

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID
PROVIDERS FOR
NONEMERGENCY AMBULANCE
TRANSPORTS TO DESTINATIONS
NOT COVERED BY MEDICARE**

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A-09-17-03018

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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: July 2018

Report No. A-09-17-03018

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.

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INTRODUCTION

WHY WE DID THIS REVIEW

A prior Office of Inspector General (OIG) review found that inappropriate payments and questionable billing for Medicare Part B ambulance transports pose vulnerabilities to Medicare program integrity.¹ 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 providers² indicated were to destinations not covered by Medicare. This review focuses on Medicare payments for CYs 2014 through 2016 for nonemergency ambulance transports to destinations not covered by Medicare. Another OIG review will focus on potentially improper payments for emergency ambulance transports to destinations other than hospitals and skilled nursing facilities (SNFs).

OBJECTIVE

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

BACKGROUND

Medicare Part B

Medicare Part B provides supplementary medical insurance to beneficiaries, including coverage of ambulance transports under a fee schedule. 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. Appendix B provides a table that shows the Medicare contractor and geographic composition for each jurisdiction.

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).³

¹ *Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports* ([OEI-09-12-00351](#)), issued September 28, 2015.

² The term “providers” refers to both independent ambulance suppliers and hospital-based ambulance providers.

³ The Social Security Act (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).

Medicare Coverage of Ambulance Transports

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 (1) basic life support (BLS), comprising transports that require an ambulance crew of at least two people, one of whom must be certified as an emergency medical technician and legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle; and (2) advanced life support (ALS), comprising transports that require an ambulance crew in which, in addition to the requirements for BLS transport, one of the two crew members must be certified at least as a paramedic or an emergency medical technician to perform one or more ALS services.

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.⁴ In addition, the transport must be to receive a medically necessary Medicare service or to return from such a service.⁵

Emergency ambulance transports are provided in response to emergency dispatches in accordance with local 911 protocols or the equivalent to treat emergency medical conditions. Examples of emergency medical conditions may include abnormal cardiac rhythm/cardiac dysrhythmia and trauma with major bleeding.⁶ Nonemergency ambulance transports are provided in response to nonemergency dispatches to treat nonemergency conditions.

Medicare covers ambulance transports to only the following destinations:

- from any point of origin to the nearest hospital (including a critical access hospital) or nearest SNF that is capable of furnishing the required level and type of care for the beneficiary’s illness or injury;
- from a hospital (including a critical access hospital) 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; or

⁴ CMS *Medicare Benefit Policy Manual*, Pub. No. 100-02 (Benefit Policy Manual), chapter 10, §§ 10.3 and 10.3.6.

⁵ Benefit Policy Manual, chapter 10, § 10.2.1.

⁶ CMS *Medicare Claims Processing Manual*, Pub. No. 100-04 (Claims Processing Manual), chapter 15, § 40.

- 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 (ESRD)), including the return trip (42 CFR § 410.40(e)).⁷

Provider Submission of Medicare Part B Nonemergency 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 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, the destination, and the total miles for the one-way transport. The provider indicates the transport level using a Healthcare Common Procedure Coding System (HCPCS) code.⁸

Providers bill for nonemergency ambulance transports and their associated ground mileage on separate claim lines using the HCPCS codes shown in Table 1 below.

Table 1: HCPCS Codes for Nonemergency Ambulance Transports⁹

HCPCS Code	Description
A0425	Ground mileage, per statute mile
A0426	Ambulance service, ALS, nonemergency transport, level 1
A0428	Ambulance service, BLS, nonemergency 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 “alpha” characters. Each alpha character represents an origin code or a destination code.¹⁰ The first-position alpha code designates the origin, and the second-position alpha code designates the destination, of the ambulance transport.¹¹ For example, the modifier RH indicates that a provider picked up a beneficiary from his or her residence and transported the

⁷ 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)).

⁸ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

⁹ Claims Processing Manual, chapter 15, § 30.B.

¹⁰ The “X” code (used for an intermediate stop at a physician’s office on the way to a hospital) is a destination code only.

¹¹ Claims Processing Manual, chapter 15, § 30.A.

beneficiary to a hospital.¹² Table 2 below shows the origin and destination codes for billing ambulance transports.

Table 2: Origin and Destination Codes for Billing Ambulance Transports¹³

Origin or Destination Code	Description
D	Diagnostic or therapeutic site other than P (physician’s office) or H (hospital) when these are used as origin codes
E	Residential, domiciliary, or custodial facility (other than a SNF)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g., an airport or a helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	SNF
P	Physician’s office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician’s office on way to hospital (destination code only)

Medicare Contractor Controls Related to Payment of Provider Claims

Medicare contractors must establish and maintain efficient and effective internal controls.¹⁴ These controls, including those over claim processing systems, are intended to prevent increased program costs caused by improper 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, prepayment edits in the contractors’ claim processing systems can detect when certain claims should not be paid.

HOW WE CONDUCTED THIS REVIEW

Medicare contractors nation-wide paid providers \$3.2 billion for approximately 18.9 million claim lines for nonemergency ambulance transports (billed using HCPCS codes A0426 and

¹² 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 origin or destination (Claims Processing Manual, chapter 15, § 30.A).

¹³ Claims Processing Manual, chapter 15, § 30.A.

¹⁴ CMS *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, § 10.

A0428) with dates of service from January 1, 2014, through December 31, 2016 (audit period). We identified 31,441 claim lines, totaling \$5,463,851, that were paid by Medicare for nonemergency ambulance transports to destinations not covered by Medicare. We also identified 31,201 claim lines, totaling \$3,170,089, that were paid by Medicare for ground mileage associated with nonemergency ambulance transports to destinations not covered by Medicare. We used computer matching, data mining, and other analytical techniques to identify these 62,642 claim lines, totaling \$8,633,940.

For each claim line, we evaluated compliance with Medicare billing requirements, and we relied on claim information to make our determination. We did not use medical review to determine whether services were medically necessary. We did not contact any of the providers but relied on the claim information they submitted for Medicare payment.

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.

FINDING

Medicare payments to providers for nonemergency ambulance transports did not comply with Federal requirements. Specifically, for our audit period, Medicare made improper payments for 62,642 claim lines, totaling \$8,633,940, for nonemergency ambulance transports to destinations not covered by Medicare (31,441 claim lines), including the identified ground mileage associated with the transports (31,201 claim lines). As of the publication of this report, the total improper payment amount of \$8,633,940 included claim lines outside of the 4-year claim-reopening period.¹⁵ Appendix C provides a summary of the improper payments to providers by jurisdiction.

These improper payments occurred because, during our audit period, CMS did not require the Medicare contractors to implement nation-wide prepayment edits specific to nonemergency ambulance transports that would deny payments for transports to destinations not covered by Medicare.

FEDERAL REQUIREMENTS

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 (Benefit Policy Manual, chapter 10, § 10.3). In addition, the transport must be to receive a medically

¹⁵ 42 CFR § 405.980(b).

necessary Medicare service or to return from such a service (Benefit Policy Manual, chapter 10, § 10.2.1).

Medicare covers ambulance transports to only the following destinations: (1) from any point of origin to the nearest hospital (including a critical access hospital) or nearest SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury; (2) from a hospital (including a critical access hospital) or SNF to the beneficiary's home; (3) 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; or (4) from a beneficiary's home to the nearest facility that furnishes renal dialysis (for a beneficiary who is receiving renal dialysis for treatment of ESRD), including the return trip (42 CFR § 410.40(e)).¹⁶

MEDICARE IMPROPERLY PAID PROVIDERS FOR NONEMERGENCY AMBULANCE TRANSPORTS TO DESTINATIONS NOT COVERED BY MEDICARE

Medicare made improper payments to providers for 31,441 claim lines for which providers billed nonemergency ambulance transports to destinations not covered by Medicare, such as the scene of an accident or acute event (destination code "S"). Therefore, the payments for these claim lines were completely unallowable.¹⁷

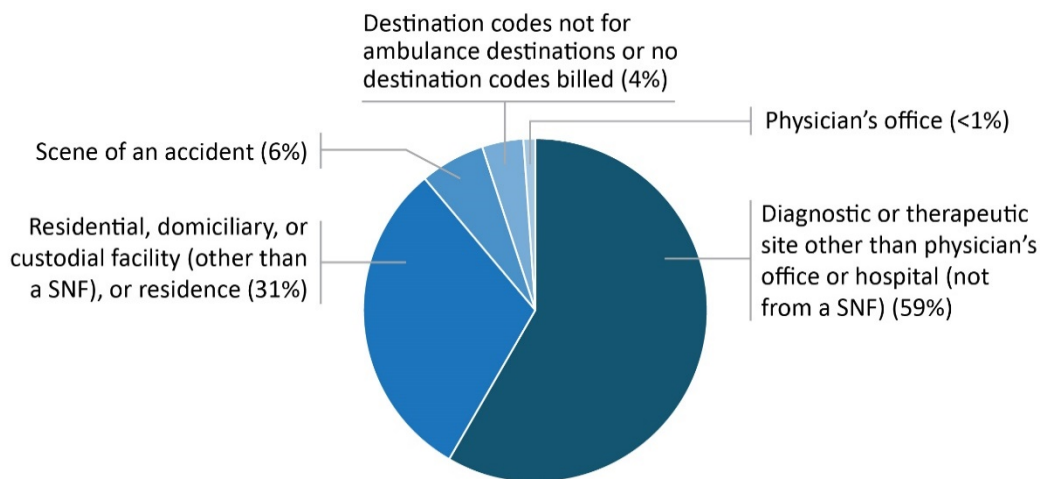
For example, one provider used modifier RS to bill for a nonemergency ambulance transport from a beneficiary's residence to a scene of an accident or acute event. The destination was not covered by Medicare for a nonemergency ambulance transport.

The figure on the following page shows the percentage of claim lines that were billed for nonemergency ambulance transports to each type of destination not covered by Medicare. The majority of these 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.

¹⁶ Even though a physician's office is not a covered destination, Medicare will cover an ambulance transport under special circumstances if it temporarily stops at a physician's office (Benefit Policy Manual, chapter 10, § 10.3).

¹⁷ We determined that an ambulance transport to a residential, domiciliary, or custodial facility (other than a SNF) or a beneficiary's residence was not covered by Medicare for a nonemergency transport if the transport originated from a location that Medicare would not determine as a covered destination and medically necessary Medicare services could not be performed at that location (e.g., the scene of an accident or acute event).

Figure: Percentage of Claim Lines for Transports to Destinations Not Covered by Medicare



As a result of the improper billing, the Medicare contractors made improper payments to providers totaling \$5,463,851 for these nonemergency ambulance transports to destinations not covered by Medicare. In addition, the contractors made improper payments to providers for 31,201 claim lines, totaling \$3,170,089, for the ground mileage associated with those transports.

PREPAYMENT EDITS WERE NOT ADEQUATE TO PREVENT IMPROPER PAYMENTS

During our audit period, CMS did not require the Medicare contractors to implement nationwide prepayment edits that would deny payments for nonemergency ambulance transports to destinations not covered by Medicare. Some Medicare contractors implemented claim processing edits specific to nonemergency ambulance transports, which resulted in fewer improper payments to providers in some jurisdictions compared with other jurisdictions. However, if CMS had required all Medicare contractors to implement these edits, it would have reduced the amount of improper payments we identified.

RECOMMENDATIONS

We recommend that CMS:

- direct the Medicare contractors to recover the portion of the \$8,633,940 in improper payments made to providers for claim lines that are within the 4-year claim-reopening period;
- for the remaining portion of the \$8,633,940, 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 in

accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation;

- 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
- 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 COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions it had taken or planned to take to implement our recommendations. 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

Medicare contractors nation-wide paid providers \$3.2 billion for approximately 18.9 million claim lines for nonemergency ambulance transports (billed using HCPCS codes A0426 and A0428) with dates of service from January 1, 2014, through December 31, 2016. We identified 31,441 claim lines, totaling \$5,463,851, that were paid by Medicare for nonemergency ambulance transports to destinations not covered by Medicare. We also identified 31,201 claim lines, totaling \$3,170,089, that were paid by Medicare for ground mileage associated with nonemergency ambulance transports to destinations not covered by Medicare. We used computer matching, data mining, and other analytical techniques to identify these 62,642 claim lines, totaling \$8,633,940.

For each claim line, we evaluated compliance with Medicare billing requirements, and we relied on claim information to make our determination. We did not use medical review to determine whether services were medically necessary. We did not contact any of the providers but relied on the claim information they submitted for Medicare payment.

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 file, but we did not assess the completeness of the file.

We conducted our audit from May 2017 to January 2018, which included contacting CMS in Baltimore, Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS staff regarding the types of system edits specific to nonemergency ambulance transports and the modifiers that providers used when billing for these transports;
- used CMS's National Claims History file to identify claim lines for nonemergency ambulance transports (billed using HCPCS codes A0426 and A0428) with dates of service for the audit period;

- used computer matching, data mining, and other analytical techniques to identify paid claim lines for nonemergency ambulance transports in which beneficiaries were transported to destinations not covered by Medicare (by evaluating the destination codes);¹⁸
- calculated the improper payment amounts for nonemergency ambulance transports to destinations not covered by Medicare;¹⁹ 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.

¹⁸ We considered nonemergency ambulance transports with destination codes “I” (site of transfer between modes of ambulance transport) and “X” (intermediate stop at a physician’s office on the way to a hospital) as allowable nonhospital destinations for nonemergency ambulance transports.

¹⁹ The improper payment for each nonemergency ambulance transport was calculated as the sum of the entire amount that the provider was paid for the nonemergency ambulance transport level of service (HCPCS codes A0426 or A0428) and the entire amount paid for ground mileage associated with the transport (HCPCS code A0425).

**APPENDIX B: MEDICARE CONTRACTOR AND GEOGRAPHIC COMPOSITION
FOR EACH JURISDICTION²⁰**

Jurisdiction	Medicare Contractor	States and Territories
5	Wisconsin Physicians Service Insurance Corporation (WPS)	Iowa, Kansas, Missouri, Nebraska
6	National Government Services, Inc. (NGS)	Illinois, Minnesota, Wisconsin
8	WPS	Indiana, Michigan
15	CGS Administrators, LLC (CGS)	Kentucky, Ohio
E	Noridian Healthcare Solutions, LLC (Noridian)	American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands
F	Noridian	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
H	Novitas Solutions, Inc. (Novitas)	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas
J	Cahaba Government Benefit Administrators, LLC (Cahaba)	Alabama, Georgia, Tennessee
K	NGS	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
L	Novitas	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania
M	Palmetto GBA, LLC (Palmetto)	North Carolina, South Carolina, Virginia, West Virginia
N	First Coast Service Options, Inc. (First Coast)	Florida, Puerto Rico, U.S. Virgin Islands

²⁰ The jurisdiction designation, Medicare contractor, and geographic composition for each jurisdiction are accurate as of October 31, 2017.

**APPENDIX C: IMPROPER PAYMENTS FOR NONEMERGENCY AMBULANCE TRANSPORTS TO DESTINATIONS
NOT COVERED BY MEDICARE (BY JURISDICTION)**

Jurisdiction	Medicare Contractor	Transports to Destinations Not Covered by Medicare		Mileage Associated With Transports to Destinations Not Covered by Medicare		Total Improper Payment
		No. of Paid Claim Lines	Improper Payment Amount	No. of Paid Claim Lines	Improper Payment Amount	
5	WPS	187	\$31,247	186	\$39,047	\$70,294
6	NGS	1,608	281,924	1,593	213,904	495,828
8	WPS	1,625	261,010	1,617	118,612	379,622
15	CGS	1,472	241,273	1,460	193,179	434,452
E	Noridian	1,885	356,614	1,861	115,104	471,718
F	Noridian	575	107,168	556	50,468	157,636
H	Novitas	1,163	197,085	1,144	184,365	381,450
J	Cahaba	18,315	3,193,202	18,210	1,813,494	5,006,696
K	NGS	91	15,350	91	4,911	20,261
L	Novitas	1,423	264,980	1,408	136,431	401,411
M	Palmetto	3,095	513,686	3,073	300,371	814,057
N	First Coast	2	312	2	203	515
Total		31,441	\$5,463,851	31,201	\$3,170,089	\$8,633,940

APPENDIX D: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY 25 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma 
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare (A-09-17-03018)

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.

CMS implemented a prior authorization model for repetitive, scheduled non-emergent ambulance transports in nine states. Since implementation in 2014, CMS has observed a decrease in expenditures for repetitive scheduled non-emergent ambulance transports and based on claims paid through February 17, 2017, has seen a savings of approximately \$340 million.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for ambulance services. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

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

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to recover the portion of the \$8,633,940 in improper payments made to providers for claim lines that are within the 4-year claim-reopening period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare contractors to recover the identified overpayments consistent with the agency's policies and procedures.

OIG Recommendation

The OIG recommends that for the remaining portion of the \$8,633,940, which is outside of the Medicare reopening and recovery periods, CMS instruct the Medicare contractors to notify providers of potential improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will analyze OIG's data to identify providers to notify of potential overpayments. CMS will then instruct its Medicare contractors to notify the identified providers of OIG's audit and the potential overpayment. CMS will track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

The OIG recommends that CMS direct the Medicare contractors to review claim lines for nonemergency ambulance transports to destinations not covered by Medicare after the audit period and recover any improper payments identified.

CMS Response

CMS concurs with this recommendation. CMS is currently conducting prior authorization reviews as part of the repetitive, schedule non-emergent ambulance transport prior authorization model. Additionally, CMS will notify the Medicare contractors of OIG's audit to consider a similar review for non-emergency ambulance transports to destinations not covered by Medicare after the audit period.

OIG Recommendation

The OIG recommends that CMS require the Medicare contractors to implement nationwide prepayment edits to ensure that payments to providers for nonemergency ambulance transports comply with Federal requirements.

CMS Response

CMS concurs with this recommendation. CMS will work to implement national prepayment edits for non-emergency ambulance transports regarding approved and inappropriate destinations.