary's Part A SNF resident status from the SNFs before billing Medicare. In addition, ambulance suppliers did not fully understand that some third-party services, such as ultrasounds, x-rays, and minor surgical procedures, did not suspend beneficiaries' SNF resident status and were subject to consolidated billing. In some instances, suppliers incorrectly believed that the transportation was for services that were excluded from consolidated billing (e.g., radiation therapy). However, in these instances, the services that the beneficiaries actually received at the outpatient facility (e.g., treatment planning/simulation) were different from those originally communicated to the ambulance supplier and were subject to consolidated billing. These suppliers did not contact the third-party providers or the SNFs to confirm that the services performed were the same as those originally planned.

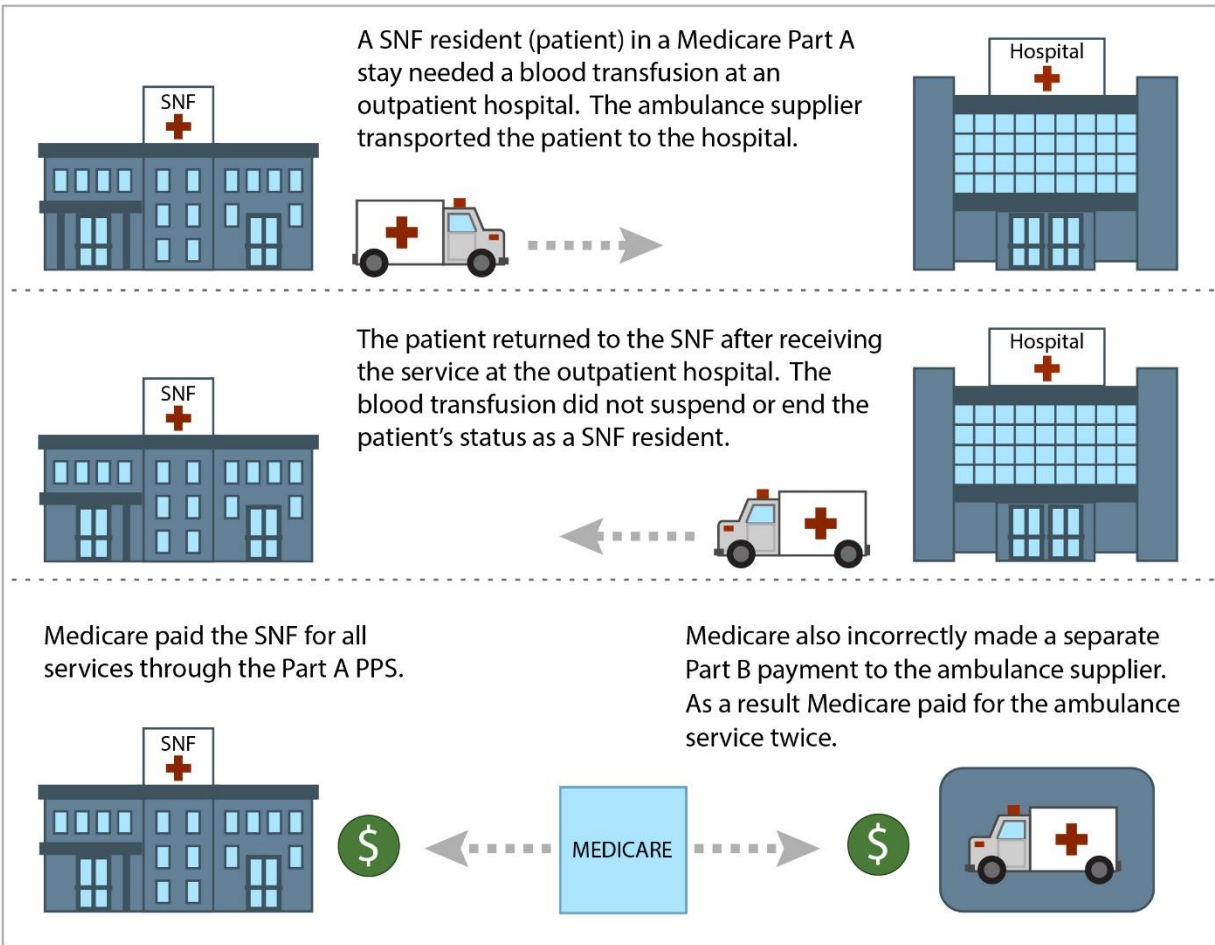
Example: Medicare Made Incorrect Part B Payments to an Ambulance Supplier

The figure on the next page illustrates a situation in which a Medicare beneficiary was a SNF resident in a Part A covered stay and needed a blood transfusion service that was not available at the SNF but could be performed on an outpatient basis at a hospital. The ambulance supplier transported the patient to the hospital. (The patient was not officially discharged from the SNF.) Once the blood transfusion had been performed, the patient returned to the SNF to continue receiving care.⁸

Medicare paid the SNF for all services, including the blood transfusion and the associated ambulance transportation, provided to the patient as part of its PPS rate. However, Medicare incorrectly made a separate Part B payment to the ambulance supplier for the transportation to the hospital. Because the blood transfusion was a nonemergency service that did not end or suspend the patient's status as a SNF resident, the transportation was subject to consolidated billing. The CWF payment edits did not identify the outpatient service (blood transfusion) as subject to consolidated billing. Consequently, the Medicare contractor also allowed payment for the ambulance service. As a result, Medicare paid for the ambulance service twice.

⁸ Although this example is for a one-way trip, if the ambulance supplier provided the return transportation to the SNF, the supplier should have billed the SNF rather than Medicare as well.

Figure: An Ambulance Supplier Transports a Medicare Patient To Receive an Outpatient Service at a Hospital While the Patient Is a SNF Resident in a Part A Stay



OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that Medicare made a total of \$19.9 million in Part B overpayments to ambulance suppliers for transportation services for beneficiaries in Part A SNF stays. In addition, we estimated that beneficiaries incurred an estimated \$5.2 million in deductible and coinsurance amounts related to these incorrect payments to ambulance suppliers.

RECOMMENDATIONS

We recommend that CMS redesign the CWF edits to prevent Part B overpayments to ambulance suppliers for transportation services provided to beneficiaries in Part A SNF stays.

We also recommend that CMS direct the Medicare contractors to:

- recover the portion of the incorrectly billed claims related to 78 sampled beneficiary days with payments totaling \$41,456 in potential overpayments that are within the 4-year reopening period;⁹
- notify the ambulance suppliers responsible for the remaining portion of the \$41,456 in potential overpayments that are outside of the 4-year reopening period, so that those suppliers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule; and identify and track any returned overpayments as having been made in accordance with this recommendation;
- notify the ambulance suppliers responsible for the remaining 57,906 nonsampled beneficiary days, with potential overpayments estimated at \$19.9 million, so that those suppliers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule;¹⁰ and identify and track any returned overpayments as having been made in accordance with this recommendation;
- identify ambulance suppliers that engage in a pattern of incorrect billing and refer them to OIG for possible additional enforcement action;¹¹
- provide guidance to ambulance suppliers on strengthening billing controls to ensure compliance with consolidated billing requirements, including obtaining confirmation of the beneficiary's Part A SNF resident status from the SNFs before billing Medicare; and
- educate ambulance suppliers not to bill Medicare Part B for services they provide to beneficiaries in a covered Part A SNF stay unless the transportation was to receive services that either suspended or ended the beneficiary's SNF resident status or were related to dialysis.

⁹ 42 CFR § 405.980(b)(2) (permitting a contractor to reopen an initial determination within 4 years for good cause).

¹⁰ 42 CFR §405.980(c)(4) (permitting a party to request that a contractor reopen for the purposes of reporting and returning an overpayment in accordance with the 60-day rule).

¹¹ Of the 2,071 ambulance suppliers related to beneficiaries in our sampling frame, 48 submitted claims with total payments greater than \$100,000. Payments to these providers totaled \$8.8 million, or approximately 35 percent of the sampling frame. We will provide a separate listing of these ambulance suppliers to CMS along with associated payment amounts.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and stated that it will instruct its contractors to recover the identified overpayments that are within the 4-year reopening period consistent with its policies and procedures. CMS also stated that it will analyze our data to identify appropriate suppliers to notify of potential overpayments. It will then instruct its contractors to (1) notify the identified suppliers of our audit and the potential overpayments and (2) track any returned overpayments as having been made in accordance with our recommendations. CMS further stated it will analyze the referral of ambulance suppliers identified by our audit and take action within the scope of its existing authorities.

With respect to our recommendation to redesign the CWF edits, CMS stated that it is working to update the claim processing system to detect these overpayments. CMS also stated it will continue to educate suppliers on the billing requirements.

CMS also provided technical comments on our draft report, which we addressed as appropriate. In its technical comments, CMS stated that it issued CMS Transmittal 2176, dated November 2, 2018, and related MLN Matters Article Number 10955, which describe planned revisions to the CWF edits to ensure accurate payment of ambulance services provided during Part A covered SNF stays. The implementation date is April 1, 2019. CMS's comments, excluding the technical comments, are included as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate the efforts CMS has taken or plans to take to address our recommendations. We believe the revisions outlined in CMS Transmittal 2176 will potentially strengthen the CWF edits and help prevent these overpayments. According to the transmittal, CMS will modify the edit to allow payment of the ambulance claim only if it matches to an outpatient claim that contains HCPCS codes for services that are excluded from the consolidated billing requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$25.3 million in Medicare Part B payments to ambulance suppliers for services provided to beneficiaries in Part A SNF stays. We did not include ambulance line items that matched to certain emergency or intensive outpatient hospital services or to dialysis services. Our sample unit was a beneficiary day. Each beneficiary day contained all ambulance claim line items for a given beneficiary having the same date of service. These ambulance claim line items were paid nationwide by Medicare Part B with dates of service from July 1, 2014, to June 30, 2016.¹²

To identify these services, we extracted ambulance, SNF, and outpatient claims from the CMS National Claims History file. We first identified Part A SNF claims, sorted them by beneficiary and admission date, and grouped the sorted claims together to identify SNF stays.

We used the beneficiary information and service dates from the SNF stays to identify Part B ambulance services that had service dates between, but not including, the admission and discharge dates on the SNF stays.¹³ We did not include ambulance line items with dates of service that matched (i.e., billed the day before, the day after, or the same day) to outpatient services that ended a beneficiary's status as a SNF resident (e.g., certain emergency or intensive outpatient hospital services) or were related to dialysis. We also did not include ambulance claims that had a date of service that matched an inpatient claim where the beneficiary was admitted through the emergency room.¹⁴

Our objective did not require an understanding or assessment of the complete internal control structure at CMS or the ambulance suppliers. Therefore, we limited our review of internal controls at CMS to the payment controls in place to prevent and detect Part B overpayments to ambulance suppliers for transportation already included in the Medicare Part A payments to SNFs. We limited our review of internal controls at the ambulance suppliers to obtaining an understanding of controls related to developing and submitting Medicare claims for transportation provided to beneficiaries during Part A SNF stays.

We conducted our audit work from April 2017 through May 2018.

¹² This was the most recent claim data available at the time the audit started.

¹³ We excluded ambulance claim line items that occurred during the noncovered portion of the SNF stay or that occurred after the SNF benefits were exhausted (i.e., after 100 days at the SNF).

¹⁴ We matched the ambulance claim's date of service to the inpatient claim's "From" date of service and to the day after the inpatient claims' "From" date of service.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS’s National Claims History file to identify ambulance claim line items that were paid nationwide by Medicare Part B for services provided to beneficiaries in Part A SNF stays and that did not match to certain emergency or intensive outpatient hospital services or to dialysis services;
- identified four strata from which we selected our sample items (see Appendix D for the details of the beneficiary days contained in each strata);
- selected a stratified random sample of 100 beneficiary days, 25 from each stratum (Appendix D);
- reviewed available claim histories from CMS’s CWF for the 172 ambulance claims associated with the sampled beneficiary days, and the corresponding SNF and outpatient claims, to determine whether the claims had been canceled or adjusted;
- contacted representatives from 79 of the 87 ambulance suppliers that submitted the 172 claims to validate payments and to determine the underlying causes of noncompliance with Medicare requirements;¹⁵
- contacted the SNFs associated with the ambulance claims to verify admission and discharge dates and to determine the reason for the ambulance transportation;
- contacted third-party providers (e.g., outpatient hospitals and dialysis facilities) associated with the ambulance claims to determine what services the beneficiaries received;
- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF edits work and to determine why Medicare made incorrect payments for ambulance transportation provided during Part A SNF stays;
- used our sample results to estimate (1) the overpayments that Medicare contractors made to ambulance suppliers nationwide for our audit period and (2) the total deductible and coinsurance amounts that may have been incorrectly collected from beneficiaries or from another payer on their behalf (Appendix E); and

¹⁵ Most of the remaining suppliers were no longer in business.

- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title¹⁶ | Report Number | Issue Date |
|---|----------------------|-------------------|
| <i>Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A in Calendar Years 2006 through 2008</i> | A-01-09-00521 | 12/17/2010 |
| <i>Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006**</i> | A-01-08-00505 | 8/25/2009 |
| <i>Payments for Outpatient Hospital, Laboratory, and Radiology Services Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A</i> | A-01-06-00503 | 1/30/2008 |
| <i>Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A</i> | A-01-05-00511 | 6/26/2007 |
| <i>Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000**</i> | A-01-02-00513 | 5/28/2004 |
| <i>Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities for Time Periods Between the Full Month Periods Covered by Our Prior Report and the Date of Discharge From the Skilled Nursing Facility</i> | A-01-01-00513 | 10/17/2001 |
| <i>Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities</i> | A-01-00-00509 | 7/23/2001 |
| <i>Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System**</i> | A-01-00-00538 | 6/5/2001 |
| <i>Review of Compliance With the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities**</i> | A-01-99-00531 | 3/27/2000 |

¹⁶ With the exception of report number A-01-01-00513, which was issued as an addendum to report number A-01-00-00509, these reports are available at <https://oig.hhs.gov>.

**These reviews included ambulance transportation.

APPENDIX C: MEDICARE REQUIREMENTS FOR THE PAYMENT OF AMBULANCE SERVICES RELATED TO PART A SKILLED NURSING FACILITY STAYS

BENEFIT PERIOD FOR POST-HOSPITAL INPATIENT EXTENDED CARE

The *Medicare Benefit Policy Manual*, chapter 3, section 20, states that Medicare beneficiaries are entitled to have Part A payments made on their behalf for up to 100 days of covered inpatient extended care services (e.g., SNF stays) in a benefit period.

SKILLED NURSING FACILITY CONSOLIDATED BILLING

Pursuant to sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most of the services, including ambulance transportation, provided to a SNF resident during a covered Part A stay.

SKILLED NURSING FACILITY BENEFIT INCLUDES AMBULANCE TRANSPORTATION PROVIDED DURING A COVERED PART A STAY

Federal regulations (42 CFR § 409.27(c)) state that the SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay.

The final rule implementing the SNF consolidated billing requirement (64 Fed. Reg. §§ 41644, 41674 (July 30, 1999)) states that when a “SNF provides or makes arrangements for a resident’s transportation by ambulance during the course of a covered Part A stay, such services are not considered Part B ambulance services under the separate Part B benefit at section 1861(s)(7) of the Act, but Part A extended care services that SNFs generally furnish under section 1861(h)(7) of the Act.” Thus, the Part A SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay. Moreover, pursuant to 42 CFR § 410.40(a)(2), when payment for ambulance transportation is made directly or indirectly under Medicare Part A, the transportation is not covered under Medicare Part B.

LIMITED EXCEPTIONS TO THE SKILLED NURSING FACILITY CONSOLIDATED BILLING REQUIREMENTS

The SNF consolidated billing requirement applies only to services provided to SNF residents during a covered Part A stay. Because a beneficiary is not a SNF resident at the beginning or end of a SNF stay, ambulance services that begin or end a beneficiary’s status as a SNF resident are not subject to consolidated billing (42 CFR § 411.15(p)(2)(x)). Federal regulations at 42 CFR § 411.15(p)(3)(i)-(iv) identify a number of events that end a beneficiary’s status as a SNF resident. In addition, the 2000 update to the final rule implementing the SNF consolidated billing requirement (65 Fed. Reg. §§ 46770, 46791, (July 31, 2000)) states that the beneficiary’s status as a SNF resident is suspended when the beneficiary receives certain outpatient hospital services. The *Medicare Claims Processing Manual* (chapter 6, § 20.1.2) further defines these

excluded outpatient hospital services as emergency services and certain intensive procedures.¹⁷ Because the beneficiary receiving these services is temporarily not a SNF resident, the ambulance transportation associated with these services is excluded from consolidated billing.

¹⁷ Examples of these services and procedures include certain types of cardiac catheterization, computerized axial tomography scans, magnetic resonance imaging, and ambulatory surgery that involves the use of a hospital operating room, radiation therapy services, and lymphatic and venous procedures. A complete list of excluded services can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html>. Accessed on February 28, 2018.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of ambulance (land only) claim line items that were paid by Medicare Part B for services provided from July 1, 2014, to June 30, 2016, to beneficiaries in Part A SNF stays. These line items did not include ambulance services that either ended a beneficiary's status as a SNF resident or that matched to services that ended a beneficiary's status as a SNF resident (e.g., certain emergency or intensive outpatient hospital services). We also excluded line items related to statutorily excluded ambulance transportation to receive dialysis services.

SAMPLING FRAME

We extracted 319,767 ambulance (land only) claim line items from the CMS National Claims History file, with total Medicare Part B payments of \$39,093,786. These line items were paid nationwide by Medicare Part B for services provided to beneficiaries in Part A SNF stays. These line items had dates of service from January 1, 2014, to June 30, 2016, and were potentially subject to SNF consolidated billing. We also extracted the SNF and outpatient claims corresponding to the ambulance line items' dates of service.

To create the sampling frame, we created queries to exclude 104,799 additional ambulance line items. Most of these additional exclusions were for ambulance line items that had either a date of service prior to July 2014 or the same date of service as a line item with a HCPCS code indicating an emergency service. We also excluded some ambulance line items that were not representative of the target population.

We grouped the remaining 214,968 ambulance line items by beneficiary health insurance claim number and date of service. We defined the grouping of line items or frame unit as a beneficiary day. The resulting sampling frame contained 58,006 beneficiary days with dates of service from July 1, 2014, to June 30, 2016, and Medicare Part B payments totaling \$25,312,644.

SAMPLE UNIT

The sample unit was a beneficiary day. All ambulance line items for a given beneficiary having the same date of service were included in the sample unit.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We selected 25 sample units each from strata 1, 2, 3, and 4 for a total of 100 sample units. See the table on the next page for details.

| Stratum | Sample Unit Payment Range¹⁸ | Number of Sample Units in the Frame | Sample Size | Dollar Value of Payments in the Frame |
|----------------|---|--|--------------------|--|
| 1 | >=\$100.35 and <=\$374.06 | 21,035 | 25 | \$6,255,513 |
| 2 | >=\$374.06 and <=\$439.96 | 16,769 | 25 | 6,800,482 |
| 3 | >=\$439.96 and <=\$598.04 | 13,480 | 25 | 6,698,791 |
| 4 | >=\$598.08 and <=\$3113.84 | 6,722 | 25 | 5,557,858 |
| Totals | | 58,006 | 100 | \$25,312,644 |

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software, RAT-STATS 2010.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 21,035 for stratum 1; 1 to 16,769 for stratum 2; 1 to 13,480 for stratum 3, and 1 to 6,722 for stratum 4. After generating 25 random numbers for each stratum, we selected the corresponding frame items for the sample.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare Part B overpayments made to ambulance suppliers for services subject to SNF consolidated billing. We also used the software to estimate the dollar value of beneficiary coinsurance and deductible liabilities. We calculated the precision of each of these estimates using a two-sided 90-percent confidence interval.

¹⁸ The strata cutoffs were applied to line numbers in the frame after it had been sorted by transaction amounts. In the case of the first three strata, the choice of cutoffs resulted in the same dollar value appearing in multiple strata.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

| Sample Results for Overpayments | | | | | | |
|--|-------------------|-----------------------|--------------------|------------------------|------------------------------|------------------------------|
| Stratum | Frame Size | Value of Frame | Sample Size | Value of Sample | Number of Overpayment | Value of Overpayments |
| 1 | 21,035 | \$6,255,513 | 25 | \$7,829 | 16 | \$5,229 |
| 2 | 16,769 | 6,800,482 | 25 | 10,051 | 21 | 8,492 |
| 3 | 13,480 | 6,698,791 | 25 | 12,481 | 18 | 8,822 |
| 4 | 6,722 | 5,557,858 | 25 | 20,369 | 23 | 18,913 |
| Total | 58,006 | \$25,312,644 | 100 | \$50,730 | 78 | \$41,456 |

| Beneficiary Coinsurance and Deductible Liabilities | | | | | | |
|---|-------------------|-----------------------|--------------------|------------------------|------------------------------|------------------------------|
| Stratum | Frame Size | Value of Frame | Sample Size | Value of Sample | Number of Overpayment | Value of Overpayments |
| 1 | 21,035 | \$ 1,658,341 | 25 | \$2,144 | 16 | \$1,481 |
| 2 | 16,769 | 1,743,988 | 25 | 2,564 | 21 | 2,166 |
| 3 | 13,480 | 1,717,576 | 25 | 3,184 | 18 | 2,251 |
| 4 | 6,722 | 1,426,383 | 25 | 5,196 | 23 | 4,825 |
| Total | 58,006 | \$6,546,288 | 100 | \$13,088 | 78 | \$10,723 |

Estimated Overpayments
(Limits Calculated at the 90-Percent Confidence Level)


| | Medicare Payment | Beneficiary Coinsurance and Deductible Liabilities |
|----------------|-----------------------------|---|
| Point estimate | \$19,938,117 | \$5,209,881 |
| Lower limit | 18,064,960 | 4,687,556 |
| Upper limit | 21,811,274 | 5,732,207 |



Administrator
Washington, DC 20201

DATE: NOV 30 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements (A-01-17-00506)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. As part of this strategy, CMS recovers identified improper payments in accordance with agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for ambulance services. CMS educates health care providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS redesign the CWF edits to prevent Part B overpayments to ambulance suppliers for transportation services provided to beneficiaries in Part A SNF stays.

CMS Response

CMS concurs with this recommendation. CMS is working to update the claims processing system to detect these claims. This update is targeted to be operational in the spring of 2019.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to recover the portion of the incorrectly billed claims related to 78 sampled beneficiary days with payments totaling \$41,456 in potential overpayments that are within the 4-year reopening period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to recover the identified overpayments that are within the 4-year reopening period consistent with the agency's policies and procedures.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to notify the ambulance suppliers responsible for the remaining portion of the \$41,456 in potential overpayments that are outside of the 4-year reopening period, so that those suppliers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule and identify and track any returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will analyze OIG's data to identify providers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to notify the ambulance suppliers responsible for the remaining 57,906 nonsampled beneficiary days, with potential overpayments estimated at \$19.9 million, so that those suppliers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule and identify and track any returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate providers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to identify ambulance suppliers that engage in a pattern of incorrect billing and refer them to OIG for possible additional enforcement action.

CMS Response

CMS concurs with this recommendation. CMS has processes to identify ambulance suppliers that engage in a pattern of aberrant billing. Additionally, CMS will analyze the referral of ambulance suppliers identified by the OIG's audit and take action within the scope of our existing authorities. Those next steps may include administrative action, referral for investigation by our program integrity contractors or referral to law enforcement.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to provide guidance to ambulance suppliers on strengthening billing controls to ensure compliance with consolidated billing requirements, including obtaining confirmation of the beneficiary's Part A SNF resident status from the SNF before billing Medicare.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate ambulance suppliers regarding proper billing of ambulance services under skilled nursing facility consolidated billing rules, including the importance of confirming the beneficiary's Part A skilled nursing facility resident status from the skilled nursing facility before billing Medicare.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to educate ambulance suppliers not to bill Medicare Part B for services they provide to beneficiaries in a covered Part A stay unless the transportation was to receive services that either suspended or ended the beneficiary's SNF resident status or were related to dialysis.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate ambulance suppliers regarding proper billing of ambulance services under skilled nursing facility consolidated billing rules, including when to bill Medicare Part B for services provided to beneficiaries in covered Part A stays.