Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE MADE IMPROPER AND POTENTIALLY IMPROPER PAYMENTS FOR EMERGENCY AMBULANCE TRANSPORTS TO DESTINATIONS OTHER THAN HOSPITALS OR SKILLED NURSING FACILITIES

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Office of Inspector General

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Report in Brief
Date: August 2018
Report No. A-09-17-03017

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

Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities

Why OIG Did This Review

A prior OIG review found that inappropriate payments and questionable billing for Medicare Part B ambulance transports pose vulnerabilities to Medicare program integrity. One issue identified was that Medicare improperly paid $2.7 million during the first half of calendar year (CY) 2012 for emergency ambulance transports that providers indicated were to nonhospital destinations. This review focuses on payments to destinations other than hospitals or skilled nursing facilities (SNFs) for CYs 2014 through 2016.

Our objective was to determine whether Medicare payments to providers for emergency ambulance transports complied with Federal requirements.

How OIG Did This Review

Medicare contractors nation-wide paid providers $7.3 billion for emergency ambulance transports with dates of service from CYs 2014 through 2016 (audit period). We identified claim lines, totaling $3.1 million, that were paid by Medicare for emergency ambulance transports to destinations other than hospitals or SNFs. We also identified claim lines, totaling $204,534, that were paid by Medicare for ground mileage associated with emergency ambulance transports to destinations not covered by Medicare. For each claim line, we evaluated compliance with Medicare billing requirements, and we relied on claim information to make our determination.

What OIG Found

Medicare payments to providers for emergency ambulance transports did not comply or potentially did not comply with Federal requirements. Specifically, Medicare made improper and potentially improper payments totaling $1.9 million: (1) improper payments of $975,154 for transports to destinations that were not covered by Medicare for either emergency or nonemergency ambulance transports, including the identified ground mileage associated with the transports, and (2) potentially improper payments of $928,092 for transports that may not have met Medicare coverage requirements or might have been paid by Medicare as nonemergency ambulance transports. During our audit period, the Centers for Medicare & Medicaid Services (CMS) did not require the Medicare contractors to implement nation-wide prepayment edits that would either deny payments or mandate prepayment review for emergency ambulance transports to destinations other than hospitals or SNFs.

What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to (1) recover the portion of the $975,154 in improper payments for emergency ambulance transports to destinations not covered by Medicare that are within the 4-year claim-reopening period and (2) review claim lines that are within that period for emergency ambulance transports that might have been covered by Medicare for nonemergency ambulance transports and recover any improper payments identified, which could represent $928,092. We also made recommendations related to (1) returning any identified improper payments for the remaining portion of the $1.9 million, which is outside of the reopening period, and (2) reviewing claim lines for emergency ambulance transports to destinations not covered by Medicare after our audit period and recovering any improper payments identified. Finally, we made two procedural recommendations.

CMS concurred with our recommendations. However, regarding our draft report's recommendation that CMS make any necessary regulatory changes to implement our second procedural recommendation, CMS stated it did not concur at this time because the regulatory recommendation was dependent on its findings from the Medicare contractors' review of a sample of claim lines conducted in keeping with our second recommendation. We revised our report to remove the recommendation related to making regulatory changes.

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INTRODUCTION

WHY WE DID THIS REVIEW

A prior Office of Inspector General (OIG) review found that inappropriate payments and questionable billing for Medicare Part B ambulance transports pose vulnerabilities to Medicare program integrity.[1] One issue identified was that Medicare improperly paid $2.7 million during the first half of calendar year (CY) 2012 for emergency ambulance transports that providers[2] indicated were to nonhospital destinations. This review focuses on Medicare payments for emergency ambulance transports to destinations other than hospitals or skilled nursing facilities (SNFs) for CYs 2014 through 2016. Another OIG review focused on nonemergency ambulance transports to destinations not covered by Medicare.[3]

OBJECTIVE

Our objective was to determine whether Medicare payments to providers for emergency ambulance transports complied with Federal requirements.

BACKGROUND

Medicare Part B

Medicare Part B provides supplementary medical insurance, including coverage for the cost of ambulance transports for beneficiaries. The Centers for Medicare & Medicaid Services (CMS) administers Part B and contracts with Medicare contractors to, among other things, determine reimbursement amounts and pay claims, conduct audits, and safeguard against fraud and abuse. Each Medicare contractor is responsible for processing claims submitted by providers within 1 of 12 designated regions, or jurisdictions, of the United States and its territories. Appendix B provides a table that shows the Medicare contractor and geographic composition for each jurisdiction.

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

[1] *Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports* (OEI-09-12-00351), issued September 28, 2015.

[2] The term "providers" refers to both independent ambulance suppliers and hospital-based ambulance providers.

[3] *Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare* (A-09-17-03018), issued July 11, 2018.

amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[4]

Medicare Coverage of Ambulance Transports

Medicare covers ambulance services that meet medical necessity and origin and destination requirements (42 CFR § 410.40(a)).[5] Ambulance services, including emergency ambulance transports, are medically necessary only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. For a billed service to be considered medically necessary, the beneficiary's condition must require both the ambulance transportation itself and the level of service provided (42 CFR § 410.40(d)).[6] Even if transportation by ambulance is medically necessary, it must meet all other program coverage criteria in order for payment to be made.[7]

Medicare covers ambulance transports to only the following destinations:

- from any point of origin to the nearest hospital (including a critical access hospital) or nearest SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury;

- from a hospital (including a critical access hospital) or SNF to the beneficiary's home;

- from a SNF to the nearest supplier of medically necessary services that are not available at the SNF where the beneficiary is a resident, including the return trip; or

- from a beneficiary's home to the nearest facility that furnishes renal dialysis (for a beneficiary who is receiving renal dialysis for treatment of end-stage renal disease (ESRD)), including the return trip (42 CFR § 410.40(e)).[8]

Medicare covers ambulance transports to the nearest appropriate facility, as well as the return transport, for a beneficiary to obtain necessary diagnostic or therapeutic services. "Appropriate

[4] Social Security Act (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).

[5] CMS *Medicare Benefit Policy Manual*, Pub. No. 100-02 (Benefit Policy Manual), chapter 10, § 10.2.1.

[6] Medicare covers nonemergency ambulance transportation if the beneficiary is bed-confined or his or her medical condition is such that transportation by ambulance is medically required (42 CFR § 410.40(d)).

[7] Benefit Policy Manual, chapter 10, § 10.2.1.

[8] Even though a physician's office is not a covered destination, Medicare Part B will cover an ambulance transport under special circumstances if it temporarily stops at a physician's office (Benefit Policy Manual, chapter 10, § 10.3). Additionally, a medically necessary ambulance transport for a SNF resident to and from a physician's office is covered under Medicare Part A (42 CFR § 409.27(c)).

facility" means that the institution is generally equipped to provide the needed hospital care or skilled nursing care for an illness or injury.[9] In addition, the transport must be to receive a medically necessary Medicare service or to return from such a service.[10]

Ambulance transports include transports by ground and air (i.e., by airplane and helicopter). Medicare covers different levels of ground ambulance transport. Transport levels vary according to the qualifications of the ambulance crew and the level of medical care provided. The transport levels for emergency and nonemergency ground ambulance transports are (1) basic life support (BLS), comprising transports that require an ambulance crew of at least two people, one of whom must be certified as an emergency medical technician and legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle; and (2) advanced life support (ALS), comprising transports that require an ambulance crew in which, in addition to the requirements for BLS transport, one of the two crew members must be certified at least as a paramedic or an emergency medical technician to perform one or more ALS services.

Provider Submission of Medicare Part B Ambulance Claims and the Use of Healthcare Common Procedure Coding System Codes

Federal law requires that providers submit accurate and complete claims to Medicare for allowable and covered services (the Act § 1833(e)). Each submitted Medicare Part B claim contains detail regarding each provided service (called a claim line in this report). To receive Medicare payment for an ambulance transport, the provider submits a claim and indicates on it the transport level, the origin, the destination, and the total miles for the one-way transport. The provider indicates the transport level using a Healthcare Common Procedure Coding System (HCPCS) code.[11]

Providers bill for emergency or nonemergency ambulance transports and their associated mileage on separate claim lines using the HCPCS codes shown in Table 1 on the following page.

[9] Benefit Policy Manual, chapter 10, §§ 10.3 and 10.3.6. For the purposes of our audit, we did not distinguish between hospitals and SNFs. In so doing, we are neither expressing nor acquiescing to contentions that SNFs are generally equipped to provide the needed care for emergency conditions.

[10] Benefit Policy Manual, chapter 10, § 10.2.1.

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

Table 1: HCPCS Codes for Ambulance Transports[12]

HCPCS Code	Description
A0425	Ground mileage, per statute mile
A0426	Ambulance service, ALS, nonemergency transport, level 1
A0427	Ambulance service, ALS, emergency transport, level 1
A0428	Ambulance service, BLS, nonemergency transport
A0429	Ambulance service, BLS, emergency transport

Providers must indicate the transport's origin and destination by adding a modifier to the end of the HCPCS code billed. Modifiers used for ambulance services are created by combining two "alpha" characters. Each alpha character represents an origin code or a destination code.[13] The first-position alpha code designates the origin, and the second-position alpha code designates the destination, of the ambulance transport.[14] For example, the modifier RH indicates that a provider picked up a beneficiary from his or her residence and transported the beneficiary to a hospital.[15]

Table 2 on the following page shows the origin and destination codes for billing ambulance transports.

[12] CMS *Medicare Claims Processing Manual*, Pub. No. 100-04 (Claims Processing Manual), chapter 15, § 30.B.

[13] The "X" code (used for an intermediate stop at a physician's office on the way to a hospital) is a destination code only.

[14] Claims Processing Manual, chapter 15, § 30.A.

[15] Although combinations of these codes may duplicate other HCPCS code modifiers, when billed with an ambulance transportation HCPCS code, the reported modifier can indicate only origin or destination (Claims Processing Manual, chapter 15, § 30.A).

Table 2: Origin and Destination Codes for Billing Ambulance Transports[16]

Origin or Destination Code	Description
D	Diagnostic or therapeutic site other than P (physician's office) or H (hospital) when these are used as origin codes
E	Residential, domiciliary, or custodial facility (other than a SNF)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g., an airport or a helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	SNF
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

Providers are required to include the ICD-9-CM or ICD-10-CM[17] codes on ambulance claims. Medicare contractors rely on medical record documentation to justify coverage. CMS has published a medical conditions list and instructions to help providers communicate a beneficiary's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service. The list differentiates between emergency conditions (e.g., abnormal cardiac rhythm/cardiac dysrhythmia) and nonemergency conditions (e.g., cardiac/hemodynamic monitoring required en route).[18]

Medicare Payment of Emergency Ambulance Transport Claims

Medicare pays for ALS and BLS ambulance transports at the emergency transport level (HCPCS codes A0427 and A0429)[19] if the services were provided in the context of an emergency response. For ambulance transports, an emergency response means responding immediately at the BLS or ALS level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the provider begins as quickly as possible to take the steps necessary to respond to the call. A call is of an emergency nature when, based

[16] Claims Processing Manual, chapter 15, § 30.A.

[17] *International Classification of Diseases,* Ninth Revision, Clinical Modification; *International Classification of Diseases*, Tenth Revision, Clinical Modification.

[18] Claims Processing Manual, chapter 15, §§ 30.1.2 and 40.

[19] Claims Processing Manual, chapter 15, § 30.B.

on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. If the call came in directly to the provider, the provider's dispatch protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. When the dispatch was inconsistent with this standard protocol, including cases in which no protocol was used, the beneficiary's condition (for example, his or her symptoms) at the scene determines the appropriate level of payment.[20]

Medicare Contractor Controls Related to Payment of Provider Claims

Medicare contractors must establish and maintain efficient and effective internal controls.[21] These controls, including those over claim processing systems, are intended to prevent increased program costs caused by improper or delayed payments. Medicare contractors use the Multi-Carrier System and CMS's Common Working File to validate providers' claims for Medicare Part B services before paying the claims. In addition, prepayment edits in the contractors' claim processing systems can detect when certain claims should not be paid.

HOW WE CONDUCTED THIS REVIEW

Medicare contractors nation-wide paid providers $7.3 billion for 23.3 million claim lines for emergency ambulance transports (billed using HCPCS codes A0427 and A0429) with dates of service from January 1, 2014, through December 31, 2016 (audit period). We identified 10,617 claim lines, totaling $3,144,358, that were paid by Medicare for emergency ambulance transports with destination codes other than "H," "I," "N," or "X."[22] We also identified 2,152 claim lines, totaling $204,534, that were paid by Medicare for ground mileage associated with emergency ambulance transports to destinations not covered by Medicare. We used computer matching, data mining, and other analytical techniques to identify these 12,769 claim lines, totaling $3,348,892.[23]

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[20] Benefit Policy Manual, chapter 10, § 30.1.1.

[21] CMS *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, § 10.

[22] We considered emergency ambulance transports with destination code "I" (site of transfer between modes of ambulance transport) as allowable destinations for emergency ambulance transports because transports to these destinations could occur en route to a hospital or SNF. We also considered emergency ambulance transports with destination code "X" (intermediate stop at a physician's office on the way to a hospital) as allowable destinations for emergency ambulance transports because transports to these destinations would occur en route to a hospital.

[23] The improper payment for each emergency ambulance transport was calculated as the sum of the entire amount that the provider was paid for the emergency ambulance transport level of service (HCPCS codes A0427 or A0429) and the entire amount paid for ground mileage associated with the transport (HCPCS code A0425). The potentially improper payment for each emergency ambulance transport was calculated as the difference between what the provider was paid for the emergency ambulance transport level of service (HCPCS codes A0427 or A0429) and what the provider might have been paid for a nonemergency ambulance transport level of service (HCPCS codes A0426 or A0428).

For each claim line, we evaluated compliance with Medicare billing requirements, and we relied solely on claim information to make our determination. We did not use medical review to determine whether services were medically necessary because we did not assess the medical necessity for each ambulance transport. We also did not determine whether each ambulance transport was dispatched as a result of a 911 call or the equivalent. We did not contact any of the providers but relied on the claim information they submitted for Medicare payment.

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.

FINDINGS

Medicare payments to providers for emergency ambulance transports did not comply or potentially did not comply with Federal requirements. Specifically, for emergency ambulance transports to destinations other than hospitals or SNFs billed during our audit period, Medicare made improper and potentially improper payments totaling $1,903,246:

- Medicare made improper payments for 4,622 claim lines, totaling $975,154, for transports to destinations that were not covered by Medicare for either emergency or nonemergency ambulance transports. These claim lines consisted of 2,470 claim lines, totaling $770,620, for the transports themselves and 2,152 claim lines, totaling $204,534, for the identified ground mileage associated with the transports.

- Medicare made potentially improper payments for 8,147 claim lines, totaling $928,092, for transports to destinations other than hospitals or SNFs that (1) may not have met Medicare coverage requirements or (2) might have been paid by Medicare as nonemergency ambulance transports.[24]

As of the publication of this report, the total amount of $1,903,246 includes claim lines outside of the 4-year claim-reopening period.[25] Appendix C provides a summary of the improper and potentially improper payments to providers by jurisdiction.

[24] We determined the 8,147 claim lines as potentially not complying with Federal requirements because we did not assess the medical necessity for these transports or whether they were dispatched as a result of a 911 call or the equivalent.

[25] 42 CFR § 405.980(b).

These improper and potentially improper payments occurred because, during our audit period, CMS did not require the Medicare contractors to implement nation-wide prepayment edits specific to emergency ambulance transports that would either deny payments or mandate prepayment review for emergency ambulance transports to destinations other than hospitals or SNFs.

FEDERAL REQUIREMENTS

Medicare covers ambulance services that meet medical necessity and origin and destination requirements (42 CFR § 410.40(a); Benefit Policy Manual, chapter 10, § 10.2.1). Ambulance services, including emergency ambulance transports, are medically necessary only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. For a billed service to be considered medically necessary, the beneficiary's condition must require both the ambulance transportation itself and the level of service provided. Medicare covers nonemergency ambulance transportation if the beneficiary is bed-confined or his or her medical condition is such that transportation by ambulance is medically required (42 CFR § 410.40(d)). Even if transportation by ambulance is medically necessary, it must meet all other program coverage criteria in order for payment to be made (Benefit Policy Manual, chapter 10, § 10.2.1).

Medicare covers ambulance transports to only the following destinations:

- from any point of origin to the nearest hospital (including a critical access hospital) or nearest SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury;

- from a hospital (including a critical access hospital) or SNF to the beneficiary's home;

- from a SNF to the nearest supplier of medically necessary services that are not available at the SNF where the beneficiary is a resident, including the return trip; or

- from a beneficiary's home to the nearest facility that furnishes renal dialysis (for a beneficiary who is receiving renal dialysis for treatment of ESRD), including the return trip (42 CFR § 410.40(e)).[26]

Medicare covers ambulance transports to the nearest appropriate facility, as well as the return transport, for a beneficiary to obtain necessary diagnostic or therapeutic services (Benefit Policy Manual, chapter 10, § 10.3). In addition, the transport must be to receive a medically necessary Medicare service or to return from such a service (Benefit Policy Manual, chapter 10, § 10.2.1).

[26] Even though a physician's office is not a covered destination, Medicare Part B will cover an ambulance transport under special circumstances if it temporarily stops at a physician's office (Benefit Policy Manual, chapter 10, § 10.3).

Medicare pays for ALS and BLS ambulance transports at the emergency transport level (HCPCS codes A0427 and A0429) if the services were provided in the context of an emergency response (Claims Processing Manual, chapter 15, § 30.B). For ambulance transports, an emergency response means responding immediately at the BLS or ALS level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the provider begins as quickly as possible to take the steps necessary to respond to the call. A call is of an emergency nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. If the call came in directly to the provider, the provider's dispatch protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. When the dispatch was inconsistent with this standard protocol, including cases in which no protocol was used, the beneficiary's condition (for example, his or her symptoms) at the scene determines the appropriate level of payment (Benefit Policy Manual, chapter 10, § 30.1.1).

MEDICARE MADE IMPROPER AND POTENTIALLY IMPROPER PAYMENTS TO PROVIDERS FOR EMERGENCY AMBULANCE TRANSPORTS TO DESTINATIONS OTHER THAN HOSPITALS OR SKILLED NURSING FACILITIES

Medicare made improper and potentially improper payments of $1,698,712 for emergency ambulance transports to destinations other than hospitals or SNFs that (1) were not covered by Medicare for either emergency or nonemergency ambulance transports or (2) might have been covered by Medicare if the transports had been billed as nonemergency ambulance transports. In addition, Medicare made improper payments of $204,534 for the ground mileage associated with transports to destinations not covered by Medicare for ambulance transports.

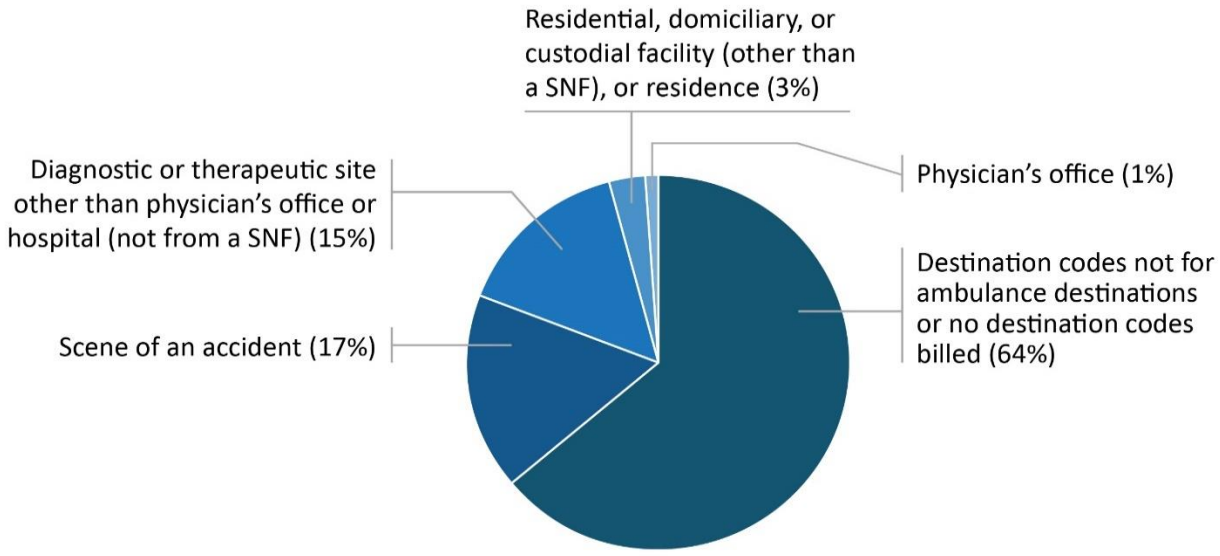
Transports to Destinations That Were Not Covered by Medicare for Ambulance Transports

Medicare made improper payments to providers for 2,470 claim lines for which providers billed emergency ambulance transports to destinations other than hospitals or SNFs, such as the scene of an accident or acute event (destination code "S"), that were not covered by Medicare for either emergency or nonemergency ambulance transports. Therefore, the payments for these claim lines were completely unallowable.[27] For example, one provider used modifier RS to bill for an emergency ambulance transport from a beneficiary's residence to a scene of an accident or acute event. The destination was not covered by Medicare for an ambulance transport.

[27] We determined that an ambulance transport to a residential, domiciliary, or custodial facility (other than a SNF) or a beneficiary's residence was not covered by Medicare for either emergency or nonemergency transport if the transport originated from a location that Medicare would not determine as a covered destination and medically necessary Medicare services could not be performed at that location (e.g., the scene of an accident or acute event).

Figure 1 below shows the percentage of claim lines that were billed for emergency ambulance transports to each type of destination other than a hospital or SNF. For the majority of these claim lines (64 percent), providers billed the transports using destination codes that were not for ambulance destinations or did not use destination codes.

Figure 1: Percentage of Claim Lines for Transports to Destinations Not Covered by Medicare for Ambulance Transports



As a result of the billing, the Medicare contractors made improper payments to providers totaling $770,620 for these emergency ambulance transports to destinations not covered by Medicare. In addition, the contractors made improper payments to providers for 2,152 claim lines, totaling $204,534, for the ground mileage associated with those transports.

Transports to Destinations That Might Have Been Covered by Medicare for Nonemergency Ambulance Transports

Medicare made potentially improper payments to providers for 8,147 claim lines for which the providers billed emergency ambulance transports to destinations other than hospitals or SNFs, such as beneficiaries' residences (codes "E" and "R")[28] and hospital-based and freestanding ESRD facilities (codes "G" and "J"),[29] that might have been covered by Medicare if the transports had been billed as nonemergency ambulance transports. These providers billed destination codes for destinations other than hospitals or SNFs (specifically, codes other than "H," "I," "N," or "X").

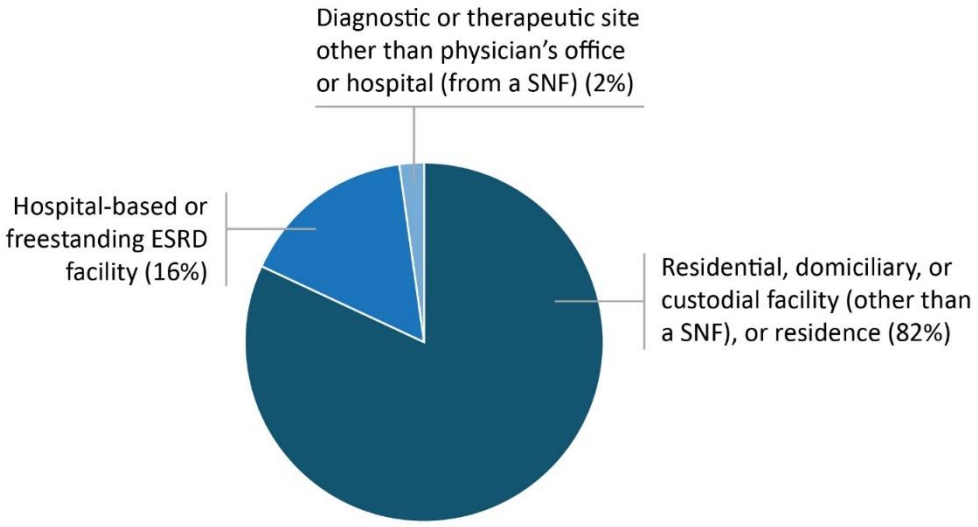
[28] We determined that an ambulance transport to a residential, domiciliary, or custodial facility (other than a SNF) or a beneficiary's residence potentially was covered by Medicare for nonemergency transport if the transport originated from a location that Medicare would determine as a covered destination and medically necessary Medicare services could be performed at that location (e.g., a hospital).

[29] Hospital-based ESRD facilities are not considered hospital destinations.

Of these 8,147 claim lines, 6,046 (74 percent) were billed as emergency ambulance transports from hospitals to beneficiaries' residences. For example, one provider used modifier HR to bill for an emergency ambulance transport from a hospital to a beneficiary's residence. Although the destination was covered by Medicare for a nonemergency ambulance transport, it was potentially not covered by Medicare for an emergency ambulance transport.

Figure 2 below shows the percentage of claim lines that were billed for emergency ambulance transports to each type of destination other than a hospital or SNF, which might have been covered by Medicare for nonemergency ambulance transports. The majority of these claim lines (82 percent) were for transports to beneficiaries' residences.

Figure 2: Percentage of Claim Lines for Emergency Ambulance Transports to Destinations That Might Have Been Covered by Medicare for Nonemergency Ambulance Transports



As a result of the billing, the Medicare contractors made payments to providers totaling $2,373,739 for emergency ambulance transports instead of $1,445,647 for nonemergency ambulance transports, resulting in a potentially improper payment of $928,092. This amount was the difference between what the provider was paid for the emergency ambulance transport level of service and what the provider might have been paid for the nonemergency ambulance transport level of service.

PREPAYMENT EDITS WERE NOT ADEQUATE TO PREVENT IMPROPER OR POTENTIALLY IMPROPER PAYMENTS

During our audit period, CMS did not require the Medicare contractors to implement nation-wide prepayment edits that would deny payments or mandate prepayment review for emergency ambulance transports to destinations other than hospitals or SNFs. Some Medicare contractors implemented claim processing edits specific to emergency ambulance transports,

which resulted in fewer improper or potentially improper payments to providers in some jurisdictions compared with other jurisdictions. However, if CMS had required all Medicare contractors to implement these edits, it would have reduced the amount of improper or potentially improper payments we identified.

RECOMMENDATIONS

We recommend that CMS:

- direct the Medicare contractors to recover the portion of the $975,154 in improper payments made to providers for claim lines for emergency ambulance transports to destinations not covered by Medicare that are within the 4-year claim-reopening period;

- direct the Medicare contractors to review claim lines that are within the 4-year claim-reopening period for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports and recover any improper payments identified, which could represent $928,092 in improper payments;

- for the remaining portion of the $1,903,246, which is outside of the Medicare reopening and recovery periods, instruct the Medicare contractors to notify providers of potentially improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation;

- direct the Medicare contractors to review claim lines after our audit period for emergency ambulance transports to destinations not covered by Medicare and recover any improper payments identified;

- require the Medicare contractors to implement nation-wide prepayment edits to deny payments for emergency ambulance transports to destinations not covered by Medicare; and

- based on the results of the Medicare contractors' review of emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports, consider (1) directing the Medicare contractors to review claim lines after our audit period and recover any improper payments identified and (2) requiring the Medicare contractors to implement nation-wide prepayment edits specific to emergency ambulance transports that would either deny payments or mandate prepayment review for emergency ambulance transports to

destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first six recommendations and described actions it planned to take to implement these recommendations. However, regarding our draft report's seventh recommendation, to make any necessary regulatory changes to implement the sixth recommendation, CMS stated that it did not concur with the recommendation at this time. CMS explained that this recommendation is dependent on its findings from the Medicare contractors' review of a sample of claim lines conducted in keeping with our second recommendation. CMS stated that, at this time, "it is unclear whether a regulatory change would be necessitated by these reviews."

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear as Appendix D.

After reviewing CMS's comments, we revised our report to remove the recommendation that CMS make any necessary regulatory changes to implement our sixth recommendation.

OTHER MATTERS: THE MAJORITY OF EMERGENCY AMBULANCE TRANSPORTS TO SKILLED NURSING FACILITIES ORIGINATED FROM FACILITIES THAT PROVIDED EMERGENCY SERVICES

During our audit period, Medicare paid providers for 12,967 claim lines, totaling $3,813,608, for emergency ambulance transports to SNFs. Of these claim lines, 10,911 (84 percent), totaling $3,200,096, were for transports that originated from hospitals. Because hospitals are capable of providing emergency services (Benefit Policy Manual, chapter 15, § 40.29), we plan to conduct a separate review of emergency ambulance transports from hospitals to SNFs to determine the appropriateness of billing for them as emergency ambulance transports.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Medicare contractors nation-wide paid providers $7.3 billion for 23.3 million claim lines for emergency ambulance transports (billed using HCPCS codes A0427 and A0429) with dates of service from January 1, 2014, through December 31, 2016. We identified 10,617 claim lines, totaling $3,144,358, that were paid by Medicare for emergency ambulance transports with destination codes other than "H," "I," "N," or "X."[30] We also identified 2,152 claim lines, totaling $204,534, that were paid by Medicare for ground mileage associated with emergency ambulance transports to destinations not covered by Medicare. We used computer matching, data mining, and other analytical techniques to identify these 12,769 claim lines, totaling $3,348,892.

For each claim line, we evaluated compliance with Medicare billing requirements, and we relied solely on claim information to make our determination. We did not use medical review to determine whether services were medically necessary because we did not assess the medical necessity for each ambulance transport. We also did not determine whether each ambulance transport was dispatched as a result of a 911 call or the equivalent. We did not contact any of the providers but relied on the claim information they submitted for Medicare payment.

We limited our review of Medicare contractors' internal controls to those that were applicable to the selected claim lines because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our audit from May 2017 to January 2018, which included contacting CMS in Baltimore, Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[30] We considered emergency ambulance transports with destination code "I" (site of transfer between modes of ambulance transport) as allowable destinations for emergency ambulance transports because transports to these destinations could occur en route to a hospital or SNF. We also considered emergency ambulance transports with destination code "X" (intermediate stop at a physician's office on the way to a hospital) as allowable destinations for emergency ambulance transports because transports to these destinations would occur en route to a hospital.

- interviewed CMS staff regarding the types of system edits specific to emergency ambulance transports and the modifiers that providers used when billing for these transports;

- used CMS's National Claims History file to identify claim lines for emergency ambulance transports (billed using HCPCS codes A0427 and A0429) with dates of service for the audit period;

- used computer matching, data mining, and other analytical techniques to identify paid claim lines for emergency ambulance transports in which beneficiaries were transported to destinations other than hospitals or SNFs (by evaluating the destination codes);[31]

- calculated the improper or potentially improper payment amounts for emergency ambulance transports to destinations other than hospitals or SNFs that (1) were not covered by Medicare for ambulance transports[32] or (2) might have been covered by Medicare if the transports had been billed as nonemergency ambulance transports;[33] and

- 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.

[31] We considered emergency ambulance transports with destination codes "I" (site of transfer between modes of ambulance transport) and "X" (intermediate stop at a physician's office on the way to a hospital) as allowable destinations for emergency ambulance transports.

[32] The improper payment for each emergency ambulance transport was calculated as the sum of the entire amount that the provider was paid for the emergency ambulance transport level of service (HCPCS codes A0427 or A0429) and the entire amount paid for ground mileage associated with the transport (HCPCS code A0425).

[33] The potentially improper payment for each emergency ambulance transport was calculated as the difference between what the provider was paid for the emergency ambulance transport level of service (HCPCS codes A0427 or A0429) and what the provider might have been paid for a nonemergency ambulance transport level of service (HCPCS codes A0426 or A0428).

APPENDIX B: MEDICARE CONTRACTOR AND GEOGRAPHIC COMPOSITION FOR EACH JURISDICTION[34]

Jurisdiction	Medicare Contractor	States and Territories
5	Wisconsin Physicians Service Insurance Corporation (WPS)	Iowa, Kansas, Missouri, Nebraska
6	National Government Services, Inc. (NGS)	Illinois, Minnesota, Wisconsin
8	WPS	Indiana, Michigan
15	CGS Administrators, LLC (CGS)	Kentucky, Ohio
E	Noridian Healthcare Solutions, LLC (Noridian)	American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands
F	Noridian	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
H	Novitas Solutions, Inc. (Novitas)	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas
J	Cahaba Government Benefit Administrators, LLC (Cahaba)	Alabama, Georgia, Tennessee
K	NGS	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
L	Novitas	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania
M	Palmetto GBA, LLC (Palmetto)	North Carolina, South Carolina, Virginia, West Virginia
N	First Coast Service Options, Inc. (First Coast)	Florida, Puerto Rico, U.S. Virgin Islands

[34] The jurisdiction designation, Medicare contractor, and geographic composition for each jurisdiction are accurate as of October 31, 2017.

APPENDIX C: IMPROPER AND POTENTIALLY IMPROPER PAYMENTS FOR EMERGENCY AMBULANCE TRANSPORTS TO DESTINATIONS OTHER THAN HOSPITALS OR SKILLED NURSING FACILITIES BY JURISDICTION

Jurisdiction	Medicare Contractor	Transports to Destinations Not Covered by Medicare for Ambulance Transports[35]		Transports to Destinations That Might Have Been Covered by Medicare for Nonemergency Transports		Total of Improper and Potentially Improper Payments
		No. of Paid Claim Lines	Improper Payment Amount[36]	No. of Paid Claim Lines	Potentially Improper Payment Amount[37]	
5	WPS	269	$63,848	1,138	$109,584	$173,432
6	NGS	424	86,485	1,150	133,030	219,515
8	WPS	76	16,615	713	70,730	87,345
15	CGS	226	53,553	75	7,945	61,498
E	Noridian	655	135,358	897	107,450	242,808
F	Noridian	1,838	381,055	1,319	169,363	550,418
H	Novitas	24	5,724	3	91	5,815
J	Cahaba	852	177,635	818	83,956	261,591
K	NGS	7	2,091	1,361	156,342	158,433
L	Novitas	159	27,255	3	453	27,708
M	Palmetto	82	23,875	47	2,495	26,370
N	First Coast	10	1,660	623	86,653	88,313
Total		**4,622**	**$975,154**	**8,147**	**$928,092**	**$1,903,246**

[35] The number of paid claim lines and improper payment amounts for emergency ambulance transports to destinations not covered by Medicare for ambulance transports include the paid claim lines and improper payment amounts associated with ground mileage.

[36] The improper payment for each emergency ambulance transport was calculated as the sum of the entire amount that the provider was paid for the emergency ambulance transport level of service (HCPCS codes A0427 or A0429) and the entire amount paid for ground mileage associated with the transport (HCPCS code A0425).

[37] The potentially improper payment for each emergency ambulance transport was calculated as the difference between what the provider was paid for the emergency ambulance transport level of service (HCPCS codes A0427 or A0429) and what the provider might have been paid for a nonemergency ambulance transport level of service (HCPCS codes A0426 or A0428).

APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUL 16 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities (A-09-17-03017)

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 is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing 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.

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 avoiding Medicare billing errors 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 direct the Medicare contractors to recover the portion of the $975,154 in improper payments made to providers for claim lines for emergency ambulance transports to destinations not covered by Medicare that are within the 4-year claim-reopening period.

CMS Response
CMS concurs with this recommendation. CMS will instruct its Medicare contractors to recover the identified overpayments consistent with the agency's policies and procedures.

OIG Recommendation
The OIG recommends that CMS direct the Medicare contractors to review claim lines that are within the 4-year claim reopening period for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency

ambulance transports and recover any improper payments identified, which could represent $928,092 in improper payments.

CMS Response
CMS concurs with this recommendation. CMS will instruct Medicare contractors to review a sample of claim lines that are within the 4-year claim reopening period for ambulance transports to destinations other than hospitals or skilled nursing facilities to ensure that claims met the requirements for emergency ambulance transports. Based on the findings of the sample review, CMS will determine the appropriate course of action. CMS will recover, as is appropriate, any identified overpayments associated with the reviews consistent with agency policy and procedures.

OIG Recommendation
The OIG recommends that for the remaining portion of the $1,903,246, which is outside of the Medicare reopening and recovery periods, CMS instruct the Medicare contractors to notify providers of potentially improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments 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. CMS will 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 review claim lines after the audit period for emergency ambulance transports to destinations not covered by Medicare and recover any improper payments identified.

CMS Response
CMS concurs with this recommendation. CMS will notify Medicare contractors of OIG's audit to consider a similar review for emergency ambulance transports to destinations not covered by Medicare after the audit period.

OIG Recommendation
The OIG recommends that CMS require the Medicare contractors to implement nationwide prepayment edits to deny payments for emergency ambulance transports to destinations not covered by Medicare.

CMS Response
CMS concurs with this recommendation. CMS will work to implement national prepayment edits for emergency ambulance transports regarding approved and inappropriate destinations.

OIG Recommendation
The OIG recommends that based on the results of the Medicare contractors' review of emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports, consider (1) directing the Medicare contractors to review claim lines after the audit period and recover any improper payments identified and (2)

requiring the Medicare contractors to implement nationwide prepayment edits specific to emergency ambulance transports that would either deny payments or mandate prepayment review for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports.

CMS Response

CMS concurs with this recommendation, which is dependent on CMS's findings from the sample review conducted in keeping with OIG's second recommendation. CMS will take appropriate action based on the sample review of emergency ambulance transports to destinations other than hospitals or skilled nursing facilities. CMS will take the OIG's suggestions under consideration when determining appropriate next steps.

OIG Recommendation

The OIG recommends that CMS make any necessary regulatory changes to implement the sixth recommendation.

CMS Response

CMS does not concur with this recommendation at this time. This recommendation is dependent on CMS's findings from the sample review conducted in keeping with OIG's second recommendation. At this time, it is unclear whether a regulatory change would be necessitated by these reviews. As stated above, CMS will take appropriate action based on the review of emergency ambulance transports to destinations other than hospitals or skilled nursing facilities.