

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MIDWOOD AMBULANCE
& OXYGEN SERVICE, INC.,
BILLED FOR NONEMERGENCY
AMBULANCE TRANSPORT
SERVICES THAT DID NOT
COMPLY WITH MEDICARE
REQUIREMENTS**

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Office of Inspector General

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

Report in Brief

Date: December 2018

Report No. A-02-16-01021

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



Why OIG Did This Review

Previous OIG reviews and investigations have identified Medicare ambulance services as highly vulnerable to waste, fraud, and abuse. Further, a 2013 OIG report indicated that the number of Medicare fee-for-service beneficiaries who received ambulance transports increased by 34 percent from 2002 to 2011, while the total number of Medicare fee-for-service beneficiaries increased by just 7 percent during the same period, and the number of ambulance suppliers increased by 26 percent. For calendar year (CY) 2016, Medicare paid ambulance suppliers approximately \$1.8 billion for nonemergency ambulance transport services.

Medicare paid Midwood Ambulance & Oxygen Service, Inc. (Midwood), \$23.5 million for 114,138 claims with payments of \$100 or more for nonemergency ambulance transport services provided during CYs 2014 and 2015.

Our objective was to determine whether Midwood complied with Medicare requirements for billing nonemergency ambulance transport services.

How OIG Did This Review

We reviewed a random sample of 100 of Midwood's nonemergency ambulance transport claims. We evaluated the claims for compliance with selected billing requirements and subjected them to medical review.

Midwood Ambulance & Oxygen Service, Inc., Billed for Nonemergency Ambulance Transport Services That Did Not Comply With Medicare Requirements

What OIG Found

Midwood did not comply with Medicare requirements for billing nonemergency ambulance transport services for 89 of the 100 claims we reviewed. Specifically, Midwood incorrectly billed Medicare for beneficiaries whose conditions did not meet medical necessity requirements and billed for services that did not meet documentation requirements. These errors occurred because Midwood did not have adequate controls to prevent the incorrect billing of nonemergency ambulance transport claims.

On the basis of our sample results, we estimated that Midwood received overpayments of at least \$19.2 million for the audit period. This amount includes claims with payment dates outside of the Medicare 4-year claim-reopening period.

What OIG Recommends and Midwood Comments

We made a series of detailed recommendations to Midwood in our report. Among them, we recommend that Midwood (1) refund to the Medicare program the portion of the estimated \$19.2 million overpayment for claims incorrectly billed that are within the Medicare reopening period; (2) for the remaining portion of the estimated \$19.2 million in overpayments for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return additional overpayments; (3) identify and return any additional similar improper payments made after our audit period; and (4) strengthen its procedures for billing nonemergency ambulance transport services.

Midwood disagreed with our first two recommendations, did not indicate concurrence or nonconcurrence with our third recommendation, and partially agreed with our fourth recommendation. Midwood stated that it could not agree with our findings without performing a detailed review of our determinations. Further, Midwood stated that it did not agree with our use of statistical sampling. Midwood also stated that the length of the Medicare reopening period cited in our recommendations was unclear. After reviewing Midwood's comments, we maintain that our recommendations are valid. Our findings were based on determinations made by a qualified independent medical review contractor. Also, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews and investigations have identified Medicare ambulance transport services as vulnerable to waste, fraud, and abuse. Further, a 2013 OIG report indicated that the number of Medicare fee-for-service beneficiaries who received ground ambulance transports increased by 34 percent from 2002 to 2011, while the total number of Medicare fee-for-service beneficiaries increased by just 7 percent during the same period, and the number of ambulance suppliers increased by 26 percent.¹ For calendar year (CY) 2016, Medicare paid providers and suppliers² approximately \$1.8 billion for nonemergency ambulance transport services.

Based on the results of our previous reviews and the rapid growth of Medicare billings for ambulance transports, we reviewed Midwood Ambulance & Oxygen Service, Inc. (Midwood), one of the highest paid ambulance service suppliers in New York City during CYs 2014 and 2015.

OBJECTIVE

Our objective was to determine whether Midwood complied with Medicare requirements for billing nonemergency ambulance transport services.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage for people aged 65 and over and those who are disabled or have permanent kidney disease. Medicare Part B covers medically necessary services such as doctors' services, outpatient care, home health services, and other medical services, including ambulance services.

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and contracts with Medicare Administrative Contractors (Medicare contractors) to, among other things, process and pay claims submitted by providers or suppliers for Medicare Part B services.

¹ *Utilization of Medicare Ambulance Transports, 2002-2011* ([OEI-09-12-00350](#)), issued September 24, 2013.

² Ambulance *providers* own and operate ambulance transportation services that provide assistance to their institutionally based operations (e.g., hospitals, skilled nursing facilities). Ambulance *suppliers* are not owned or operated by a provider and are enrolled in Medicare as independent ambulance suppliers. Examples include volunteer fire and ambulance companies and privately owned and operated ambulance companies.

Medicare Nonemergency Ambulance Transport Services

Medicare covers nonemergency ambulance transportation when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated (i.e., other means of transportation could endanger the beneficiary's health). Medicare pays for medically necessary ambulance services if the supplier meets applicable vehicle, staffing, billing, and reporting requirements, and the transportation meets origin and destination requirements. Medicare also pays for mileage related to each trip.

Medicare pays for two levels of nonemergency ambulance transports: Basic Life Support (BLS) and Advanced Life Support (ALS).^{3, 4} These levels are differentiated by the qualifications and training of the ambulance crew and the level of medical care provided.

Ambulance and Staffing Requirements

Federal regulations (42 CFR § 410.41) require ambulances to be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing emergency transportation vehicles. In addition, each vehicle must be staffed by at least two people who meet the requirements of State and local laws where the services are being furnished.

In New York, ambulance providers must have valid certificates of inspection from both the Department of Health and the Department of Motor Vehicles on each vehicle. Providers and suppliers must also maintain personnel files for all drivers, first responders, and emergency medical technicians that include documentation of the employees' qualifications; training and certifications; and health records, including immunization status (10 New York Codes, Rules and Regulations §§ 800.21(a) and (k)).⁵

Medical Necessity and Documentation Requirements

Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (Social Security Act (the Act) § 1862(a)(1)(A)). To be considered medically necessary, Medicare ambulance services must be furnished to a beneficiary whose medical condition requires both the ambulance transportation itself and the level of service provided (42 CFR § 410.40(d)(1)).

³ BLS transports require an ambulance crew certified at least as basic emergency medical technicians. ALS transports require an ambulance crew certified at least as intermediate or paramedic emergency medical technicians (42 CFR § 410.41(b)).

⁴ We note that after our audit period, the Medicare fee schedule for BLS services (i.e., nonemergency ambulance transports) for beneficiaries with end-stage renal disease was reduced by 23 percent, pursuant to section 53108 of the Bipartisan Budget Act of 2018 (P.L. No. 115-123).

⁵ New York's regulations do not distinguish between ambulance providers and suppliers.

Medicare documentation requirements for nonemergency ambulance transport services vary depending on whether a beneficiary requires repetitive (e.g., weekly dialysis appointments) or nonrepetitive services. For beneficiaries requiring repetitive services, ambulance transport service providers must obtain a written order from the beneficiary's attending physician certifying that Medicare medical necessity requirements are met, and the order must be dated no earlier than 60 days before the date of the service (42 CFR § 410.40(d)(2)). For beneficiaries requiring nonrepetitive services (e.g., trip from hospital to residence), ambulance transport service providers must obtain a written order within 48 hours after the transport from the beneficiary's attending physician certifying that Medicare medical necessity requirements are met.⁶

Ambulance providers and suppliers must keep appropriate documentation on file and, upon request, present it to the Medicare contractor. In addition, the presence of a signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary. The ambulance service must meet all other program criteria for payment to be made (42 CFR §§ 410.40(d)(2)(ii) and 410.40(d)(3)(v)).⁷

Midwood Ambulance & Oxygen Service, Inc.

Midwood is a privately owned ambulance company in Brooklyn, New York, that provides BLS and ALS transport services. According to CMS's National Claims History (NCH) data, National Government Services, Midwood's Medicare contractor, paid Midwood \$23,534,691 for 114,862 claims for nonemergency ambulance transport services provided to beneficiaries during CYs 2014 and 2015 (audit period).

HOW WE CONDUCTED THIS REVIEW

Our review covered \$23,450,178 in Medicare payments to Midwood for 114,138 nonemergency ambulance transport service claims with payments of \$100 or more for services provided to beneficiaries during the audit period. A claim included payments for a one-way ambulance trip plus related mileage. We selected a random sample of 100 of these claims and evaluated the claims for compliance with selected billing requirements. We contracted with an independent medical review contractor that reviewed the medical records for the sampled claims to determine whether related services met Medicare medical necessity and documentation requirements.

⁶ Ambulance transport service providers are not required to obtain certifications for nonrepetitive services for beneficiaries residing at home or in a facility who are not under the direct care of a physician (42 CFR § 410.40(d)(3)).

⁷ Under a demonstration project, CMS requires ambulance transport service providers to obtain prior authorization for certain repetitive nonemergency ambulance transport services in eight States and the District of Columbia, as of February 1, 2018. New York is not among those eight States.

OIG believes that this audit report constitutes credible information of potential overpayments. Providers that receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).⁸

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 contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Midwood did not comply with Medicare requirements for billing nonemergency ambulance services for most of the claims in our sample. Of the 100 claims in our sample, 11 complied with Medicare requirements, but 89 did not. Specifically, for 82 claims, Midwood billed for services for beneficiaries whose conditions did not meet Medicare medical necessity requirements. For 49 claims, Midwood billed for services that did not meet Medicare documentation requirements related to physician certifications. The total adds to more than 89 because 42 claims were deficient for both reasons.⁹

These errors occurred because Midwood did not have adequate controls to prevent the incorrect billing of nonemergency ambulance transport claims. Specifically, Midwood did not have adequate procedures to ensure that it billed Medicare only for transports for beneficiaries who met Medicare medical necessity requirements for ambulance transport and that it obtained physician certifications that were completed, signed, and dated within required timeframes.

⁸ The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

⁹ All 100 sample claims met Medicare vehicle and staffing requirements.

On the basis of our sample results, we estimated that Midwood received overpayments of at least \$19,292,158 for our audit period.¹⁰ This amount includes claims with payment dates outside of the 4-year claim-reopening period.¹¹

MEDICAL NECESSITY REQUIREMENTS NOT MET

Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation could endanger the beneficiary's health. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided for the billed service to be considered medically necessary (42 CFR § 410.40(d)(1)). While the presence of a signed physician certification statement is required to meet the documentation requirements, it does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met for payment to be made (42 CFR §§ 410.40(d)(2)(ii) and 410.40(d)(3)(v)).

For 82 sampled claims, Midwood billed Medicare for nonemergency ambulance transport services for which the beneficiary's condition did not meet medical necessity requirements. Specifically, the medical reviewers determined that the beneficiaries associated with these claims did not have conditions that met medical necessity requirements for ambulance transport and could have been safely transported by other means (e.g., ambulette or ambulance van).¹² For example, for one claim, the medical reviewer determined that the beneficiary had hypertension, diabetes, congestive heart failure, and renal failure. However, the beneficiary's medical record did not indicate that her condition required ambulance transport services or that other modes of transportation could not be used. Further, she was stable and told Midwood personnel that she was "just tired."

These errors occurred because Midwood did not have adequate procedures to ensure that it billed Medicare only for transports for beneficiaries who met Medicare medical necessity requirements.

PHYSICIAN CERTIFICATION DOCUMENTATION REQUIREMENTS NOT MET

Medicare covers medically necessary nonemergency ambulance transports if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order

¹⁰ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time.

¹¹ 42 CFR § 405.980(b)(2).

¹² We note that CMS does not allow Medicare coverage for means of transportation other than ambulance. However, transportation services via ambulette and vans are available through Medicaid (42 CFR § 440.170(a)). Of the 73 beneficiaries associated with this finding, 68 were also covered by Medicaid at the time the nonemergency ambulance services were provided.

from the beneficiary's attending physician certifying that medical necessity requirements are met. For scheduled, repetitive ambulance services, the physician's order must be dated no earlier than 60 days before the date the service is furnished (42 CFR § 410.40(d)(2)). For nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis, the ambulance supplier must obtain a written order from the beneficiary's attending physician within 48 hours after the transport certifying that medical necessity requirements are met (42 CFR § 410.40(d)(3)). In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the Medicare contractor (42 CFR §§ 410.40(d)(2)(ii) and 410.40(d)(3)(v)).

For 49 sampled claims, Midwood billed Medicare for nonemergency ambulance transport services for which Medicare documentation requirements related to physician certifications were not met.

For these claims, the physician certifications were not documented or were not dated within the required timeframe.¹³ All of the beneficiaries associated with the sampled claims were under the direct care of a physician.

These errors occurred because Midwood did not have adequate procedures to ensure that physician certifications for nonemergency ambulance transport services were completed, signed, and dated within the required timeframe. Specifically, while Midwood required its staff to contact physicians to obtain certifications, its procedures did not ensure that staff followed up with physicians to ensure that the certifications were obtained and dated within required timeframes.

RECOMMENDATIONS

We recommend that Midwood:

- refund to the Medicare program the portion of the estimated \$19,292,158 overpayment for claims incorrectly billed that are within the reopening period;¹⁴

¹³ Of these 49 claims, 9 claims did not have a physician certification on file, 13 claims had a physician certification that was not signed and dated, and 27 claims for repetitive transports had a physician certification that covered the date of transport, but the physician signed and dated the certification 1 to 232 days after the date of the transport.

¹⁴ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a Medicare contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

- for the remaining portion of the estimated \$19,292,158 overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;
- exercise reasonable diligence to identify and return any additional similar improper payments outside of our audit period, in accordance with the 60-day rule, and identify any returned improper payments as having been made in accordance with this recommendation; and
- strengthen its procedures to ensure that (1) nonemergency ambulance transport services are billed only for transports for beneficiaries who meet Medicare medical necessity requirements and (2) physician certifications for billed nonemergency ambulance transports are completed, signed, and dated within the required timeframe.

MIDWOOD COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Midwood disagreed with our first two recommendations, did not indicate concurrence or nonconcurrence with our third recommendation,¹⁵ and partially agreed with our fourth recommendation. Midwood stated that it could not agree with our findings without performing a detailed review of our determinations. Further, Midwood stated that it did not agree with our use of statistical sampling. Midwood also stated that the length of the Medicare reopening period cited in our second recommendation was unclear. In addition, Midwood stated that it is nearly impossible for it to ensure that physician certifications meet Medicare documentation requirements.

Midwood also stated that, subsequent to the issuance of our draft report, the company was sold as part of an “asset purchase agreement” and plans to no longer provide ambulance services.¹⁶ Midwood’s comments are included in their entirety as Appendix D.

After reviewing Midwood’s comments, we maintain that our recommendations are valid for the reasons described below. We revised our first recommendation for clarity purposes. Regarding Midwood’s statement that it could not agree with our findings without performing a detailed review, we point out that our findings were based on determinations made by a qualified independent medical review contractor. We have provided Midwood with the determinations for all 89 claims in error.

¹⁵ Specifically, Midwood stated that, because it disagreed with our first recommendation, it did not believe that our third recommendation was warranted. However, elsewhere in its comments, Midwood left open the possibility that it would review potential overpayments. See below for further discussion.

¹⁶ Midwood also stated that it will be deactivating its Medicare provider number.

STATISTICAL SAMPLING METHODOLOGY

Midwood Comments

Midwood stated that extrapolation is not appropriate in medical necessity situations because it would deny Midwood due process. Midwood also stated that Federal law indicates that extrapolation is only proper upon approval by the Secretary of Health and Human Services where there is high or sustained rate of payment error. Midwood also cited Medicare guidance (CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.4 et seq.) that, according to Midwood, suggests that statistical sampling is appropriate after a probe sample may have first detected a high rate of error. In addition, Midwood stated that our sample size of 100 claims represented "a mere 0.08 [percent] of the entire universe of 114,138 Medicare claims" and was "hardly a statistically representative sample" of the universe upon which extrapolation can be based.

Office of Inspector General Response

The use of statistical sampling and extrapolation to determine overpayment amounts in Medicare does not violate due process because the auditee is given the opportunity to appeal the audit results through the Medicare appeals process. See *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *34 (S.D. Tex. 2012). In addition, the requirement that a determination of a sustained or high level of payment error must be made before extrapolation applies only to Medicare contractors, as per the Act § 1893(f)(3) and CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, § 8.4.1.1 (effective June 28, 2011).

Regarding Midwood's comments on our sample, we note that sample sizes smaller than the sample used in this review (100 claims) have routinely been upheld by the Departmental Appeals Board and Federal courts.¹⁷ The legal standard for a sample size is that it be sufficient to be statistically valid, not that it be the most precise methodology.¹⁸ In addition, we recommend recovery at the lower limit. This approach results in an estimate that is lower than the actual overpayment amount 95 percent of the time, and thus it generally favors the provider.¹⁹ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for

¹⁷ See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 10 (E.D.N.Y. 2012) (upholding a sample size of 95 claims); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *30-31 (S.D. Tex. 2012) (upholding a sample size of 30 claims).

¹⁸ See *John Balko & Assoc. v. Sebelius*, 2012 WL 6738246 at *12 (W.D. Pa. 2012), aff'd 555 F. App'x 188 (3d Cir. 2014); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012).

¹⁹ See *Puerto Rico Dep't of Health*, DAB No. 2385, at 10 (2011); *Oklahoma Dep't of Human Servs.*, DAB No. 1436, at 8 (1993) (stating that the calculation of the disallowance using the lower limit of the confidence interval gave the State the "benefit of any doubt" raised by use of a smaller sample size).

the extrapolation. We maintain that our sampling methodology is valid. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.²⁰

MEDICARE REOPENING PERIOD

Midwood Comments

Regarding potential overpayments prior to our audit period, Midwood stated that Medicare has two periods for reopening providers' claims—1 year and 4 years—and indicated that our second recommendation did not indicate which reopening period the recommendation references. Midwood also stated that, to the extent it agrees that overpayments were made, it will consider taking steps to identify additional potential overpayments associated with services beyond the scope of our audit.

Office of Inspector General Response

In both our first and second recommendation, we are referring to the 4-year reopening period under 42 CFR § 405.980(b)(2). In addition, as described on page 4 of the report, providers who receive notification of potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).²¹

PHYSICIAN CERTIFICATION DOCUMENTATION REQUIREMENTS

Midwood Comments

Midwood stated that it is nearly impossible for it to ensure that physician certifications are completed, signed, and dated within the required timeframe and that it cannot force third parties responsible for completing the physician certification forms to meet certain requirements. However, Midwood indicated that its staff can refrain from billing for services for which physician certification documentation requirements are not met. Midwood asked that we rephrase the second part of our fourth recommendation to clarify this point.

²⁰ See *Yorktown Med. Lab., Inc., v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc., v. Sebelius*, 2014 WL 199061 at *9 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

²¹ The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

Office of Inspector General Response

We agree that Midwood cannot force third parties to ensure that physician certification documentation requirements are met. However, we note that the second part of our fourth recommendation relates to billed services. Midwood should have ensured that physician certifications were completed, signed, and dated within the required timeframe before billing for the nonemergency ambulance services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered \$23,450,178 in Medicare payments to Midwood for 114,138 claims paid in CYs 2014 and 2015 for nonemergency ambulance transport services. We selected for review a simple random sample of 100 claims. We define a claim as a payment for a one-way ambulance trip plus any related mileage. We evaluated compliance with selected billing requirements and subjected all 100 claims to focused medical review to determine whether the services met medical necessity and documentation requirements.

We limited our review of Midwood's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the file.

We conducted our fieldwork at Midwood and at various medical facilities throughout New York City from September 2016 to January 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with CMS and Medicare contractor officials to gain an understanding of Medicare Part B requirements related to nonemergency ambulance transports;
- met with Midwood officials to discuss their policies and procedures related to providing, documenting, and billing Medicare Part B for nonemergency ambulance transport services;
- obtained from CMS's NCH file a database of all claims for nonemergency ambulance transport services provided by Midwood during CYs 2014 and 2015, and removed claims with paid amounts less than \$100 as well as claims reviewed and adjusted by the CMS Recovery Audit Contractor;
- created a sampling frame of 114,138 claims totaling \$23,450,178;
- selected a simple random sample of 100 claims from our sampling frame of 114,138 claims;

- for each of the 100 sampled claims, obtained and reviewed medical, billing, and payment records from Midwood, the physician who certified the service, and the medical facility to or from which the associated beneficiary was transported;
- submitted medical records for each of the 100 claims to an independent medical review contractor to determine whether the services were medically necessary and met Medicare coverage requirements;
- obtained and reviewed vehicle and staff dispatch information related to each claim to determine whether Medicare vehicle and staff requirements were met;
- estimated the total Medicare overpayments to Midwood for nonemergency ambulance transport services in our sampling frame; and
- discussed our results with Midwood officials.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

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 B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of all Medicare Part B claims paid to Midwood for nonemergency ambulance transport services provided during CYs 2014 and 2015 with paid amounts greater than \$100. We define a claim as payment for a one-way ambulance trip plus related mileage.

SAMPLING FRAME

The sampling frame was an Access database containing 114,138 Medicare Part B claims with paid amounts greater than \$100 paid to Midwood for nonemergency ambulance transport services provided in CYs 2014 and 2015, totaling \$23,450,178.²² The claim data were extracted from CMS's NCH file.

SAMPLE UNIT

The sample unit was a nonemergency ambulance transport services claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the claims in the sampling frame. After generating 100 random numbers, we selected the corresponding claims for review.

²² We excluded 528 claims with payments of \$100 or less totaling \$46,187 and 196 claims totaling \$38,326 under Recovery Audit Contractor review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of overpayments made to Midwood during the audit period at the lower limit of the two-sided 90-percent confidence interval. We also used this software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Claims in Frame	Total Value of Frame	Sample Size	Total Value of Sample	No. of Incorrectly Billed Sample Items	Value of Overpayments in Sample
114,138	\$23,450,178	100	\$20,200	89	\$18,007

ESTIMATES

**Estimated Value of Medicare Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$20,552,613
Lower limit	19,292,158
Upper limit	21,813,067

APPENDIX D: MIDWOOD COMMENTS



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09/14/18

Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Report Number: A-02-16-01021

To Whom It May Concern:

As President of Midwood Ambulance & Oxygen Service, Inc. ("Midwood"), I am writing to respond the OIG Report referenced above. As a preliminary matter, please note that although the OIG's Report was dated August 1, 2018, it was not received until the first week of September.

Before addressing the OIG Draft Report, please be advised that Midwood was sold, as of September 10, 2018, by an asset purchase agreement. This sale was in process for many months, and, by mere coincidence, happened to coincide with the time the Draft Report was issued. For approximately three months prior to the sale being finalized, Midwood was neither performing nor billing for ambulance services. Midwood no longer intends to provide ambulance services, and in fact, will be deactivating its Medicare Provider Number in the very near future. The sale was necessary because Midwood was losing money and had extensive debts. The business was sold at a loss, with barely enough to cover existing debts.

We appreciate the opportunity to respond to this Draft OIG Report. The following presents Midwood's response to the specific recommendations.

- refund to the Medicare program the portion of the estimated \$19,292,158 overpayment for claims incorrectly billed that are within the recovery period;¹⁴

¹⁴ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a Medicare contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a hearing before an Administrative Law Judge. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is reestimated depending on the result of the appeal.

Midwood disagrees with this recommendation for several reasons:

First, medical necessity is a highly subjective determination. Without reviewing each of the 89 transports deemed overpayments in great detail, Midwood is in no position to simply agree with the OIG's findings and refund this exorbitant amount based solely on the OIG's findings.

Second, there is insufficient information contained in Appendix B to substantiate the statistical methodology used. For instance, the 100 claims reviewed represents a mere 0.08% of the entire universe of 114,138 Medicare claims. This is hardly a statistically representative sample of the entire universe upon which extrapolation can be based.

Third, Midwood does not believe that extrapolation is appropriate in medical necessity situations, because doing so denies due process to both Midwood and to Medicare beneficiaries. When extrapolation is used, specific patient transports are not identified. Instead, the ambulance service makes simply a financial overpayment. Doing so precludes both the ambulance service and individual beneficiaries from challenging the merits of individual transports. Also, because patients can be billed for non-covered transports denied for lack of medical necessity, using extrapolation prevents the ambulance service from being able to identify individual patients for potential financial liability. As a result, the ambulance service is financially harmed and stripped of its legal right to collect from patients.

Fourth, Federal law indicates extrapolation is only proper upon approval by the Secretary of HHS (see e.g., 42 U.S.C. § 1395ddd(f)(3)) where there is high or sustained rate of payment error. Medicare guidance (see e.g. Medicare Program Integrity Manual (100-08, Chapter 8, Section 8.4 et seq.) suggests that statistical sampling is appropriate after a probe sample may have first detected a high rate of error. This OIG audit might be best classified as a "probe" for which a second statistically valid random sample could then be drawn upon which extrapolation could be based. In this case, there was but one sample, and the results of that sample used extrapolation. This approach defies Medicare guidance. While Midwood understands and respects the general ability for Medicare to use extrapolation, the process must be used properly. In this case, there is insufficient evidence sampling and extrapolation was done properly, and as a result, Midwood cannot simply accept the OIG's findings and make such an exorbitant refund without the ability to further investigate individual claims, learn more about the sampling process, verify and validate the extrapolation calculation used, and challenge any defects or flaws in the process. In short, Midwood is not convinced a \$19 million overpayment refund is warranted.

- for the remaining portion of the estimated \$19,292,158 overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;

Midwood disagrees with this recommendation for several reasons:

First, the recommendation is unclear. Medicare regulations effectively have two reopening windows: one year, and four years (upon evidence of good cause being met). It is not clear whether the OIG suggests the one-year or four-year reopening period applies. The OIG notes that it audited transports with dates of service from 2014 and 2015. Without additional information of the perceived "reporting period," Midwood is unable to calculate what portion of the alleged \$19 million overpayment applies within the reporting period and which portion might be outside of the reporting period (or what the OIG even means by the "reporting period."

Second, it is unclear as to how this recommendation is functionally different than the first recommendation. This recommendation suggests Midwood "exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule." The first recommendation did not have this additional language, and instead implies there is *no* ability for Midwood to exercise reasonable diligence, but that it must accept that some unknown overpayment (within the recovery period) must be refunded. Midwood believes it should exercise due diligence to identify any potential overpayments, not just those that may be outside of some "reopening period."

- exercise reasonable diligence to identify and return any additional similar improper payments outside of our audit period, in accordance with the 60-day rule, and identify any returned improper payments as having been made in accordance with this recommendation; and

Midwood does not dispute the fact that Federal laws require due diligence to further investigate additional overpayments once a party might be "on notice" of potential overpayments. However, and as discussed above, Midwood does not agree with the significantly high error rate as detected in this audit, or with the identified overpayment. Only where Midwood might agree with some degree of overpayment would Midwood have a duty to further investigate. In short, Midwood does not believe the \$19 million overpayment calculation is accurate. As such, the findings for these claims from 2014-2015, cannot warrant retrospective auditing for more recent claims (i.e. 2016-2018). To the extent Midwood indeed agrees that there *are* overpayments, then it will consider taking further steps to identify additional potential overpayments for dates of service beyond the scope of the OIG audit.

- strengthen its procedures to ensure that (1) nonemergency ambulance transport services are billed only for transports for beneficiaries who meet Medicare medical necessity requirements and (2) physician certifications for billed nonemergency ambulance transports are completed, signed, and dated within the required timeframe.

Midwood agrees in part and disagrees in part, as follows:

First, Midwood agrees that there is always room for improvement, and taking steps to ensure that all Medicare coverage criteria are met (including medical necessity) is a compliant practice. However, as mentioned at the outset, Midwood no longer performs ambulance transports, and will be disenrolling from the Medicare Program. Thus, prospectively taking steps to improve its practices is moot, as Midwood is no longer in business.

Second, Midwood agrees that it is important for ambulance services to ensure compliance with all Medicare coverage criteria, including the PCS. However, Midwood disagrees with the recommendation as stated. It is nearly impossible for Midwood to ensure that physician certification statements ("PCS forms") are "completed, signed, and dated within the required timeframe." Midwood cannot force third parties responsible for completing PCS forms to meet certain requirements. However, Midwood staff *can* refrain from billing nonemergency ambulance transports where PCS forms may be deficient, incomplete or otherwise invalid.

Therefore, Midwood suggests this recommendation be re-phrased to state "(2) nonemergency ambulance transport services are billed only for transports where physician certification statements are completed, signed, and dated within the required timeframe." This minor adjustment puts the proper onus on the ambulance service to ensure proper *billing* based on the PCS forms, and not on the ambulance service to force the PCS authors to meet certain requirements. Midwood cannot control the actions or inactions of third parties. It can, however, improve billing decisions. Nonetheless, as above, since Midwood has ceased to operate, and will be rescinding its Medicare Provider Number, prospectively taking steps to improve compliance moving forward is effectively moot.

We appreciate the opportunity to respond to this Draft Report. Please let us know if there is any additional information you might require of us before the OIG issues the Final Report.

Very Truly Yours,



Al Rapisarda, President