



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

February 15, 2007

Report Number: A-06-06-00046

Ms. Susan DeVore
Assistant Vice President
Corporate Compliance Officer
Covenant Health System
3615 19th Street
Lubbock, Texas 79410

Dear Ms. DeVore:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Audit of Air Ambulance Claims Paid to Covenant Health System During Calendar Year 2002." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to report number A-06-06-00046 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink that reads "Gordon L. Sato".

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures-as stated

Direct Reply to HHS Action Official:

Tom Lenz
Regional Administrator
Centers for Medicare and Medicaid Services
Region VII
Richard Bolling Federal Building Room 235
601 East 12th Street
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF AIR AMBULANCE
CLAIMS PAID TO COVENANT
HEALTH SYSTEM DURING
CALENDAR YEAR 2002**



Daniel R. Levinson
Inspector General

February 2007
A-06-06-00046

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health care coverage to people age 65 and over, the disabled, and people with end-stage renal disease. Administered by the Centers for Medicare & Medicaid Services, the program consists of four parts, including Part B, Supplemental Medical Insurance. Part B covers a multitude of medical and other health care services, including air ambulance services. Medicare fiscal intermediaries process Part B claims for hospital-based air ambulance providers.

Medicare Air Ambulance Services

Medicare reimburses air ambulance providers for transporting Medicare patients by airplane (fixed wing aircraft) or helicopter (rotary wing aircraft). To be covered by Medicare, air ambulance services must be medically reasonable, necessary, and appropriate.

Covenant

Covenant Health System (Covenant) is a health care institution based in Lubbock, Texas. Covenant operates a hospital-based air ambulance service that provides 24-hour fixed wing and rotary wing air transportation services for Covenant Medical Center, Covenant Medical Center-Lakeside, and Covenant Children's Hospital, which are also in Lubbock.

OBJECTIVE

Our objective was to determine whether 100 air ambulance claims for which Covenant received payment during calendar year 2002 were allowable in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Covenant improperly billed the Medicare program for air ambulance services for 24 of the 100 sample claims, resulting in Medicare overpayments totaling \$15,183 during calendar year 2002. Specifically, Covenant improperly billed for:

- air transportation that was not documented as medically necessary and appropriate (14 claims),
- mileage beyond the nearest hospitals with appropriate facilities to treat the patients (6 claims),
- inaccurate mileage (3 claims), and

- rotary wing transport when fixed wing transport was provided (1 claim).

Covenant improperly billed the Medicare program for these air ambulance claims because it did not have effective policies and procedures in place to ensure that these services were (1) medically necessary and appropriate and (2) correctly billed to Medicare.

RECOMMENDATIONS

We recommend that Covenant refund to the Medicare program \$15,183 in overpayments it received for air ambulance services during calendar year 2002. Covenant should establish procedures to ensure that it bills Medicare only for:

- services that are medically necessary and appropriate,
- mileage to the nearest hospital with appropriate facilities to treat the patient's illness or injury,
- accurate mileage, and
- services using the correct billing code.

COVENANT HEALTH SYSTEM'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

Covenant had a physician perform a medical review of the improperly billed claims, and, as a result, disagreed with two of our four report findings. Specifically, Covenant disagreed that it had improperly billed for:

- air transportation that was not documented as medically necessary and appropriate and
- mileage beyond the nearest hospital with appropriate facilities to treat the patient.

Although Covenant provided a summary of the physician's review, it did not provide additional medical records to support the physician's conclusions and refute our findings. For one of the claims disallowed due to mileage beyond the nearest hospital with appropriate facilities, Covenant stated that the nearest hospital refused the transfer because a bed was unavailable. We reviewed the information previously obtained and found that Covenant's assertion was correct. Therefore, we removed this claim from our findings; however, due to Medicare's reimbursement methodology for air ambulance claims, removing the claim from our findings did not affect the overpayment amount. We continue to believe that Covenant should refund the entire \$15,183.

Covenant's written comments on our draft report are included as the Appendix.

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INTRODUCTION

BACKGROUND

Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health care coverage to people age 65 and over, the disabled, and people with end-stage renal disease. Administered by the Centers for Medicare & Medicaid Services (CMS), the program consists of four parts, including Part B, Supplemental Medical Insurance. Part B covers a multitude of medical and other health care services, including air ambulance services. Medicare fiscal intermediaries process Part B claims for hospital-based air ambulance providers. Mutual of Omaha is the fiscal intermediary that processes claims for Covenant Health System's (Covenant) air ambulance services.

Medicare Air Ambulance Services

Medicare reimburses air ambulance providers for transporting Medicare patients by airplane (fixed wing aircraft) or helicopter (rotary wing aircraft). To be covered by Medicare, air ambulance services must be medically reasonable, necessary, and appropriate. The patient's condition should be such that transportation by either a basic or an advanced life support ground ambulance would pose a threat to the patient's survival or seriously endanger the patient's health due to the distance to the hospital, ground transport time requirements, or unstable weather conditions.

Covenant

Covenant is a health care institution based in Lubbock, Texas. Its major hospitals include Covenant Medical Center, Covenant Medical Center-Lakeside, and Covenant Children's Hospital, which are also in Lubbock. Covenant operates a hospital-based air ambulance service under the business name "AeroCare," which provides 24-hour critical care fixed wing and rotary wing air ambulance services for these hospitals. Covenant bills Medicare and receives payment for these air ambulance services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether 100 air ambulance claims for which Covenant received payment during calendar year 2002 were allowable in accordance with Medicare reimbursement requirements.

Scope

We selected Covenant as part of a nationwide review of air ambulance services. In calendar year 2002, Covenant received about \$1.6 million in Medicare payments for 545 air ambulance claims.

We did not assess Covenant's overall internal control structure. We limited our internal control review to obtaining an understanding of the policies and procedures Covenant used to arrange air ambulance transports and bill Medicare for them. We conducted our fieldwork at Covenant in Lubbock, Texas.

Methodology

To accomplish our objective, we:

- reviewed the applicable Federal regulations and Medicare requirements;
- interviewed Covenant officials to obtain an understanding of the policies and procedures Covenant used to arrange air ambulance transports and bill Medicare for them;
- identified all of the Medicare claims for air ambulance services paid to Covenant in calendar year 2002 and selected a random sample of 100 claims for review;
- obtained Covenant's air ambulance medical and billing records for the sample claims; and
- obtained the originating hospitals' medical records, if applicable, and the destination hospitals' medical records for the sample claims (for the 24-hour period before and after transport).

We contracted with Nebraska-based IntegriGuard, LLC (IntegriGuard), a program safeguard contractor for CMS, to conduct a medical review of the documentation for the sample claims. IntegriGuard reviewed the 100 claims to determine whether Covenant:

- documented services as medically necessary and appropriate;
- billed Medicare only for transportation to the nearest acute care hospital with appropriate facilities;
- calculated and billed mileage correctly;
- billed for duplicate, or "unbundled," services or equipment; and
- overcharged Medicare because it was the secondary payer.

Because our audit period overlapped two of Covenant's fiscal years, Mutual of Omaha calculated the Medicare overpayment for us by removing the value of the improperly billed claims from the applicable years' cost reports.¹

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

FINDINGS AND RECOMMENDATIONS

Covenant improperly billed Medicare for air ambulance services for 24 of the 100 sample claims, resulting in overpayments totaling \$15,183 during calendar year 2002. Specifically, Covenant improperly billed for:

- air transportation that was not documented as medically necessary and appropriate (14 claims),
- mileage beyond the nearest hospitals with appropriate facilities to treat the patients (6 claims),
- inaccurate mileage (3 claims), and
- rotary wing transport when fixed wing transport was provided (1 claim).

Covenant improperly billed these air ambulance claims because it did not have effective policies and procedures to ensure that these services were (1) medically necessary and appropriate and (2) correctly billed to Medicare. During the conference to discuss our audit findings, Covenant officials told us that they were in the process of implementing quality control procedures for reviewing air ambulance claims for medical necessity and appropriateness.

IMPROPERLY BILLED AIR AMBULANCE SERVICES

Air Transportation Not Documented as Medically Necessary and Appropriate

For 14 claims, Covenant billed for air ambulance transports that were not documented as medically necessary and appropriate. In these instances, the medical records indicated that the beneficiary did not require any type of ambulance service or that air transportation was inappropriate because the patient could have been transported by ground.

Medical Records Indicated Beneficiaries Did Not Require Ambulance Service

Regulations (42 CFR § 410(d)(1)) state:

Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that

¹Covenant's fiscal year is July 1 to June 30. Our audit period was calendar year 2002, which encompassed the second half of Covenant's fiscal year 2002 (January 1 to June 30, 2002), and the first half of Covenant's fiscal year 2003 (July 1 to December 31, 2002).

other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation and the level of service provided in order for the billed services to be considered medically necessary.

For five claims, Covenant billed for air ambulance services when the medical records indicated that the beneficiaries did not require any type of ambulance transport, resulting in \$3,359 in overpayments. In all five instances, the medical reviewer determined that the documentation did not support the medical necessity of ambulance transport. For a claim in which a beneficiary was transferred from one hospital to another, the medical reviewer stated that the documentation indicated that the beneficiary chose to be transferred and that the beneficiary could have been transported by other means, such as a private vehicle.

Medical Records Indicated Ground Transportation Was Appropriate

The "Medicare Intermediary Manual," part III, chapter II, section 3114.11(b), states: "Medical appropriateness [of air ambulance transportation] is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by land, or the instability of transportation by land, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health."

For nine claims, Covenant billed for air ambulance transportation when the medical records indicated that ground transportation would have been appropriate, resulting in \$9,820 in overpayments. In all nine instances, the IntegriGuard medical reviewer determined that the medical records supported the need for ground ambulance transportation but did not meet the Medicare requirements for air transportation. In one case, for example, the medical reviewer stated that the beneficiary was stable, his symptoms were controlled, and that ground ambulance transportation would have safely accomplished the needed transfer.

Mileage Beyond the Nearest Hospital With Appropriate Facilities

Regulations (42 CFR § 410.40(e)) state that Medicare covers ambulance transports from "any point of origin to the nearest hospital . . . that is capable of furnishing the required level and type of care for the beneficiary's illness or injury."

For six claims, Covenant billed air ambulance mileage for beneficiaries transported beyond the nearest hospitals with appropriate facilities to treat them, resulting in \$1,495 in overpayments. In all six instances, the medical reviewer determined that there were other appropriate facilities available that were closer than the facilities to which Covenant transported the beneficiaries.

In one instance, Covenant transported the beneficiary from Lincoln County Medical Center in Ruidoso, New Mexico, to Covenant Medical Center in Lubbock, Texas, because the patient was experiencing weakness, nausea, and vomiting. The medical reviewer stated that Presbyterian Hospital in Albuquerque, New Mexico, which is 84 miles closer than Lubbock, was the nearest acute care hospital. Covenant billed the full 217 miles from Ruidoso to Lubbock, rather than billing only the 133 miles to the nearest hospital with appropriate facilities.

Billed for Inaccurate Mileage

Title XVIII of the Social Security Act, § 1862(a)(1)(A), states that no payment may be made under Medicare Part A or Part B for items or services that are not reasonable and necessary.

For three claims, Covenant billed unsupported mileage amounts, resulting in \$84 in overpayments. The medical reviewer partially denied the three claims because the mileage billed was 3, 6, and 7 miles more than the mileage indicated in Covenant's clinical records.

Billed for Rotary Wing Transport When Fixed Wing Transport Was Provided

The "Medicare Claims Processing Manual," chapter 15, section 30, states that air ambulance services are to be billed using the following Healthcare Common Procedure Coding System billing codes:

- A0430 – Ambulance service, fixed wing
- A0431 – Ambulance service, rotary wing
- A0435 – Air mileage, fixed wing
- A0436 – Air mileage, rotary wing

For one claim, Covenant used rotary wing billing codes to bill for transport when fixed wing transport was provided, resulting in a \$425 overpayment.

Lacked Effective Policies and Procedures

Covenant improperly billed the 24 air ambulance claims because it did not have effective policies and procedures in place to ensure that these services were (1) medically necessary and appropriate and (2) correctly billed to Medicare.

During the conference to discuss our audit findings, Covenant officials told us that they were in the process of implementing quality control procedures in which two physicians and a nurse would review air ambulance claims for medical necessity and appropriateness after they were billed to Medicare.

RECOMMENDATIONS

We recommend that Covenant refund to the Medicare program \$15,183 in overpayments it received for air ambulance services during calendar year 2002. Covenant should establish procedures to ensure that it bills Medicare only for:

- services that are medically necessary and appropriate,
- mileage to the nearest hospital with appropriate facilities to treat the patient's illness or injury,
- accurate mileage, and

- services using the correct billing code.

COVENANT HEALTH SYSTEM'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

At Covenant's behest, a physician performed a medical review of the improperly billed claims. Based on the results, Covenant disagreed with two of our four report findings. Specifically, Covenant disagreed that it had improperly billed for:

- air transportation that was not documented as medically necessary and appropriate and
- mileage beyond the nearest hospital with appropriate facilities to treat the patient.

Covenant said that a State operations manual required the physician at the transferring hospital to determine the appropriate mode of transportation, and that the receiving hospital was obligated to accept these transfers under the Federal Emergency Medical Treatment and Active Labor Act.

Although Covenant provided a summary of the physician's review, it did not provide additional medical records to support its position. We contracted with IntegriGuard, a program safeguard contractor (PSC), to conduct a medical review of the documentation for the sample claims. In accordance with the Health Insurance Portability and Accountability Act of 1996, CMS created PSCs to perform medical reviews and other functions. CMS verified the qualifications of the PSCs when it awarded their contracts and through performance evaluations. IntegriGuard is the PSC with jurisdiction over Medicare Part A providers that, like Covenant, have chosen Mutual of Omaha as their fiscal intermediary. Accordingly, we relied on IntegriGuard's medical review determinations for this review.

In addition, for one claim classified as improperly billed for mileage beyond the nearest hospital with appropriate facilities, Covenant stated that the nearest hospital had refused the transfer because a bed was unavailable. We reviewed the information previously obtained and found that Covenant's assertion was correct. As such, we removed the claim from our findings. Due to Medicare's payment methodology for air ambulance claims, removing the claim from our findings did not affect the overpayment amount.

As a result, we continue to believe that Covenant should refund the entire \$15,183.

Covenant's written comments on our draft report are included as the Appendix. We did not include an attachment to the comments that summarized the physician's review because it contained information that identified patients.

APPENDIX

Covenant Medical Center
3615 19th Street
Lubbock, Texas 79410
806-725-1011 Tel



November 29, 2006

Gordon L. Sato
Regional Inspector General for Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

RE: A-06-06-00046

Dear Mr. Sato,

Thank you for the opportunity to comment on the US Department of Health and Human Services, Office of the Inspector General, Office of Audit Services' draft report entitled "Audit of Air Ambulance Claims Paid to Covenant Health System During Calendar Year 2002."

Covenant understands that in order to be covered by Medicare, air ambulance services must be medically reasonable, necessary, and appropriate. As such, we are committed to ensuring compliance in this area and have taken steps outlined below to ensure process improvement to prevent inadvertent errors. Covenant is also committed to providing the highest quality patient care and ensuring that the continuity of care is provided without delay.

Section 489.24 of the State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 1,05-21-04) Part II sets forth that Covenant, as a qualifying hospital, is required to accept appropriate transfers of individuals with emergency medical conditions if the receiving hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals;" Section 489.24(f) expands on this to require that hospitals such as Covenant having specialized facilities not refuse to accept a transfer from a transferring hospital. **Furthermore, Section 489.24(e)(2)(iv) sets forth that the physician at the transferring hospital has the responsibility to determine the appropriate mode of transportation, equipment, and attendants for transfer.**

Given the citations that I've referenced, we respectfully offer the following comments on each category of review, followed by specific information about each transfer:

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Improperly Billed Air Ambulance Services – 14 cases

With respect to each case reviewed in this area, we believed that the physician at the transferring facility assessed the patient, requested the transfer, and made the determination that air transport was the appropriate mode of transfer given the patient's medical condition. Covenant and Aerocare responded as required by EMTALA in accepting the transfer at the request of the transferring facility based on the recommendation by the treating physician; that the air transfer was medically reasonable, necessary and appropriate.

Mileage Beyond the Nearest Hospital With Appropriate Facilities – 7 cases

With respect to each case reviewed in this area, Covenant was contacted by the transferring hospital and accepted the transfers based on our capability and capacity at that time, fulfilling our EMTALA requirements. Covenant accepted these transfers based on the assumption that the physician at the transferring facility had made the determination that transfer of the patient to Covenant was medically reasonable, necessary and appropriate, and that closer facilities with capabilities were either unable to accept the transfer or not contacted. In one case reviewed by your office, Pecos requested the transfer of a patient to Covenant (Lubbock), though Odessa is closer in proximity to Pecos. Upon review, the clinical record indicates that Odessa refused the transfer of this patient due to unavailability of beds at which time Covenant was subsequently contacted by the Pecos facility to request acceptance of this patient. Covenant was the closest facility with capability in this example, which would make the billing accurate.

Billed for Inaccurate Mileage – 3 cases

Covenant inadvertently billed the mileage for the respective cases inappropriately. This was caused by manual error by an employee who has since left Covenant. In order to mitigate any future errors, employee education will be performed with current staff and a monitoring system put in place with required reporting to Covenant's Compliance Committee quarterly. Covenant will repay the difference between the correct and incorrect amounts.

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Billed for Rotary Wing Transport When Fixed Wing Transport Was Provided – 1 case

It has been determined that this error was due to a manual error by an employee that has since left Covenant. In order to mitigate any future errors, employee education will be performed with current staff and a monitoring system put in place with required reporting to Covenant's Compliance Committee quarterly. The \$ 425.00 overpayment will be repaid.

Lack of Effective Policies and Procedures

As previously referenced, the transferring facility, and not the receiving facility, is required to ensure medical necessity, appropriateness and mode of transfer for its patients per the EMTALA rules. It would seem most appropriate and consistent with the regulation that the treating physician at the transferring facility make the medical necessity determination as to mode of transport. We would appreciate any guidance that your office can provide regarding how a receiving facility (such as Covenant) can effectively conduct a medical necessity review for patients who are in transfer to our facility and have yet to be assessed, except in a retrospective fashion. The flight crew would not be capable of making a medical necessity decision as the responsibility of the crew is to transport the patient at the request of the transferring facility.

The attached spreadsheet summarizes the OIG findings. The last column of the sheet reflects Medical Review by Fred Hagedorn, MD, a 20+ year experienced Emergency Room physician. Dr. Hagedorn is also on the State Advisory Board for Texas Emergency Medical Services and is a member of the Regional Advisory Council for Trauma in West Texas, and is available to answer any question you might have. He can be reached through my office at 806-725-0085.

Thank you for the opportunity to respond. We look forward to your follow up review and comments.

Sincerely,



Susan H. DeVore, RHIA, MBA, CHC
Corporate Compliance Officer
Covenant Health System
3615 19th St.
Lubbock, TX 79410