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Washington, D.C. 20201

**TO:** Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services

**FROM:** Daniel R. Levinson *Daniel R. Levinson*  
Inspector General

**SUBJECT:** Medicare Part B Payments for Ambulance Services Rendered to  
Beneficiaries During Inpatient Stays: 2001 Through 2003  
(A-01-04-00513)

The attached final report provides the results of our review of Medicare Part B payments for ambulance services rendered during inpatient stays. The objective of our review was to determine whether carriers made inappropriate Part B payments for ambulance services provided to Medicare beneficiaries during inpatient stays at prospective payment system (PPS) hospitals.

Under the PPS for acute care hospitals, suppliers that render Part B services during inpatient stays are required to bill the hospitals, not the carriers, for those services. Carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients.

During calendar years 2001-2003, carriers inappropriately made Part B payments for 203,377 ambulance services provided to PPS hospital inpatients. Rather than billing the hospitals for these services, ambulance suppliers billed the carriers and received separate payments. As a result, Medicare potentially overpaid \$21.7 million for ambulance services by paying twice: once to the hospital as part of the prospective payment and again to the ambulance supplier under Part B. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid more than \$6.2 million in coinsurance and deductibles related to these potential Medicare overpayments.

Neither the Centers for Medicare & Medicaid Services (CMS) nor its carriers had established computerized edits to detect and prevent these Part B payments. In addition, CMS officials advised us that CMS had no postpayment review procedures for identifying payments for Part B ambulance services provided to hospital inpatients that duplicated a portion of the prospective payments.

We recommend that CMS:

- instruct the Medicare carriers to recover the \$21.7 million in potential overpayments identified in our review and monitor the recovery of these overpayments;

- establish payment controls to detect and prevent separate payments for Medicare Part B ambulance services provided to beneficiaries during inpatient stays in PPS hospitals, or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings; and
- alert the Medicare carriers to the most common types of payment errors and help them educate ambulance suppliers about such improper billings.

In its comments on the draft report, CMS agreed with our recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-01-04-00513 in all correspondence.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PART B PAYMENTS FOR  
AMBULANCE SERVICES RENDERED  
TO BENEFICIARIES DURING  
INPATIENT STAYS:  
2001 THROUGH 2003**



**Daniel R. Levinson  
Inspector General**

**MARCH 2006  
A-01-04-00513**

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<http://oig.hhs.gov>

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Under Medicare's inpatient prospective payment system (PPS), fiscal intermediaries reimburse acute care hospitals a predetermined amount for services furnished to Medicare beneficiaries based on their illness and its classification under a diagnosis-related group (DRG). The DRG payment for inpatient services covers nonphysician outpatient services that Medicare beneficiaries receive during an inpatient stay. These nonphysician outpatient services include transportation of an inpatient by ambulance to and from another facility to receive specialized services not available at the hospital where the beneficiary is an inpatient. Accordingly, ambulance suppliers that render Part B services during inpatient stays are required to bill the PPS hospitals, not the Medicare carriers, for those services. In addition, Medicare carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients.

This audit follows up on a prior review of nonphysician services provided during inpatient stays at PPS hospitals in calendar years 1998-2000.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) generally agreed with that report's recommendations to recover inappropriate payments and establish procedures to preclude such payments.

### **OBJECTIVE**

The objective of our audit was to determine whether carriers made inappropriate Part B payments for ambulance services provided to Medicare beneficiaries during inpatient stays at PPS hospitals.

### **SUMMARY OF FINDING**

During calendar years 2001-2003, carriers inappropriately made Part B payments for 203,377 ambulance services provided to PPS hospital inpatients. Rather than billing the hospitals for these services, ambulance suppliers billed the carriers and received separate payments. As a result, Medicare potentially overpaid \$21.7 million for ambulance services by paying twice: once to the hospital as part of the DRG payment and again to the ambulance supplier under Part B. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid more than \$6.2 million in coinsurance and deductibles related to these potential Medicare overpayments.

Neither CMS nor its carriers had established computerized edits to detect and prevent these Part B payments. In addition, CMS officials advised us that CMS had no postpayment review procedures for identifying payments for Part B ambulance services provided to hospital inpatients that duplicated a portion of the DRG payments.

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<sup>1</sup>“Nationwide Review of Compliance With Medicare Billing Rules for Ambulance and Radiology Services Rendered by an Independent Entity During an Inpatient Hospital Stay” (A-01-01-00502, issued August 6, 2002).

## **RECOMMENDATIONS**

We recommend that CMS:

- instruct the Medicare carriers to recover the \$21.7 million in potential overpayments identified in our review and monitor the recovery of these overpayments;
- establish payment controls to detect and prevent separate payments for Medicare Part B ambulance services provided to beneficiaries during inpatient stays in PPS hospitals, or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings; and
- alert the Medicare carriers to the most common types of payment errors and help them educate ambulance suppliers about such improper billings.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments on the draft report, CMS agreed with our recommendations. CMS's comments are included in their entirety as an appendix.

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# INTRODUCTION

## BACKGROUND

### **Inpatient Prospective Payment System**

Section 1886(d) of the Social Security Act established a prospective payment system (PPS) for inpatient services furnished to Medicare beneficiaries by acute care hospitals for cost-reporting periods beginning on or after October 1, 1983. Under the PPS, Medicare fiscal intermediaries reimburse hospitals a predetermined amount for services based on a beneficiary's illness and its classification under a diagnosis-related group (DRG).

The DRG payment for inpatient services covers nonphysician outpatient services that the beneficiary receives during an inpatient stay. These nonphysician outpatient services include transportation by ambulance to and from another facility to receive specialized services not available at the hospital where the beneficiary is an inpatient. Accordingly, ambulance suppliers that provide Part B services to beneficiaries during inpatient stays are required to bill the PPS hospitals, not the Medicare carriers, for those services. In addition, Medicare carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients.

### **Prior Review**

This audit follows up on a prior review of nonphysician services provided during inpatient stays at PPS hospitals in calendar years (CYs) 1998-2000.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) generally agreed with that report's recommendations to recover inappropriate payments and establish procedures to preclude such payments.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### **Objective**

The objective of our audit was to determine whether carriers made inappropriate Part B payments for ambulance services provided to Medicare beneficiaries during inpatient stays at PPS hospitals.

### **Scope**

Our audit covered the period January 1, 2001, through December 31, 2003. We limited consideration of the internal control structure to CMS's Common Working File and selected Medicare carriers' Part B claims processing systems. Our objective did not require an understanding or assessment of the complete internal control structure of CMS or its contractors.

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<sup>1</sup>“Nationwide Review of Compliance With Medicare Billing Rules for Ambulance and Radiology Services Rendered by an Independent Entity During an Inpatient Hospital Stay” (A-01-01-00502, issued August 6, 2002).

We did not assess the completeness of the file extracted from CMS's National Claims History File. Also, we did not extend our audit work beyond 150 sampled beneficiary days because, in our professional judgment, additional work would not have produced different results.<sup>2</sup> We based this conclusion on the results of our review of the 150 sampled items, as well as on the results of our prior audit.

We conducted our review from October 2004 to March 2005.

## **Methodology**

To accomplish our objectives, we:

- reviewed applicable Medicare laws and regulations;
- performed a nationwide computer match (using CMS's National Claims History File) to identify Medicare Part B payments for ambulance services provided to Medicare beneficiaries during inpatient stays at PPS hospitals, excluding the days of admission and discharge;
- matched the dates of inpatient stays during CYs 2001-2003 with the dates that ambulance suppliers provided Part B services during that period (and for which the suppliers received reimbursement);
- randomly selected a sample of 50 beneficiary days for each of the 3 CYs;
- verified admission and discharge dates for the sampled claims with hospitals to ensure that no leaves of absence disrupted the inpatient stays;
- contacted 130 Part B ambulance suppliers to determine why the suppliers billed the Medicare carriers instead of the hospitals for the services provided;
- contacted 11 Medicare carriers to determine whether their computer systems had edits that would detect and prevent Part B payments for nonphysician services provided to Medicare beneficiaries who were hospital inpatients;
- contacted CMS officials to follow up on the status of actions taken on the recommendations made in our prior review; and
- discussed the results of our review with CMS central office officials.

We conducted our review in accordance with generally accepted government auditing standards.

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<sup>2</sup>A beneficiary day represents all ambulance services provided to a beneficiary on a date of service.

## **FINDING AND RECOMMENDATIONS**

During the 3-year audit period, carriers inappropriately made Part B payments for 203,377 ambulance services provided to PPS hospital inpatients. Rather than billing the hospitals for these services, ambulance suppliers billed the carriers and received separate payments. As a result, Medicare potentially overpaid \$21.7 million for ambulance services by paying twice: once to the hospital as part of the DRG payment and again to the ambulance supplier under Part B. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid more than \$6.2 million in coinsurance and deductibles related to these potential Medicare overpayments.

Neither CMS nor its carriers had established computerized edits to detect and prevent these Part B payments. In addition, CMS officials advised us that CMS had no postpayment review procedures for identifying payments for Part B ambulance services provided to hospital inpatients that duplicated a portion of the DRG payments.

### **PROGRAM REQUIREMENTS**

The “Medicare Claims Processing Manual,” Publication 100-04, Chapter 3, section 10.4, provides, in part, that inpatient nonphysician services for Medicare beneficiaries may be covered only if they are furnished, directly or under arrangements, by a hospital. Ambulance transportation furnished to hospital inpatients is covered as a hospital service under Part A, and carriers are responsible for ensuring that they do not pay for these services.

Furthermore, Publication 100-04, Chapter 15, section 10, provides that ambulance services are separately reimbursable only under Part B. A beneficiary who has been admitted to a hospital may need to be transported to another hospital or other site for temporary, specialized care while maintaining inpatient status at the original provider. This movement is considered “patient transportation” and is covered as an inpatient hospital service under Part A. Because the service is covered and payable under Part A, it may not be classified as an ambulance service and paid under Part B. Similarly, intracampus transfers between different departments of the same hospital, even when the departments are located in separate buildings, are not payable under the Part B ambulance benefit.

### **ADHERENCE TO PROGRAM REQUIREMENTS**

Our nationwide computer match for CYs 2001-2003 identified a significant number of potentially overpaid claims for ambulance services that were provided to Medicare beneficiaries during inpatient stays in PPS hospitals. We identified 203,377 ambulance services within 78,564 beneficiary days that may have been inappropriately paid. We limited our population to beneficiary days for which the Medicare Part B payment totaled at least \$100. To verify that our computer match was valid, we randomly selected a sample of all ambulance services provided for 50 beneficiary days in each of the 3 CYs. Our sample totaled \$39,277 in Medicare payments. Table 1 details our population and sample.

**Table 1: Population and Sample**

CY	Population				Sample	
	Ambulance Services	Beneficiary Days	Medicare Payments	Deductibles and Coinsurance	Beneficiary Days	Medicare Payments
2001	65,398	25,237	\$6,811,100	\$2,110,653	50	\$14,081
2002	68,426	26,503	7,268,259	2,055,796	50	12,563
2003	69,553	26,824	7,625,651	2,029,290	50	12,633
<b>Total</b>	<b>203,377</b>	<b>78,564</b>	<b>\$21,705,010</b>	<b>\$6,195,739</b>	<b>150</b>	<b>\$39,277</b>

Based on information available at the time of the payments, carriers had incorrectly paid for all of the ambulance services provided for the 150 beneficiary days reviewed. Further review determined that carriers had correctly paid only 3 of the 150 sampled items. For one sampled item, the inpatient claim was canceled, and for the two others, there was a break in inpatient status. Accordingly, we believe that the vast majority of the amounts that our computer match identified represent amounts submitted in error by ambulance suppliers and incorrectly paid by carriers.

A limited number of suppliers were responsible for a large share of the potential overpayments. Specifically, about one-third of the ambulance suppliers in our population accounted for approximately 88 percent of the potential overpayments, as shown in Table 2.

**Table 2: Distribution of Potential Overpayments Among Suppliers**

	Ambulance Suppliers		Potential Overpayments	
	Number of Suppliers	Percentage of Total Suppliers	Total Overpayments	Percentage of Total Overpayments
One-third of suppliers	2,468	33.34%	\$19,029,775	87.88%
Remainder	4,935	66.66%	2,675,235	12.12%
<b>Total</b>	<b>7,403</b>	<b>100.00%</b>	<b>\$21,705,010</b>	<b>100.00%</b>

**NEED FOR STRONGER INTERNAL CONTROLS**

**Centers for Medicare & Medicaid Services**

Although CMS generally agreed with the recommendations in our prior audit report (A-01-01-00502), it had not implemented them by the end of our current audit period. In our prior report, we recommended that CMS (1) establish payment controls to detect and prevent separate payments for Medicare Part B nonphysician services provided to Medicare beneficiaries during inpatient stays in PPS hospitals and/or (2) develop computer applications to identify providers who frequently submit and receive payments for inappropriate billings. We also recommended that CMS alert Medicare carriers to the most

common types of payment errors and direct them to educate their suppliers about such improper billings.

During our current audit, CMS acknowledged that it had made significant improper payments for ambulance services provided to hospital inpatients. Accordingly, on September 2, 2005, CMS issued Transmittal 668, Change Request 3933, requiring implementation of an edit in the Common Working File to prevent these improper payments effective January 3, 2006.

## **Carriers**

The 11 Medicare carriers that we contacted did not have adequate controls to deny improper payments for ambulance services provided to hospital inpatients. Although all of the carriers contacted said that they had an edit in place for hospital-to-hospital transportation claims, they still erroneously paid claims. Most of the carriers indicated that they had provided education, training, and workshops to ambulance suppliers on the proper billing procedures for services provided to Medicare beneficiaries during inpatient stays.

## **Ambulance Suppliers**

We used our randomly selected sample to validate our computer match and to determine why ambulance suppliers billed the carriers instead of the hospitals. We found that:

- For 52 of the 150 sampled items, ambulance supplier officials:
  - did not know that the beneficiary was an inpatient at the time of transport (28 sampled items),
  - billed incorrectly with no specific reason given (20 sampled items), or
  - were not aware of the Medicare program requirements (4 sampled items).
- For 50 of the 150 sampled items, the ambulance suppliers billed the wrong date of service (42 sampled items) or the hospitals' inpatient stay dates were incorrect (8 sampled items). Our computer match identified these payments as inappropriate because the ambulance suppliers or the hospitals submitted incorrect information.
- For 3 of the 150 sampled items, the carrier appropriately paid for the ambulance services because the inpatient claim was canceled (1 sampled item) or there was a break in inpatient status (2 sampled items).
- For the remaining 45 of the 150 sampled items, ambulance suppliers did not respond or did not dispute the results of our computer match.

If CMS had implemented appropriate edits, the carriers would not have paid most of these 150 sampled items.

## **POTENTIAL OVERPAYMENTS FOR AMBULANCE SERVICES**

Our review identified 78,564 Medicare Part B beneficiary days containing 203,377 ambulance services valued at more than \$21.7 million that potentially should not have been paid. This amount represents total provider-specific potential overpayments, not a statistical projection of sample results. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, and their supplemental insurers could have paid more than \$6.2 million in coinsurance and deductibles related to these potential Medicare overpayments.

## **RECOMMENDATIONS**

We recommend that CMS:

- instruct the Medicare carriers to recover the \$21.7 million in potential overpayments identified in our review and monitor the recovery of these overpayments;
- establish payment controls to detect and prevent separate payments for Medicare Part B ambulance services provided to beneficiaries during inpatient stays in PPS hospitals, or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings; and
- alert the Medicare carriers to the most common types of payment errors and help them educate ambulance suppliers about such improper billings.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its December 22, 2005, comments on the draft report, CMS agreed with all of our recommendations. CMS's comments are included in their entirety in the appendix.

# **APPENDIX**

*Administrator*  
Washington, DC 20201

DEC 22 2005

**TO:** Daniel R. Levinson  
Inspector General  
Office of Inspector General

**FROM:** Mark B. McClellan, M.D., Ph.D. *MM*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report, "Medicare Part B Payments for Ambulance Services Rendered to Beneficiaries During Inpatient Stays: 2001 Through 2003" (A-01-04-00513)

The Centers for Medicare and Medicaid Services (CMS) would like to thank the OIG for their investigation into this program vulnerability. We appreciate the opportunity to provide the following comments on this report.

Under Medicare's inpatient prospective payment system (IPPS), fiscal intermediaries reimburse acute care hospitals a predetermined amount for services furnished to Medicare beneficiaries based on their illness and its classification under a diagnosis-related group (DRG). The DRG payment for inpatient services covers non-physician outpatient services that Medicare beneficiaries receive during an inpatient stay. These outpatient services include transportation of an inpatient by ambulance to and from another facility to receive specialized services not available at the hospital where the beneficiary is an inpatient.

The OIG found that during calendar years 2001-2003, carriers inappropriately made Part B payments for 203,377 ambulance services provided to IPPS hospital inpatients. Medicare potentially overpaid \$21.7 million by paying the hospital as part of the DRG and also paying the supplier under Part B. Additionally, Medicaid may have overpaid more than \$6.2 million in coinsurance and deductibles.

The OIG found that neither CMS nor its carriers had computerized edits to detect and prevent these payments. In addition, CMS had no postpayment review procedures to identify payments for Part B ambulance services provided to hospital inpatients that duplicated a portion of the DRG payment.

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OIG Recommendation

The OIG recommends that CMS instruct the Medicare carriers to recover the \$21.7 million in potential overpayments identified in the OIG's review and monitor the recovery of those overpayments.

CMS Response

The CMS agrees with the OIG's recommendation to instruct the Medicare carriers to recover the \$21.7 million in potential overpayments and to monitor the recovery of those overpayments. See our technical comments below.

OIG Recommendation

The OIG recommends that CMS establish payment controls to detect and prevent separate payments for Medicare Part B ambulance services provided to beneficiaries during inpatient stays in PPS hospitals, or develop postpayment review procedures to identify providers that submit and receive payments for inappropriate billings.

CMS Response

The CMS agrees with this recommendation and is scheduled to implement an edit in the Common Working File (CWF) to prevent improper payments for ambulance services provided to hospital inpatients on January 3, 2006. (See Transmittal 668, Change Request 3933, issued on September 2, 2005.) This edit will be constructed to reject an ambulance line item received by the carrier from an independent supplier of ambulance services when the ambulance line item service date falls within the admission and discharge dates on a hospital inpatient bill that is posted to the CWF. If the ambulance claim is received prior to the hospital inpatient bill, upon receipt of the inpatient bill, CWF will provide notification to the carrier to adjust the line item and recoup payment. (Please note that the implementation date for this new edit is January 3, 2006, rather than the January 1, 2006 date, included on page 5 of the OIG report.)

In addition, CMS anticipates an increased ability to develop postpayment review procedures to identify services that are billed to both Part A and Part B as we transition to the Medicare Administrative Contractor (MAC) environment. MACs will be tasked with processing both Part A and Part B claims, thus facilitating the prevention of inappropriate payments for services that could be billed to both Part A and Part B. We will revisit this issue when the MACs are implemented.

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OIG Recommendation

The OIG recommends that CMS alert the Medicare carriers to the most common types of payment errors and help them to educate ambulance suppliers about such improper billings.

CMS Response

The CMS is working hard to reduce improper payments. As part of our Comprehensive Error Rate Testing (CERT) program, we recently calculated the national Medicare fee-for-service claims payment error rate at 5.2 percent for fiscal year (FY) 2005. This is a nearly 50 percent decrease from FY 2004. Additionally, the current ambulance error rate for carriers is 5.1 percent. Given that the OIG's report was conducted using 2001-2003 data, CMS believes that many of these errors have been addressed. That said, CMS continues to share error rates with its contractors and use error rates to help evaluate contractor performance and identify program vulnerabilities.

When claims are denied as a result of medical review interventions or automated edits, or if a vulnerability is identified for a particular provider of ambulance services, Local Provider Education and Training is critical. We will encourage our carriers to examine this report and their CERT error rate and then take appropriate local educational actions as necessary. In addition, we will direct the intermediaries and carriers to broadly educate hospitals and ambulance suppliers on the proper billing of transport claims.