

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE INCORRECTLY PAID  
PROVIDERS FOR EMERGENCY  
AMBULANCE TRANSPORTS  
FROM HOSPITALS TO SKILLED  
NURSING FACILITIES**

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## Report in Brief

Date: September 2019  
Report No. A-09-18-03030

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



### Why OIG Did This Review

A prior OIG review found that Medicare made improper and potentially improper payments of \$1.9 million to providers for emergency ambulance transports to destinations other than hospitals or skilled nursing facilities (SNFs) with dates of service from calendar years (CYs) 2014 through 2016. As part of that review, we identified \$3.2 million in payments for emergency ambulance transports from hospitals to SNFs. Because hospitals are capable of providing emergency services, we conducted this separate review of emergency ambulance transports from hospitals to SNFs to determine the appropriateness of billing for them as emergency ambulance transports.

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

### How OIG Did This Review

Our review covered Medicare Part B payments of \$2.6 million made by Medicare contractors nation-wide for 8,880 claim lines for emergency ambulance transports that providers indicated were from hospitals to SNFs with dates of service from CYs 2015 through 2017 (audit period). We selected a random sample of 100 claim lines and excluded 1 claim line from our review because we were unable to contact the provider. We reviewed the remaining 99 claim lines for billing errors and the impact of any errors on the claim-line payments.

## Medicare Incorrectly Paid Providers for Emergency Ambulance Transports From Hospitals to Skilled Nursing Facilities

### What OIG Found

Medicare payments to providers for emergency ambulance transports from hospitals to SNFs did not comply with Federal requirements. Specifically, providers incorrectly billed all 99 sampled claim lines for emergency ambulance transports that providers indicated were from hospitals to SNFs. For these 99 claim lines, Medicare contractors made incorrect payments for 86 of them, totaling \$9,563. During our audit period, the Centers for Medicare & Medicaid Services (CMS) oversight was not adequate to identify incorrect billing of claim lines for emergency ambulance transports from hospitals to SNFs. If CMS had had oversight mechanisms in place, such as a fraud prevention model, it would have reduced the number of claim lines that providers incorrectly billed and the resulting overpayments we identified. (A fraud prevention model is used to identify inappropriately billed services or incorrectly coded payments, which may indicate incidents of potential fraud, waste, or abuse.)

On the basis of our sample results, we estimated that (1) providers incorrectly billed for emergency ambulance transports from hospitals to SNFs on 99 percent of the total claim lines billed and (2) Medicare made incorrect payments of \$849,170. If the rate of incorrect billings in our sample had continued through CY 2018, the year after our audit period, we estimated that Medicare would have made an additional \$119,548 in incorrect payments.

### What OIG Recommends and CMS Comments

We recommend that CMS develop a fraud prevention model specific to emergency ambulance transports from hospitals to SNFs to help ensure that payments for these ambulance transports comply with Federal requirements, which could have saved an estimated \$849,170 during our audit period and \$119,548 in CY 2018.

CMS concurred with our recommendation and described actions that it planned to take to address our recommendation.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

A prior Office of Inspector General (OIG) review found that Medicare made improper and potentially improper payments of \$1.9 million to providers<sup>1</sup> for emergency ambulance transports to destinations other than hospitals or skilled nursing facilities (SNFs) with dates of service from calendar years (CYs) 2014 through 2016.<sup>2</sup> As part of that review, we identified \$3.8 million in payments for emergency ambulance transports made to SNFs, of which \$3.2 million (84 percent) was for transports that originated from hospitals. Because hospitals are capable of providing emergency services,<sup>3</sup> we conducted this separate review of emergency ambulance transports from hospitals to SNFs to determine the appropriateness of billing for them as emergency ambulance transports.

### OBJECTIVE

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

### BACKGROUND

#### Medicare Part B

Medicare Part B provides supplementary medical insurance, including coverage for the cost of ambulance transports for beneficiaries. The Centers for Medicare & Medicaid Services (CMS) administers Part B and contracts with Medicare contractors to, among other things, determine reimbursement amounts and pay claims, conduct audits, and safeguard against fraud and abuse. Each Medicare contractor is responsible for processing claims submitted by providers within 1 of 12 designated regions, or jurisdictions, of the United States and its territories.

#### Medicare Part B Coverage of Ambulance Transports

Medicare Part B covers ambulance services that meet medical necessity and origin and destination requirements (42 CFR §§ 410.40(a), (d), and (e)).<sup>4</sup> Ambulance services, including emergency ambulance transports, are medically necessary only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are

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<sup>1</sup> The term “provider” refers to both independent ambulance suppliers and hospital-based ambulance providers.

<sup>2</sup> *Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities* ([A-09-17-03017](#)), issued August 15, 2018.

<sup>3</sup> *CMS Medicare Benefit Policy Manual*, Pub. No. 100-02 (Benefit Policy Manual), chapter 15, § 40.29.

<sup>4</sup> *Benefit Policy Manual*, chapter 10, § 10.2.1.

contraindicated. For a billed service to be considered medically necessary, the beneficiary's condition must require both the ambulance transportation itself and the level of service provided (42 CFR § 410.40(d)).<sup>5</sup> Even if transportation by ambulance is medically necessary, it must meet all other program coverage criteria in order for payment to be made.<sup>6</sup>

Medicare Part B covers ambulance transports from and to only the following origins and destinations, respectively:

- from any point of origin to the nearest hospital (including a critical access hospital (CAH)) or nearest SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury;<sup>7</sup>
- from a hospital (including a CAH) or SNF to the beneficiary's home;
- from a SNF to the nearest supplier of medically necessary services that are not available at the SNF where the beneficiary is a resident, including the return trip; and
- from a beneficiary's home to the nearest facility that furnishes renal dialysis (for a beneficiary who is receiving renal dialysis for treatment of end-stage renal disease), including the return trip (42 CFR § 410.40(e)).<sup>8</sup>

Medicare covers ambulance transports to the nearest appropriate facility, as well as the return transport, for a beneficiary to obtain necessary diagnostic or therapeutic services. "Appropriate facility" means that the institution is generally equipped to provide the needed hospital care or skilled nursing care for an illness or injury.<sup>9</sup> In addition, the transport must be to receive a medically necessary Medicare service or to return from such a service.<sup>10</sup>

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<sup>5</sup> Medicare Part B covers nonemergency ambulance transportation if (1) the beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated or (2) his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required (42 CFR § 410.40(d)).

<sup>6</sup> Benefit Policy Manual, chapter 10, § 10.2.1.

<sup>7</sup> The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

<sup>8</sup> Even though a physician's office is not a covered destination, Medicare Part B will cover an ambulance transport under special circumstances if it temporarily stops at a physician's office (Benefit Policy Manual, chapter 10, § 10.3). Additionally, a medically necessary ambulance transport for a SNF resident to and from a physician's office is covered under Medicare Part A (42 CFR § 409.27(c)).

<sup>9</sup> Benefit Policy Manual, chapter 10, §§ 10.3 and 10.3.6.

<sup>10</sup> Benefit Policy Manual, chapter 10, § 10.2.1.

Ambulance transports include transports by ground and air (i.e., by airplane and helicopter). Medicare covers different levels of ground ambulance transport. Transport levels vary according to the qualifications of the ambulance crew and the level of medical care provided.

The transport levels for emergency and nonemergency ground ambulance transports are basic life support (BLS) and advanced life support (ALS). Both BLS and ALS comprise transports that require an ambulance crew of at least two people who meet the requirements of State and local laws in the locations where the services are being furnished. For BLS, at least one of the two crewmembers must be certified at a minimum as an Emergency Medical Technician (EMT)–Basic by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. For ALS, at least one of the two crewmembers must meet the staff requirements for BLS transport and be certified as an EMT–Intermediate or EMT–Paramedic by the State or local authority where services are being furnished.

### **Provider Submission of Medicare Part B Ambulance Claims and the Use of Healthcare Common Procedure Coding System Codes**

Federal law requires that providers submit accurate and complete claims to Medicare for allowable and covered services (the Social Security Act § 1833(e)). Each submitted Medicare Part B claim contains detail regarding each provided service (called a claim line in this report). To receive Medicare payment for an ambulance transport, the provider submits a claim and indicates on it the transport level, the origin, and the destination for the one-way transport. The provider indicates the transport level using a Healthcare Common Procedure Coding System (HCPCS) code.<sup>11</sup> Providers bill for emergency or nonemergency ambulance transports on separate claim lines using the HCPCS codes shown in Table 1.

**Table 1: HCPCS Codes for Ambulance Transports<sup>12</sup>**

<b>HCPCS Code</b>	<b>Description</b>
A0426	Ambulance service, ALS, nonemergency transport, level 1 <sup>13</sup>
A0427	Ambulance service, ALS, emergency transport, level 1
A0428	Ambulance service, BLS, nonemergency transport
A0429	Ambulance service, BLS, emergency transport

Providers must indicate the transport’s origin and destination by adding a modifier to the end of the HCPCS code billed. Modifiers used for ambulance services are created by combining two

<sup>11</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

<sup>12</sup> CMS *Medicare Claims Processing Manual*, Pub. No. 100-04 (Claims Processing Manual), chapter 15, § 30.B.

<sup>13</sup> An ALS ambulance transport can be performed at either level 1 or level 2, representing different levels of medically necessary supplies and services provided. Our review covered only ALS level 1 HCPCS codes.

“alpha” characters. Each alpha character represents an origin code or a destination code. The first-position alpha code designates the origin, and the second-position alpha code designates the destination, of the ambulance transport.<sup>14</sup> For example, the modifier HN is used to indicate that a provider picked up a beneficiary from a hospital (“H”) and transported the beneficiary to a SNF (“N”).<sup>15</sup>

### **Medicare Payment of Emergency Ambulance Transport Claims**

Medicare pays for reasonable and medically necessary ALS and BLS ambulance transports at the emergency transport level (HCPCS codes A0427 and A0429)<sup>16</sup> if the services were provided in the context of an emergency response and the transports meet Medicare’s conditions for payment and coverage. For ambulance transports, an emergency response means responding immediately at the BLS or ALS level of service to a 911 call or the equivalent in areas without a 911 call system.<sup>17</sup>

### **Medicare Contractor Controls Related to Payment of Provider Claims**

Medicare contractors must establish and maintain efficient and effective internal controls.<sup>18</sup> These controls, including those over claim processing systems, are intended to prevent increased program costs caused by incorrect or delayed payments. Medicare contractors use the Multi-Carrier System and CMS’s Common Working File to validate providers’ claims for Medicare Part B services before paying the claims. In addition, CMS is responsible for the development of nation-wide edits used in the contractors’ claim processing systems. These edits perform the following functions: select certain claims; evaluate or compare information on the selected claims or from other accessible sources; and, depending on the evaluation, take action on the claims, such as paying them in full, paying them in part, denying payment for them, or suspending them for manual review.

### **HOW WE CONDUCTED THIS REVIEW**

Our review covered Medicare Part B payments of \$2.6 million made by Medicare contractors nation-wide for 8,880 claim lines for emergency ambulance transports (billed using HCPCS codes A0427 and A0429) that providers indicated were transports from hospitals to SNFs (billed using modifier HN) with dates of service from CYs 2015 through 2017 (audit period). We

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<sup>14</sup> Claims Processing Manual, chapter 15, § 30.A.

<sup>15</sup> Although combinations of these codes may duplicate other HCPCS code modifiers, when billed with an ambulance transportation HCPCS code, the reported modifier can indicate only the origin and destination of the ambulance transport (Claims Processing Manual, chapter 15, § 30.A).

<sup>16</sup> Claims Processing Manual, chapter 15, § 30.B.

<sup>17</sup> 42 CFR § 414.605 and Benefit Policy Manual, chapter 10, § 30.1.1.

<sup>18</sup> CMS *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, § 10.

selected a simple random sample of 100 of these claim lines, for which Medicare paid \$29,685. We excluded one claim line from our review because we were unable to contact the provider and determine compliance with Federal requirements. We reviewed the remaining 99 claim lines for billing errors and the impact of any errors on the claim-line payments. For each claim line, we evaluated compliance with selected Medicare billing requirements, but we did not use medical review to determine whether services were medically necessary.

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 objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

## FINDINGS

Medicare payments to providers for emergency ambulance transports from hospitals to SNFs did not comply with Federal requirements. Specifically, providers incorrectly billed all 99 sampled claim lines for emergency ambulance transports that providers indicated were from hospitals to SNFs. For these 99 claim lines, Medicare contractors made incorrect payments for 86 of them, totaling \$9,563.<sup>19</sup> During our audit period, CMS oversight was not adequate to identify incorrect billings or payments for emergency ambulance transports that were indicated as transports from hospitals to SNFs.

### Findings-at-a-Glance

All 99 sampled claim lines for emergency ambulance transports were incorrectly billed. Of these claim lines, 86 were incorrectly paid, totaling \$9,563.

On the basis of our sample results, we estimated that:

- 99 percent of 8,880 claim lines were incorrectly billed and
- Medicare made incorrect payments of \$849,170.



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<sup>19</sup> We classified the payments for claim lines as non-errors if (1) the claim lines were rebilled as nonemergency ambulance transports because the providers originally incorrectly billed and received payments for the claim lines as emergency ambulance transports and the incorrect payments were refunded before our audit; (2) the claim lines had billing errors that did not affect the payment amounts received (e.g., a claim line that was correctly billed for an emergency ambulance transport but billed with an incorrect modifier indicating the origin and destination); or (3) the claim line was incorrectly billed as an emergency ambulance transport but the payment was based on the claim line's charge amount because that amount was less than the standard amount that Medicare would have paid for the transport (which resulted in the provider receiving the same payment amount regardless of whether the claim line had been billed as an emergency or a nonemergency ambulance transport).

On the basis of our sample results, we estimated that (1) providers incorrectly billed for emergency ambulance transports from hospitals to SNFs on 8,791 claim lines (99 percent of the 8,880 total claim lines billed<sup>20</sup>) and (2) Medicare made incorrect payments of \$849,170. If the rate of incorrect billings in our sample had continued through CY 2018, the year after our audit period, we estimated that Medicare would have made an additional \$119,548 in incorrect payments.

## **FEDERAL REQUIREMENTS**

Medicare Part B covers ambulance services that meet origin and destination requirements (42 CFR §§ 410.40(a), (d), and (e)). Medicare covers ambulance transports to various destinations, including from any point of origin to the nearest hospital (including a CAH) or nearest SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury (42 CFR § 410.40(e)).

Medicare pays for reasonable and medically necessary ALS and BLS ambulance transports at the emergency transport level (HCPCS codes A0427 and A0429) if the services were provided in the context of an emergency response (Claims Processing Manual, chapter 15, § 30.B) and the transports meet Medicare's conditions for payment and coverage. For ambulance transports, an emergency response means responding immediately at the BLS or ALS level of service to a 911 call or the equivalent in areas without a 911 call system (42 CFR § 414.605 and Benefit Policy Manual, chapter 10, § 30.1.1).

An immediate response is one in which the provider begins as quickly as possible to take the steps necessary to respond to the call. A call is of an emergency nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. If the call came in directly to the provider, the provider's dispatch protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. When the dispatch was inconsistent with this standard protocol, including cases in which no protocol was used, the beneficiary's condition (for example, his or her symptoms) at the scene determines the appropriate level of payment (Benefit Policy Manual, chapter 10, § 30.1.1).

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<sup>20</sup> We could not determine whether an estimated 1 percent of the claim lines in the sampling frame were incorrectly billed because of the unavailability of the provider that billed for one sampled claim line. (See the previous section "How We Conducted This Review.")

## **PROVIDERS INCORRECTLY BILLED MEDICARE FOR EMERGENCY AMBULANCE TRANSPORTS FROM HOSPITALS TO SKILLED NURSING FACILITIES**

All 99 of the sampled claim lines were incorrectly billed by providers as emergency ambulance transports from hospitals to SNFs. Specifically, these claim lines had the following errors:

- Ninety-three claim lines were incorrectly billed as emergency instead of nonemergency ambulance transports. For example, a beneficiary was transported from a hospital to a SNF after being treated for chest pain and cleared to return to the SNF. The transport did not result from a dispatcher receiving a 911 call for the beneficiary, and the call to the dispatcher for the beneficiary did not require an emergency response dispatch for ambulance services. Therefore, the provider incorrectly billed for this service as a BLS emergency transport (HCPCS code A0429) instead of as a BLS nonemergency ambulance transport (HCPCS code A0428).
- Five claim lines were correctly billed as emergency ambulance transports but billed with incorrect origin/destination modifiers. For example, a beneficiary was transported from a SNF to a hospital because the beneficiary was having chest pains. The transport resulted from the dispatcher receiving a 911 call for the beneficiary, and the call to the dispatcher for the beneficiary required an emergency response dispatch for ambulance services. Although the provider correctly billed for this service as an ALS level 1 emergency ambulance transport (HCPCS code A0427), it incorrectly billed for the transport with modifier HN (transport from hospital to SNF) instead of modifier NH (transport from SNF to hospital).
- One claim line for an ambulance transport was billed twice, once incorrectly as a BLS emergency ambulance transport (HCPCS code A0429) and once correctly as a BLS nonemergency ambulance transport (HCPCS code A0428).

On the basis of our sample results, we estimated that providers incorrectly billed for emergency ambulance transports from hospital to SNFs on 8,791 claim lines (99 percent of the 8,880 total claim lines billed).

## **MEDICARE MADE INCORRECT PAYMENTS FOR AMBULANCE TRANSPORTS THAT WERE BILLED AS EMERGENCY AMBULANCE TRANSPORTS FROM HOSPITALS TO SKILLED NURSING FACILITIES**

Eighty-six of the ninety-nine sampled claim lines (87 percent) that were billed by providers as emergency ambulance transports from hospitals to SNFs were incorrectly paid by Medicare contractors.

Specifically, the 86 claim lines had the following errors that resulted in the incorrect payments:<sup>21</sup>

- Eighty-five claim lines were incorrectly billed as emergency instead of nonemergency ambulance transports, resulting in overpayments of \$9,293.
- One claim line was incorrectly billed for the same ambulance transport twice, once incorrectly as a BLS emergency ambulance transport and once correctly as a BLS nonemergency ambulance transport, resulting in an overpayment of \$270.

As a result, Medicare contractors made total incorrect payments of \$9,563.

### **CMS OVERSIGHT WAS NOT ADEQUATE TO IDENTIFY INCORRECT BILLINGS OR PAYMENTS**

During our audit period, CMS oversight was not adequate to identify incorrect billing of claim lines for emergency ambulance transports from hospitals to SNFs. If CMS had had oversight mechanisms in place, such as a fraud prevention model,<sup>22</sup> it would have reduced the number of claim lines that providers incorrectly billed and the resulting overpayments we identified.

### **MEDICARE OVERPAID PROVIDERS AN ESTIMATED \$849,170 DURING OUR AUDIT PERIOD AND \$119,548 AFTER OUR AUDIT PERIOD**

On the basis of our sample results, we estimated that the Medicare contractors made incorrect payments of \$849,170. If the rate of incorrect billings in our sample had continued through CY 2018, the year after our audit period, we estimated that Medicare would have made an additional \$119,548 in incorrect payments.

### **RECOMMENDATION**

We recommend that the Centers for Medicare & Medicaid Services develop a fraud prevention model specific to emergency ambulance transports from hospitals to SNFs to help ensure that payments for these ambulance transports comply with Federal requirements, which could have saved an estimated \$849,170 during our audit period and \$119,548 in CY 2018.

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<sup>21</sup> We classified the remaining 13 incorrectly billed claim lines as correctly paid: 7 claim lines were rebilled as nonemergency ambulance transports because the providers originally incorrectly billed and received payments for the claim lines as emergency ambulance transports, and the incorrect payments were refunded before our audit; 5 claim lines had billing errors that did not affect the payment amounts received (e.g., a claim line that was correctly billed for an emergency ambulance transport but billed with an incorrect modifier indicating the origin and destination); and 1 claim line was incorrectly billed as an emergency ambulance transport but the payment was based on the claim line's charge amount because that amount was less than the standard amount that Medicare would have paid for the transport (which resulted in the provider receiving the same payment amount regardless of whether the claim line had been billed as an emergency or a nonemergency ambulance transport).

<sup>22</sup> A fraud prevention model is used to identify inappropriately billed services or incorrectly coded payments, which may indicate incidents of potential fraud, waste, or abuse.

## **CMS COMMENTS**

In written comments on our draft report, CMS concurred with our recommendation and described actions that it planned to take to address our recommendation. CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear as Appendix D.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our review covered Medicare Part B payments of \$2,634,727 made by Medicare contractors nation-wide for 8,880 claim lines for emergency ambulance transports (billed using HCPCS codes A0427 and A0429) that providers indicated were transports from hospitals to SNFs (billed using modifier HN) with dates of service from CYs 2015 through 2017 (January 1, 2015, through December 31, 2017). We selected a simple random sample of 100 of these claim lines, for which Medicare paid \$29,685. We excluded one claim line from our review because we were unable to contact the provider and determine compliance with Federal requirements. We reviewed the remaining 99 claim lines for billing errors and the impact of any errors on the claim-line payments.

For each claim line, we evaluated compliance with selected Medicare billing requirements, but we did not use medical review to determine whether services were medically necessary.

We limited our review of Medicare contractors' internal controls to those that were applicable to the selected claim lines because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit from August 2018 to February 2019, which included contacting CMS in Baltimore, Maryland, and the providers that received payments for 99 sampled claim lines.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS staff regarding the types of edits specific to emergency ambulance transports and the modifier that providers used when billing for these transports from hospitals to SNFs (modifier HN);
- used CMS's NCH file to identify claim lines for emergency ambulance transports from hospitals to SNFs (billed using HCPCS codes A0427 and A0429 and modifier HN) with dates of service for our audit period;
- selected a simple random sample of 100 claim lines for emergency ambulance transports from hospitals to SNFs with dates of service for our audit period and:

- obtained from providers supporting documentation for each sampled claim line to determine (1) the origin and destination of the transport, (2) whether the ambulance dispatcher received a 911 call for the beneficiary, and (3) whether the call to the dispatcher for the beneficiary required an emergency response dispatch for ambulance services;
  - determined whether providers met Medicare requirements for billing emergency ambulance transports;
  - calculated the incorrect payment for each sampled claim line that was incorrectly billed as the difference between what the provider was paid for the claim line and what the provider would have been paid if the claim line had been billed as a nonemergency ambulance transport (HCPCS codes A0426 or A0428); and
  - estimated the (1) total number and percentage of incorrectly billed claim lines and (2) potential cost savings if the claim lines had been billed as nonemergency instead of emergency ambulance transports;
- extracted paid claim line data for emergency ambulance transports that providers indicated were from hospitals to SNFs with dates of service during CY 2018;
  - applied the rate of incorrect billings identified during our audit period to the year after the audit period (CY 2018)<sup>23</sup> to calculate the potential incorrect payments for emergency ambulance transports that providers indicated were from hospitals to SNFs and were billed after our audit period; and
  - discussed the results of our review with CMS officials.

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 objectives.

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<sup>23</sup> To determine whether it was reasonable to assume that the rate of incorrect billings for our audit period would not have materially changed in CY 2018, we reviewed the stability of the rate of incorrect billings across the audit period within our sample data. These data supported our assumption; the observed rate of incorrect billings varied by only 1 percent across the 3 years (CYs 2015 through CYs 2017).

## **APPENDIX B: SAMPLE DESIGN AND METHODOLOGY**

### **TARGET POPULATION**

The target population consisted of Medicare Part B claim lines for emergency ambulance transports that providers indicated were from hospitals to SNFs with dates of service during our audit period.

### **SAMPLING FRAME**

We obtained from CMS's NCH file the claim data for emergency ambulance transports that providers indicated were from hospitals to SNFs with dates of service during our audit period, consisting of 9,188 claim lines totaling \$2,723,799. We excluded from our review 169 claim lines, totaling \$49,353, that were processed under the Railroad Retirement Board. We also excluded from our review 139 claim lines, totaling \$39,719, that were reviewed by other review entities (e.g., the Recovery Audit Contractors). As a result, the sampling frame consisted of 8,880 claim lines totaling \$2,634,727.

### **SAMPLE UNIT**

The sample unit was a paid Medicare Part B claim line for an emergency ambulance transport for which the provider indicated a beneficiary was transported from a hospital to a SNF.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a total of 100 sample units.

### **SOURCE OF RANDOM NUMBERS**

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

### **METHOD OF SELECTING SAMPLE UNITS**

We consecutively numbered the sample units in the sampling frame from 1 to 8,880. After generating 100 random numbers, we selected the corresponding frame items.

## **ESTIMATION METHODOLOGY**

We used the OIG,OAS, statistical software to estimate (1) the total number and percentage of incorrectly billed emergency ambulance transports from hospitals to SNFs, (2) the total dollar amount of the incorrect payments for emergency ambulance transports from hospitals to SNFs, and (3) the percentage of claim lines in the sampling frame that were unreviewable because of the unavailability of the billing provider.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

No. of Items in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Items Reviewed	No. of Billing Errors	No. of Incorrect Payments	Value of Incorrect Payments
8,880	\$2,634,727	100	\$29,685	99	99	86	\$9,563

**Table 3: Estimated Numbers and Percentages of Incorrectly Billed Claim Lines for Our Audit Period  
(Limits Calculated for a 90-Percent Confidence Interval)**

Estimate Description	Point Estimate	Lower Limit	Upper Limit
Number of Claim Lines Incorrectly Billed	8,791	8,469	8,875
Percentage of Claim Lines Incorrectly Billed	99.0%	95.3%	99.9%
Percentage of Claim Lines Associated With Unavailable Providers <sup>24</sup>	1.0%	0.1%	4.7%

**Table 4: Estimated Value of Incorrect Payments for Our Audit Period  
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$849,170
Lower limit	783,556
Upper limit	914,785

<sup>24</sup> We could not determine whether an estimated 1 percent of the claim lines in the sampling frame were incorrectly billed because we were unable to contact the provider associated with the one sampled claim line and determine compliance with Federal requirements. The percentage of claim lines associated with unavailable providers is not a type of error but rather a limit on what we could review.

## APPENDIX D: CMS COMMENTS



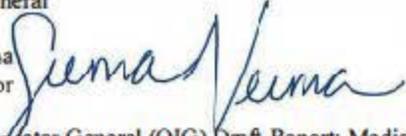
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** July 30, 2019

**TO:** Joanne Chiedi  
Inspector General

**FROM:** Seema Verma  
Administrator 

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Incorrectly Paid Providers for Emergency Ambulance Transports From Hospitals to Skilled Nursing Facilities (A-09-18-03030)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. As part of this strategy, CMS recovers identified improper payments in accordance with relevant law and agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for ambulance services. CMS does so through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, since the audit period, CMS has revised and released a Medicare Learning Network Booklet titled Medicare Ambulance transports which provides detail on ground transport coverage requirements.<sup>1</sup>

The OIG's recommendations and CMS' responses are below.

### **OIG Recommendation**

The OIG recommends that CMS develop a fraud prevention model specific to emergency ambulance transports from hospitals to SNFs to help ensure that payments for these ambulance transports comply with Federal requirements which could have saved an estimated \$849,170 during our audit period and \$119,548 in CY 2018.

### **CMS Response**

CMS concurs with this recommendation. CMS will develop a fraud prevention model specific to emergency ambulance transports from hospitals to skilled nursing facilities to help ensure that payments for these ambulance transports comply with Federal requirements.

<sup>1</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf>