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

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

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

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

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

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

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

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91703017.asp.