

Report in Brief

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



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 \$17.4 million during the first half of calendar year (CY) 2012 for nonemergency ambulance transports that providers indicated were to destinations not covered by Medicare. This review focuses on payments for CYs 2014 through 2016.

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

How OIG Did This Review

Medicare contractors nation-wide paid providers \$3.2 billion for nonemergency ambulance transports with dates of service from CYs 2014 through 2016 (audit period). We identified claim lines, totaling \$5.5 million, that were paid by Medicare for nonemergency ambulance transports to destinations not covered by Medicare. We also identified claim lines, totaling \$3.2 million, that were paid by Medicare for ground mileage associated with nonemergency 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 Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare

What OIG Found

Medicare made improper payments of \$8.7 million to providers for nonemergency ambulance transports to destinations not covered by Medicare, including the identified ground mileage associated with the transports. Medicare covers ambulance transports to only certain destinations, such as hospitals, skilled nursing facilities (SNFs), and beneficiaries' residences. Medicare also covers these transports from a SNF to the nearest supplier of medically necessary services (diagnostic or therapeutic sites) when the beneficiary is a SNF resident and those services are not available at the SNF. The majority of the improperly billed claim lines (59 percent) were for transports to diagnostic or therapeutic sites, other than a physician's office or a hospital, that did not originate from SNFs. As of the publication of this report, the total improper payment amount of \$8.7 million included claim lines outside of the 4-year claim-reopening period.

What OIG Recommends and CMS Comments

We recommend that the Centers for Medicare & Medicaid Services (CMS) (1) direct the Medicare contractors to recover the portion of the \$8.7 million in improper payments made to providers for claim lines that are within the claim-reopening period; (2) for the remaining portion of the \$8.7 million, which is outside of the Medicare reopening and recovery periods, instruct the Medicare contractors to notify providers of potentially improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments, and identify and track any returned improper payments; (3) direct the Medicare contractors to review claim lines for nonemergency ambulance transports to destinations not covered by Medicare after our audit period and recover any improper payments identified; and (4) require the Medicare contractors to implement nation-wide prepayment edits to ensure that payments to providers for nonemergency ambulance transports comply with Federal requirements.

CMS concurred with our recommendations and described actions it had taken or planned to take to implement our recommendations.