AUG 25 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006 (A-01-08-00505)

The attached final report provides the results of our review of payments for ambulance transportation provided to beneficiaries in skilled nursing facility (SNF) stays covered under Medicare Part A in calendar year (CY) 2006.

Under the prospective payment system, some ambulance transportation provided by outside suppliers to SNF residents is included in the SNFs' Medicare Part A payments and is subject to consolidated billing. Therefore, Medicare Part B payments that suppliers receive for the transportation are overpayments.

The objective of our review was to determine whether ambulance suppliers complied with consolidated billing requirements in CY 2006.

Ambulance suppliers did not always comply with consolidated billing requirements in CY 2006. Of the 114 claims that we reviewed, 61 claims totaling $26,983 were incorrectly billed to Medicare Part B for transporting beneficiaries to receive services that did not suspend or end their SNF resident status and were not related to dialysis. The ambulance transportation was thus subject to consolidated billing and should not have been billed to Medicare Part B. As a result, the Medicare program paid twice for the ambulance transportation: once to the SNF under the Part A prospective payment system and again to the ambulance supplier under Part B. For the 53 remaining claims, suppliers correctly billed Part B for transportation excluded from consolidated billing because the transportation either ended the beneficiaries' SNF resident status or was for services that suspended their SNF resident status or were related to dialysis services.

Based on our sample results, we estimated that Medicare Part B carriers made a total of $12.7 million in potential overpayments to suppliers for ambulance transportation provided to beneficiaries in Part A SNF stays in CY 2006. These potential overpayments occurred because

ambulance suppliers did not have the necessary controls to prevent incorrect billing to Medicare Part B and because SNFs did not always provide the suppliers with accurate information regarding SNF residents' Medicare Part A status. In addition, the payment controls in the Centers for Medicare & Medicaid Services' (CMS) Common Working File were not designed to prevent and detect Part B overpayments to ambulance suppliers for all transportation subject to consolidated billing.

We recommend that CMS:

- instruct its carriers to recover the $26,983 in overpayments for the 61 incorrectly billed claims that we identified;

- instruct its carriers to review the 97,799 claims that we did not review, which represent $12.7 million in potential Part B overpayments;

- provide additional guidance on its Web site to assist ambulance suppliers and SNFs in complying with consolidated billing requirements;

- instruct its carriers and fiscal intermediaries to provide guidance to suppliers and SNFs on strengthening billing controls to ensure compliance with consolidated billing requirements, including timely and accurate communication between suppliers and SNFs regarding beneficiaries' Medicare Part A status; and

- either establish additional edits in its Common Working File to prevent and detect Part B overpayments for ambulance transportation subject to consolidated billing or instruct its carriers to develop a postpayment data match and recover any identified overpayments.

In comments on our draft report, CMS concurred with our recommendations.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

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 email at George.Reeb@oig.hhs.gov. Please refer to report number A-01-08-00505 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PAYMENTS FOR AMBULANCE TRANSPORTATION PROVIDED TO BENEFICIARIES IN SKILLED NURSING STAYS COVERED UNDER MEDICARE PART A IN CALENDAR YEAR 2006

Daniel R. Levinson
Inspector General

August 2009
A-01-08-00505

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Section 1888(e) of the Social Security Act (the Act) established a Medicare prospective payment system for skilled nursing facilities (SNF). Under the prospective payment system, most of the services that outside suppliers provide to SNF residents are included in the SNFs' Medicare Part A payments. Accordingly, pursuant to the Act's consolidated billing requirements, SNFs are responsible for billing Medicare Part A for these services, and suppliers are responsible for billing the SNFs. Therefore, Medicare Part B payments that suppliers receive for these services are overpayments.

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.

Federal regulations state that, with the exception of transportation to receive dialysis services, the SNF benefit includes ambulance transportation provided to SNF residents during a covered Part A stay. The consolidated billing provision applies only to those services that are provided to SNF residents. 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.

Our nationwide audit covered 97,913 Medicare Part B ambulance claims valued at $23,679,926 with dates of service in calendar year (CY) 2006 that matched 46,694 Part A SNF stays and that thus represented potential overpayments.

OBJECTIVE

The objective of our review was to determine whether ambulance suppliers complied with consolidated billing requirements in CY 2006.

SUMMARY OF FINDINGS

Ambulance suppliers did not always comply with consolidated billing requirements in CY 2006. Of the 114 claims that we reviewed, 61 claims totaling $26,983 were incorrectly billed to Medicare Part B for transporting beneficiaries to receive services that did not suspend or end their SNF resident status and were not related to dialysis. The ambulance transportation was thus subject to consolidated billing and should not have been billed to Medicare Part B. As a result, the Medicare program paid twice for the ambulance transportation: once to the SNF under the Part A prospective payment system and again to the ambulance supplier under Part B. For the 53 remaining claims, suppliers correctly billed Part B for transportation excluded from consolidated billing because the transportation either ended the beneficiaries' SNF resident status or was for services that suspended their SNF resident status or were related to dialysis.

Based on our sample results, we estimated that Medicare Part B carriers made a total of $12.7 million in potential overpayments to ambulance suppliers for transportation provided to beneficiaries in Part A SNF stays in CY 2006. These potential overpayments occurred because ambulance suppliers did not have the necessary controls to prevent incorrect billing to Medicare Part B and because SNFs did not always provide the suppliers with accurate information regarding SNF residents' Medicare Part A status. In addition, the payment controls in the Centers for Medicare & Medicaid Services' (CMS) Common Working File were not designed to prevent and detect Part B overpayments to ambulance suppliers for all transportation subject to consolidated billing.

RECOMMENDATIONS

We recommend that CMS:

- instruct its carriers to recover the $26,983 in overpayments for the 61 incorrectly billed claims that we identified;

- instruct its carriers to review the 97,799 claims that we did not review, which represent $12.7 million in potential Part B overpayments;

- provide additional guidance on its Web site to assist ambulance suppliers and SNFs in complying with consolidated billing requirements;

- instruct its carriers and fiscal intermediaries to provide guidance to suppliers and SNFs on strengthening billing controls to ensure compliance with consolidated billing requirements, including timely and accurate communication between suppliers and SNFs regarding beneficiaries' Medicare Part A status; and

- either establish additional edits in its Common Working File to prevent and detect Part B overpayments for ambulance transportation subject to consolidated billing or instruct its carriers to develop a postpayment data match and recover any identified overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations. CMS's comments are included in their entirety as Appendix E.

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INTRODUCTION

BACKGROUND

Prospective Payment System and Consolidated Billing Regulations

Section 1888(e) of the Social Security Act (the Act) established a prospective payment system for skilled nursing facilities (SNF) for cost-reporting periods beginning on or after July 1, 1998. Under the prospective payment system, Medicare Part A pays SNFs through per diem, prospective, case-mix-adjusted payment rates that cover virtually all of their costs for furnishing services to Medicare beneficiaries. Accordingly, 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 provided to beneficiaries in SNF stays covered under Part A, including services that outside suppliers provide under arrangement. 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 Included in Consolidated Billing

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. 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.

Ambulance Transportation Excluded From Consolidated Billing

The SNF consolidated billing requirement applies only to those services that are provided to a SNF resident. As a result, ambulance transportation that begins or ends beneficiaries' SNF stays is excluded from consolidated billing. 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. 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.

Ambulance transportation to receive dialysis services is statutorily excluded from consolidated billing.

Medicare Contractors

Medicare Part B carriers, under contract with the Centers for Medicare & Medicaid Services (CMS), process and pay claims submitted by noninstitutional providers, including ambulance

suppliers. Medicare Part A fiscal intermediaries process and pay Part A and Part B claims submitted by institutional providers, including hospitals and SNFs.[1]

Common Working File Edits To Prevent and Detect Overpayments

To prevent and detect Part B overpayments made on behalf of beneficiaries in Part A SNF stays, CMS implemented comprehensive edits in its Common Working File in calendar year (CY) 2002 for most types of Part B services (e.g., outpatient, radiology, and laboratory services). However, 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. 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.

Prior Office of Inspector General Reports

Prior Office of Inspector General audits, which are listed in Appendix A, identified a total of $431.3 million in potential Medicare Part B overpayments to various types of suppliers on behalf of beneficiaries during Part A SNF stays during CYs 1998−2003.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether ambulance suppliers complied with consolidated billing requirements in CY 2006.

Scope

Our nationwide audit covered 97,913 Medicare Part B ambulance claims valued at $23,679,926 with dates of service in CY 2006 that matched 46,694 Part A SNF stays and that thus represented potential overpayments.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at CMS, the Medicare carriers, or the ambulance suppliers. Therefore, we limited our review of internal controls at CMS and selected carriers to the payment controls in place to prevent and detect Part B overpayments to ambulance suppliers for transportation already included in 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.

[1]Since October 2005, CMS has transferred some contracted services from carriers and fiscal intermediaries to Medicare administrative contractors.

Our fieldwork consisted of contacting ambulance suppliers; SNFs; and third-party providers, including outpatient hospitals, physician offices, and dialysis facilities, nationwide from September 2008 through March 2009. We also contacted two Medicare carriers.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and Medicare program guidance;

- used data from CMS's National Claims History file to perform a nationwide computer match of ambulance, SNF, and outpatient claims and eliminated ambulance transportation excluded from consolidated billing to determine the number of potential Medicare Part B overpayments to ambulance suppliers for CY 2006 (Appendix B);

- selected a stratified random sample of 100 claims from the 97,899 ambulance claims identified by our computer match with paid amounts of $2,000 or less and reviewed all 14 claims that had paid amounts greater than $2,000, for a total of 114 claims reviewed (Appendix C);

- reviewed available data from CMS's Common Working File for the 114 ambulance claims and the corresponding SNF and outpatient claims to validate the results of our computer match;

- contacted representatives from 81 of the 95 ambulance suppliers that submitted the 114 claims[2] to confirm the overpayments and to determine the underlying causes of noncompliance with Medicare requirements;

- contacted the SNFs associated with the ambulance claims to verify admission and discharge dates and to determine the reason for the ambulance transportation;

- contacted the third-party providers associated with the ambulance claims to determine what services the beneficiaries had received and whether the third-party providers had billed Medicare for the services;

- contacted CMS and two of its carriers to obtain an understanding of how the consolidated billing edits in the Common Working File prevent and detect Medicare Part B overpayments to ambulance suppliers;

- estimated the potential overpayments that Medicare Part B carriers made to ambulance suppliers nationwide in CY 2006 (Appendix D); and

- discussed the results of our review with CMS.

[2]Most of the 14 remaining suppliers were no longer in business or were under investigation by the Office of Inspector General.

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 objective.

FINDINGS AND RECOMMENDATIONS

Ambulance suppliers did not always comply with consolidated billing requirements in CY 2006. Of the 114 claims that we reviewed, 61 claims totaling $26,983 were incorrectly billed to Medicare Part B for transporting beneficiaries to receive services that did not suspend or end their SNF resident status and were not related to dialysis. The ambulance transportation was thus subject to consolidated billing and should not have been billed to Medicare Part B. As a result, the Medicare program paid twice for the ambulance transportation: once to the SNF under the Part A prospective payment system and again to the ambulance supplier under Part B. For the 53 remaining claims, suppliers correctly billed Part B for transportation excluded from consolidated billing because the transportation either ended the beneficiaries' SNF resident status or was for services that suspended their SNF resident status or were related to dialysis.

Based on our sample results, we estimated that Medicare Part B carriers made a total of $12.7 million in potential overpayments to ambulance suppliers for transportation provided to beneficiaries in Part A SNF stays in CY 2006. These potential overpayments occurred because ambulance suppliers did not have the necessary controls to prevent incorrect billing to Medicare Part B and because SNFs did not always provide the suppliers with accurate information regarding SNF residents' Medicare Part A status. In addition, the payment controls in CMS's Common Working File were not designed to prevent and detect Part B overpayments to ambulance suppliers for all transportation subject to consolidated billing.

PROGRAM REQUIREMENTS

The "Medicare Benefit Policy Manual," Pub. No. 100-02, chapter 3, section 20, states that 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.

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. 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.

Consolidated billing applies only to services provided to SNF residents. Because a beneficiary is not a SNF resident at the beginning or end of a SNF stay, 42 CFR § 411.15(p)(2)(x) provides that ambulance services that begin or end a beneficiary's status as a SNF resident are not subject to consolidated billing. 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," Pub. No. 100-04, chapter 6, section 20.1.2, further defines these excluded outpatient hospital services as emergency services and certain intensive procedures.[3] Because the beneficiary receiving these services is temporarily not a SNF resident, ambulance transportation associated with these services is excluded from consolidated billing.

Moreover, ambulance transportation provided in connection with dialysis services is statutorily excluded from consolidated billing pursuant to section 1888(e)(2)(A)(ii) of the Act.

INCORRECT PART B BILLING

For 61 of the 114 claims that we reviewed, ambulance suppliers incorrectly billed Medicare Part B for transporting beneficiaries to receive services that did not suspend or end their SNF resident status and that were not related to dialysis. These claims were thus subject to consolidated billing. The incorrectly billed claims were for transporting beneficiaries, mostly to outpatient hospitals, to receive services that included x-rays, ultrasounds, and minor outpatient surgical procedures. The incorrect billing resulted in overpayments totaling $26,983.

Based on the results of our statistical sample and our additional review of all claims that exceeded $2,000, we estimated that Medicare Part B carriers nationwide made a total of $12.7 million in potential overpayments to ambulance suppliers for transportation subject to consolidated billing.

CAUSES OF OVERPAYMENTS

Inadequate Controls at Ambulance Suppliers and Skilled Nursing Facilities

Ambulance suppliers did not have the necessary controls to prevent the incorrectly billed claims that we identified. Specifically, suppliers did not fully understand that some third-party services, such as ultrasounds, suture removals, and blood transfusions, did not suspend beneficiaries' SNF resident status and were thus subject to consolidated billing. In some instances, ambulance suppliers incorrectly believed that the transportation was for services that were excluded from consolidated billing (e.g., an MRI). However, in these instances, the services that the beneficiaries actually received at the outpatient facility (e.g., an ultrasound) were different from

[3]Examples of these services and procedures include certain types of cardiac catheterization, computerized axial tomography scans, magnetic resonance imaging (MRI), 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.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp. Accessed on April 17, 2009.

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.

In addition, SNFs did not always accurately communicate beneficiaries' Part A SNF resident status to ambulance suppliers, and the suppliers did not obtain confirmation of such status from SNFs before billing Medicare. Instead, the suppliers mistakenly assumed that the beneficiaries' Part A benefits had ended and that the beneficiaries were covered under Part B.

Inadequate Medicare Payment Controls

Medicare Part B carriers made overpayments to ambulance suppliers for transportation subject to consolidated billing because the payment controls in CMS's Common Working File were not designed to prevent and detect these overpayments. Specifically, the Common Working File did not have edits that were (1) based on applicable Healthcare Common Procedure Codes and revenue center codes and (2) designed to identify transportation for services that did not suspend the beneficiaries' SNF resident status and were not related to dialysis services.

Example: Overpayment Billed by Supplier and Undetected by Edit

An ambulance supplier transported a SNF resident covered under Medicare Part A to a hospital to receive a scheduled wound debridement. Because this nonemergency service did not suspend the beneficiary's SNF resident status, the transportation was subject to consolidated billing. However, the supplier billed Part B instead of the SNF because the supplier was unaware that wound debridement is a minor surgical procedure that does not suspend or end the beneficiary's SNF resident status. The Common Working File edits did not identify the ambulance service as subject to consolidated billing because the edits were not designed to detect claims for transporting SNF residents to hospitals for nonemergency outpatient services. As a result, Medicare paid for the ambulance service twice.

RECOMMENDATIONS

We recommend that CMS:

- instruct its carriers to recover the $26,983 in overpayments for the 61 incorrectly billed claims that we identified;

- instruct its carriers to review the 97,799 claims that we did not review, which represent $12.7 million in potential Part B overpayments;

- provide additional guidance on its Web site to assist ambulance suppliers and SNFs in complying with consolidated billing requirements;

- instruct its carriers and fiscal intermediaries to provide guidance to suppliers and SNFs on strengthening billing controls to ensure compliance with consolidated billing requirements, including timely and accurate communication between suppliers and SNFs regarding beneficiaries' Medicare Part A status; and

- either establish additional edits in its Common Working File to prevent and detect Part B overpayments for ambulance transportation subject to consolidated billing or instruct its carriers to develop a postpayment data match and recover any identified overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations. CMS stated that it would recover the overpayments consistent with its policies and procedures and requested that we furnish the data necessary for it to review claims and recover the overpayments. CMS also stated that it had published provider education materials relating to ambulance transportation subject to consolidated billing and described other corrective actions planned or already underway. CMS's comments are included in their entirety as Appendix E.

As requested, we provided the data necessary for CMS to initiate its review and recovery effort.

APPENDIXES

APPENDIX A

PREVIOUS OFFICE OF INSPECTOR GENERAL REPORTS ON MEDICARE PART B PAYMENTS MADE ON BEHALF OF BENEFICIARIES DURING PART A SKILLED NURSING FACILITY STAYS

Report Title and Number[1]	Period Covered by Review	Total Overpayments Identified	Issue Date
"Review of Compliance With the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities" (A-01-99-00531)	Oct. 1, 1998 – April 30, 1999	$0	Mar. 27, 2000
"Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System" (A-01-00-00538)	Calendar year (CY) 1999	$47.6 million[2]	June 5, 2001
"Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities" (A-01-00-00509)	CYs 1996 – 1998	$35 million	July 23, 2001
"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" (A-01-01-00513)	CYs 1999 – 2000	$10.5 million	Oct. 17, 2001
"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" (A-01-02-00513)	CYs 1999 – 2003	$108.3 million	May 28, 2004
"Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A" (A-01-05-00511)	CYs 1999 – 2003	$112 million	June 26, 2007
"Payments for Outpatient Hospital, Laboratory, and Radiology Services Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A" (A-01-06-00503)	CYs 2001– 2003	$124.8 million	Jan. 30, 2008

[1]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 http://oig.hhs.gov.

[2]As noted in report number A-01-02-00513, we reduced the $47.6 million to $40.7 million to account for improper payments refunded by suppliers after this review, as well as refinements in our matching methodology.

COMPUTER MATCH METHODOLOGY TO IDENTIFY POTENTIAL OVERPAYMENTS

COMPILING DATA TO IDENTIFY POTENTIAL OVERPAYMENTS

Skilled Nursing Facility Data

For skilled nursing facility (SNF) claims, we:

- extracted claim information from the National Claims History file for CY 2006;
- limited the population to claims with revenue center code 0022, denoting a prospective payment;
- eliminated claims involving hospital swing beds (type of bill 18X);
- eliminated claims for managed care organization enrollees (condition code 04); and
- sorted claims by beneficiary and admission date and grouped the sorted claims together to identify SNF stays.

Outpatient Data

For outpatient claims, we:

- extracted paid claim information from the National Claims History file for CY 2006 for dialysis and related services, as identified by revenue center codes 0820–0859, and
- extracted paid claim information from the National Claims History file for CY 2006 for:
    - emergency room services, as identified by revenue center codes 0450–0459, and
    - intensive services excluded from consolidated billing, as identified by applicable Healthcare Common Procedure Coding System (HCPCS) codes in program guidance from the Centers for Medicare & Medicaid Services (CMS).

Ambulance Data

For ambulance claims, we:

- extracted paid claim information from the National Claims History file for CY 2006, as denoted by type of service code D (ambulance) and place of service code 41 (land only), and
- matched the paid claim information to the grouped SNF stays based on beneficiaries' health insurance claim numbers from the SNF claim data.

IDENTIFYING POTENTIAL OVERPAYMENTS

To identify potential overpayments, we eliminated the following allowable ambulance transportation and professional services:

- transportation that had a $0 Medicare payment, $0 coinsurance payment, and $0 deductible;
- services provided during ambulance transportation with an HCPCS modifier indicating a professional component;
- transportation that matched outpatient claims for dialysis and related services, as identified by revenue center codes 0820–0859;
- transportation that matched outpatient claims billed the day before, the day after, or the same day for:
    - emergency room services, as identified by revenue center codes 0450–0459, and
    - intensive services excluded from consolidated billing, as identified by the applicable HCPCS codes in CMS program guidance;
- transportation provided during the noncovered portion of the SNF stay; and
- transportation provided on the day of SNF admission or discharge.

SAMPLING DESIGN AND METHODOLOGY

POPULATION

The population consisted of claims for ambulance transportation provided to beneficiaries in Part A SNF stays during CY 2006.

SAMPLING FRAME

The sampling frame was a database of 97,913 claims totaling $23,679,926 for ambulance transportation provided to beneficiaries in Part A SNF stays during CY 2006. We stratified the frame into three strata based on Medicare paid amounts. Stratum 1 consisted of 63,104 claims for which Medicare paid $0 to $250, stratum 2 consisted of 34,795 claims for which Medicare paid $250.01 to $2,000, and stratum 3 consisted of 14 claims for which Medicare paid more than $2,000.

SAMPLE UNIT

The sample unit was a claim billed by an ambulance supplier on behalf of a beneficiary in a Part A SNF stay.

SAMPLE DESIGN

We used a stratified random sample.

SAMPLE SIZE

We selected 60 ambulance claims from stratum 1 and 40 from stratum 2. We also reviewed all 14 claims in stratum 3, for a total of 114 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 63,104 for stratum 1 and from 1 to 34,795 for stratum 2. After generating 60 random numbers for stratum 1 and 40 for stratum 2, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the potential overpayments.

SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Sample Size	Value of Sample	Number of Incorrectly Billed Claims	Value of Incorrectly Billed Claims
Payments of $0 to $250.00	63,104	60	$11,209	34	$6,236
Payments of $250.01 to $2,000	34,795	40	13,629	21	7,035
Payments greater than $2,000	14	14	36,194	6	13,712
Total	**97,913**	**114**	**$61,032**	**61**	**$26,983**

Estimated Value of Incorrectly Billed Claims
(*Limits Calculated for a 90-Percent Confidence Interval*)

Point estimate	$12,691,511
Lower limit	$10,648,596
Upper limit	$14,734,427

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL 30 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report: "Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered under Medicare Part A in Calendar Year 2006" (A-01-08-00505)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to respond to the Office of Inspector General's (OIG) draft report, "Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered under Medicare Part A in Calendar Year 2006." The objective of the review was to determine whether ambulance suppliers complied with consolidated billing requirements in calendar year (CY) 2006. The OIG found that some ambulance suppliers incorrectly billed Medicare. Like the OIG, CMS is concerned that ambulance suppliers did not always comply with consolidated billing requirements in CY 2006.

When the skilled nursing facility prospective payment system (SNF PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. Under the SNF consolidated billing provision of the Social Security Act, the Medicare billing responsibility is placed with the SNF itself for most of its residents' services. The SNF consolidated billing requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare claims processing contractor almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision.

These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare claims processing contractor, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B claims processing contractor. Ambulance services have not been identified as a type of service that is categorically excluded from the consolidated billing provisions, and certain types of ambulance transportation have been identified as being separately billable in specific situations, as you describe in your report.

OIG Recommendation

CMS should instruct its carriers to recover the $26,983 in overpayments for the 61 incorrectly billed claims that we identified.

CMS Response

We concur with this recommendation. CMS agrees that the $26,983 in overpayments should be recovered. CMS plans to recover the overpayments identified consistent with the Agency's policies and procedures, which includes limiting recoveries to those recoveries that are administratively cost effective.

The OIG will be required to furnish, for each overpayment or potential overpayment, the data necessary (Medicare contractor numbers, provider numbers, claims information - including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor-specific data should be written to separate CD-ROMs or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

CMS should instruct its carriers to review the 97,799 claims that the OIG did not review, which represent $12.7 million in potential Part B overpayments.

CMS Response

We concur with this recommendation. CMS will share the OIG report and any additional claim information received from the OIG with the Medicare claims administration contractors. CMS will instruct the Medicare contractors to consider the issues identified in this report and the additional claim information when prioritizing their medical review strategies or other interventions. This information will also be provided to the Recovery Audit Contractors to determine if this is an area they wish to conduct review for claims on or after October 1, 2007.

OIG Recommendation

CMS should provide additional guidance on its Web site to assist ambulance suppliers and SNFs in complying with consolidated billing.

CMS Response

We concur with this recommendation. On January 9, CMS published an MLN Matters Special Edition article on "Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services" (MLN matters Number SE0433) to provide additional guidance and describe SNF

Consolidated Billing as it applies to ambulance services. This article is available online at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0433.pdf.

OIG Recommendation

CMS should instruct its carriers and fiscal intermediaries to provide guidance to suppliers and SNFs on strengthening billing controls to ensure compliance with consolidated billing requirements, including timely and accurate communication between suppliers and SNFs regarding beneficiaries' Medicare Part A status.

CMS Response

We concur with this recommendation. CMS issued a manual instruction on May 21, 2004, and December 23, 2004, to explain to the Medicare contractors, SNFs, and suppliers of the requirement that must be met in order for Medicare SNFs to have a valid "arrangement" in effect with an outside supplier in order to prevent potential problems. In addition, on January 24, 2005, CMS published an MLN Matters article on "Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under an "Arrangement" with an Outside Entity" (MLN Matters number MM3592) to further clarify the purpose of arrangements between suppliers and SNFs. This article is available online at www.cms.hhs.gov/MLNMattersArticles/downloads/MM3592.pdf.

OIG Recommendation

CMS should either establish additional edits in its Common Working File to prevent and detect Part B overpayments for ambulance transportation subject to consolidated billing or instruct its carriers to develop a postpayment data match and recover any identified overpayments.

CMS Response

We concur with the OIG's recommendation and the need to ensure proper payments are made in regard to ambulance transportation subject to the SNF consolidated billing requirement. By September 2009, we will complete our research and analyses to determine if the OIG's suggested solutions would work the best or whether another solution should be considered. Pending the results of our analyses, we will complete implementation of the identified solution by April 2010.

In closing, your report provides additional insight to the billing practices of ambulance suppliers. We appreciate your attention to the SNF consolidated billing policy as it relates to ambulance services. We look forward to working with you to address this very important issue.