

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 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.