

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAL NECESSITY
OF MEDICARE AMBULANCE SERVICES**



**JUNE GIBBS BROWN
Inspector General**

**DECEMBER 1998
OEI-09-95-00412**

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to assess the medical necessity of a sample of Medicare ambulance services that did not result in hospital or nursing home admissions or emergency room care.

BACKGROUND

Medicare pays for medically necessary ambulance services when other methods of transportation would endanger the beneficiary's health. Medicare reimbursement for ambulance services has increased substantially over the last decade from \$602 million to almost \$2.1 billion.

We examined the Health Care Financing Administration's (HCFA) 1 percent sample of all ambulance claims submitted and paid by Medicare carriers from January through June 1996. We divided the 1 percent sample into groups based on where the ambulance supplier transported the patient, and we reviewed the associated claims for other significant services on the same date of service that may explain the medical necessity of the transport. Of these, we identified a group of ambulance claims that did not result in hospital or nursing home admissions or emergency room care on the same date of service. This group, hereafter called Group 7, comprised 6.3 percent of all ambulance services. We then randomly selected 30 beneficiaries from Group 7 and collected the medical records for all services rendered on the same date as the ambulance transport. Staff at two Medicare carriers completed the medical review and assessed whether (1) the transport and associated services were medically necessary and (2) the level of service was appropriate to the patient's condition.

FINDINGS

Two-thirds of ambulance services in Group 7 were not medically necessary

Twenty of the 30 sampled cases were not medically necessary because alternative transportation would not have endangered the patient's health. Of the 20 unnecessary cases, 70 percent were for nonemergency services such as routine transports for outpatient diagnostic tests or transports between doctors' offices and nursing homes.

We recognize that the 30-case sample is small, but with such a high percentage of unnecessary services, the sample size is sufficient to show that more than half of the services in this group are medically unnecessary at the 95 percent confidence level.

Medicare allows approximately \$104 million each year for medically unnecessary Group 7 ambulance services

Based on the sample, we estimate that approximately 70 percent of the allowed reimbursement was for ambulance services that did not result in hospital or nursing home admissions or emergency room care and for which an alternate, less costly means of transportation would have been more appropriate.

RECOMMENDATION

The HCFA should develop a prepayment edit to verify the medical necessity of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care

The Office of Inspector General is aware that HCFA plans to work with the ambulance industry and other affected parties to establish a negotiated fee schedule effective January 1, 2000. This recommendation would provide a solution for one group of ambulance services until HCFA and the industry can better address issues of medical necessity, including clear and consistent definitions.

AGENCY COMMENTS

We received comments on the draft report from HCFA. The HCFA concurred with the need for medical review of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care. However, due to HCFA's efforts to ensure that Medicare payment systems are renovated before January 1, 2000, the agency does not believe that it can implement a prepayment edit prior to implementation of the major overhaul of ambulance payment policies required by *The Balanced Budget Act of 1997*. In the interim, HCFA will ask its Medicare carriers to review ambulance data and decide whether edits accompanied by local medical review policies or focused medical review of potential aberrant suppliers are appropriate.

OFFICE OF INSPECTOR GENERAL RESPONSE

The Office of Inspector General appreciates that HCFA is undertaking a massive effort to ensure that all health care payment systems are fully and correctly operational before January 1, 2000. We suggest that HCFA take whatever action it can now consistent with available resources and also include the issue identified in this report on their agenda during negotiations on the ambulance fee schedule.

We also made changes based on HCFA's technical comments. The full text of HCFA's comments appears in appendix C.

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INTRODUCTION

PURPOSE

The purpose of this inspection was to assess the medical necessity of a sample of Medicare ambulance services that did not result in hospital or nursing home admissions or emergency room care.

BACKGROUND

Medicare Coverage and Reimbursement of Ambulance Services

Medicare pays for ambulance services when "the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations."¹ Health Care Financing Administration (HCFA) regulations state that ambulance services are covered only if other forms of transportation would endanger the beneficiary's health. Usually, the patients are not ambulatory; that is, they are bedridden. Medicare does not cover other forms of transportation, such as a wheelchair or stretcher van, that could transport patients who do not require ambulance services.

Medicare beneficiaries may receive medically necessary ambulance services while they are in the hospital under Part A coverage. For example, a bedridden patient may be transported from one hospital to another for specialized treatments, such as radiology imaging or chemotherapy services. The ambulance supplier is reimbursed by the first hospital because payment for these services is included in the hospital's prospective payment for the patient's stay.

Part B covers ambulance services when Part A coverage is unavailable and the following three criteria are met:

1. The vehicle and personnel providing the service meet certain quality and crew size requirements;
2. Other methods of transportation would endanger the patient's health; and
3. The ambulance trip, as a general rule, stays within certain distance and destination limitations.

The cost of Medicare ambulance services has increased substantially over the last decade.

¹*The Social Security Act*, Section 1861(s)(7).

Reimbursement more than tripled between 1987 and 1996 from \$602 million to almost \$2.1 billion. To address the increases, HCFA implemented new codes in 1995 that instructed Medicare carriers to assign one of four billing methods to ambulance suppliers in their jurisdictions. The four methods differ by the degree to which suppliers can bill separately for their various charges including base rate, mileage, and supplies. Currently, suppliers bill with codes that are based on the service status (emergency or nonemergency), the level of service (basic or advanced life support), and the billing system (all-inclusive rate or base rate, mileage, and supplies billed separately).

Medical Necessity of Ambulance Services

Medicare criteria state that ambulance services must be reasonable for the treatment of the illness or injury involved. Other criteria may include, but are not limited to:

- ▶ emergency situations, such as accidents, injury, or acute illness;
- ▶ the need to restrain the patient;
- ▶ an unconscious patient;
- ▶ the instability of the patient's condition during transport;
- ▶ sustained acute stroke or heart attack; or
- ▶ severe brain hemorrhages.

Current HCFA guidelines do not define clearly the term "medical necessity." Over the years, HCFA has allowed the Medicare contractors to interpret the term based on the medical practices of the local community. Therefore, definitions may differ among the 25 Part B Medicare carriers who process ambulance claims. An ambulance claim that is denied by one carrier might be paid by another.

Previous Office of Inspector General Work on Medicare Ambulance Services

The Office of Inspector General (OIG) has released several reports about the medical necessity of ambulance services. In 1992 and 1994, the OIG found that advanced life support ambulances were used routinely for nonemergency trips, when, based on patients' medical conditions, basic life support ambulances could have met their transportation needs.² Furthermore, Medicare's allowance for advanced life support ambulance services had almost tripled in 4 years.³ Other OIG reviews of ambulance services to kidney dialysis patients found medically unnecessary transports and significant variances in payments to

²Office of Inspector General, *Review of Medical Necessity for Ambulance Services*, October 1992 (A-01-91-00513).

³_____, *Follow-Up to Review of Medical Necessity for Ambulance Services*, June 1995 (A-01-94-00528).

suppliers within the same geographical areas.⁴

Recent reports noted that (1) the current Medicare payment system “lacks common sense,”⁵ (2) Medicare ambulance costs and services are skyrocketing, and (3) while all States regulate ambulance services, less than half mandate levels of service and only one State requires advanced life support.⁶ The OIG continued to recommend that HCFA base reimbursement on the patient’s medical condition rather than the type of vehicle and personnel used.

Proposed Changes for Medicare Ambulance Services

The HCFA released a proposed regulation in June 1997 to revise the Medicare guidelines and reimbursement for ground ambulance services (air services were excluded). The proposed regulation would base reimbursement primarily on services that are medically necessary for the *beneficiary's condition* rather than the type of vehicle and personnel used. Several new provisions, such as requiring suppliers to obtain written physician certification for scheduled nonemergency ambulance transports, were included.

After HCFA released the proposed regulation, President Clinton signed *The Balanced Budget Act of 1997*. The Act includes several provisions for ambulance services. Major provisions:

- ▶ mandate that HCFA work with the industry to establish a negotiated fee schedule effective January 1, 2000;
- ▶ restrict Medicare increases to the Consumer Price Index minus 1 percent for 3 years; and
- ▶ authorize three demonstration projects with local governments to study alternative reimbursement methods for ambulance services.

In March 1998, some members of Congress were concerned that various sections of HCFA’s proposed regulation overlapped with ambulance payment issues in *The Balanced Budget Act*. They then urged HCFA to incorporate these sections into the negotiations. The HCFA will start negotiations with the ambulance industry and other affected parties before the end of 1998.

⁴ ___, *Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity*, August 1994 (OEI-03-90-02130) and *Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices*, March 1994 (OEI-03-90-02131).

⁵ ___, *Medicare Ambulance Payments*, November 1997 (OEI-05-95-00300).

⁶ ___, *State Ambulance Policies and Services*, February 1998 (OEI-09-95-00410).

METHODOLOGY

Targeted Sample Selection

During initial data analysis, we examined a 1 percent sample of all Medicare ambulance claims paid under Part B between January and June 1996. We reviewed combined hospital, nursing home, and outpatient data for each beneficiary. We then:

- ▶ divided the 1 percent sample into groups based on *where* the ambulance supplier transported the patient and *when* the service occurred,
- ▶ reviewed some claims within each group for (a) consistency of the expected association between the transport and the explanatory claims and (b) correct coding, and
- ▶ adjusted the placement of claims within each group, if necessary.

The following table shows the breakdown of the 1 percent sample of Medicare ambulance claims for January through June 1996. The groups show the association between the transport and the patient outcome. The percents may not total 100.0 percent due to rounding.

Group	Description of Ambulance Service	Frequency	Percent of Services	Allowed Amounts
1	At beginning of inpatient stay	16,429	43.8	\$ 4,621,716
2	Included with emergency room visit	9,710	25.9	2,695,118
3	At end of inpatient stay	5,545	14.8	1,154,362
4	At end of skilled nursing stay	383	1.0	84,403
5	At end of multiple-day outpatient claim	419	1.1	134,311
6	Patients with end-stage renal disease	2,666	7.1	1,020,681
7	<i>Other claims not included above</i>	2,368	6.3	724,437
TOTAL		37,520	100.0	\$ 10,435,028

After reviewing a sample of claims in each group, we noted that one group (population size 2,368 claims) was for ambulance transports that did not result in the expected hospital or nursing home admissions or emergency room care on the same date of service. We selected this group, hereafter called Group 7, for further review. We reviewed both Part A and Part B claims for this population. Group 7 claims usually were not associated with other significant services on the same date of service that may explain the medical necessity

of the ambulance trip. For the first half of 1996, Medicare reimbursed the 1 percent population of suppliers in Group 7 approximately \$724,437. If we assume that the last 6 months mirror the first 6 months, we estimate that Medicare reimbursed suppliers in Group 7 approximately \$149.28 million for calendar year 1996.

Medical Review

We selected a simple random sample of 30 beneficiaries from Group 7 for medical review. We requested copies of ambulance trip reports and documentation submitted with ambulance claims. We then collected medical records for other services rendered on the same date as the transport, such as physicians' records and nursing home records. When a patient used an ambulance within 1 week before and 1 week after the sampled transport, we requested additional records to document further the medical necessity for multiple transports.

Post payment medical review staff at two Medicare carriers completed the medical review. We asked the medical reviewers to assess whether (1) the transport and associated services were medically necessary and (2) the level of service was appropriate to the patient's condition. We originally intended to use the 30 cases as a medical probe sample. After completion of the medical review and analysis, we determined that we did not need a larger sample because the results of the 30-case sample were statistically valid.

We used the results to:

- ▶ determine the percent of medically unnecessary ambulance services,⁷
- ▶ calculate the overpayment for medically unnecessary services in the sampled Group 7, and
- ▶ estimate the potential savings for all claims in Group 7 for calendar year 1996, assuming the last 6 months mirror the first 6 months of the year.

Interviews with Ambulance Suppliers

We interviewed ambulance suppliers whose medical records were included in the simple random sample. Respondents were national, municipal, and small family-owned suppliers. Using a structured discussion guide, we obtained data on their revenue mix of emergency, nonemergency, advanced life support, and basic life support services. Suppliers described how they document medical necessity on ambulance trip reports and Medicare claims.

This report is part of a series on Medicare ambulance services prepared by the Office of

⁷See appendix A for the point estimate and confidence intervals for the proportion of medically unnecessary services.

Inspector General.

FINDINGS

The following findings relate to the 6.3 percent of ambulance services in Group 7 only.

Two-thirds of ambulance services in Group 7 were not medically necessary

Most cases did not meet Medicare's criteria for medical necessity

In 20 of the 30 sampled cases, transportation by ambulance was unnecessary because other means of transportation would *not* have endangered the patient's health. The 20 cases did not meet a major criterion for Medicare payment. Other medical records, especially from nursing homes and hospital outpatient departments, often disputed the patient's bedridden status that was claimed in the ambulance report. The table on the following page shows the sample's breakdown by service status (emergency or nonemergency) and level of service (basic or advanced life support).⁸

⁸*Basic life support* services are rendered by basic and intermediate emergency medical technicians, while the more intensive *advanced life support* services generally are rendered by paramedic emergency medical technicians. Though some suppliers may use different vehicles, the more important distinction between the levels of service is the personnel who staff the ambulance.

Service Status and Level of Service		Medically Necessary?			
		Yes		No	
		Cases in Sample	Percent of Cases	Cases in Sample	Percent of Cases
Emergency	Basic Life Support	3	10.0	2	6.7
	Advanced Life Support	4	13.3	4	13.3
Non- emergency	Basic Life Support	2	6.7	12	40.0
	Advanced Life Support	1	3.3	2	6.7
Total		10	33.3	20	66.7

We recognize that the 30-case sample is small, but with such a high percentage of medically unnecessary services, the sample size is sufficient to show that more than half of the services in this group are medically unnecessary at the 95 percent confidence level. (Refer to appendix A for details.)

The 10 medically necessary cases were billed at the appropriate level of service. Medical reviewers noted that the emergency advanced life support cases involved unconscious and unresponsive patients or patients with chest pain. Services, such as oxygen and intravenous medications, were appropriate to the patients' conditions and well-documented in the ambulance reports. Though the medical necessity was questionable for one case, the patient's condition was severe enough for hospital admission within 1 week.

Most unnecessary transports were for nonemergency services

Though medical reviewers found medically unnecessary cases in each service status and level of service, about 70 percent were for nonemergency services. For example:

- ▶ a patient was sitting unaided in a chair the day *of* and the day *after* the ambulance transport;
- ▶ another patient was sitting in a wheelchair for a long period of time before the transport, and she refused to be assisted back to bed once the ambulance arrived;
- ▶ guerny transport would have been appropriate for two patients;

- ▶ a patient called for an ambulance himself because he wanted an injection to control his trembling after drinking alcohol for 12 hours;
- ▶ one patient was transported to the doctor’s office for a follow-up appointment and then back to the nursing facility (a nonapproved Medicare transport); and
- ▶ a pleasant and cooperative 92-year-old patient was ambulatory with a walker and minimal assistance from ambulance staff.

Interviewed suppliers reported that they provide more nonemergency than emergency transports. They report that 60 to 93 percent of their transports are nonemergency while 7 to 40 percent are emergency transports. They described that, aside from inter-facility transfers, their nonemergency transports include standby for special events such as high school sporting events, community fairs, holiday celebrations with fireworks, and music concerts. They also provide emergency transportation as backup for their community’s primary 9-1-1 supplier.

Suppliers claim that many medically unnecessary transports stem from lack of adequate information prior to pickup

Some ambulance suppliers expressed frustration with the lack of complete and valid medical data on incoming calls, especially for nonemergency transports. Ambulance staff often arrive and find that some patients, particularly in nursing homes, do not meet Medicare’s criteria for ambulance transportation. Some nonemergency ambulance transports are completed for the *convenience* of the nursing home staff, especially for difficult patients. For example, one patient was ambulatory with assistance from a nursing aide or a wheelchair. However, the staff called an ambulance because the patient was noncommunicative (which was a normal situation for this patient) and exhibited obsessive-compulsive tendencies.

Suppliers often will transport patients with questionable medical necessity due to local medical standards and potential liability. They prefer to err on the side of being overly cautious rather than denying transport. One supplier commented, “We make a lot of runs to take blood pressure and put patients back in their beds who have fallen out. You never know when something will be serious.”

Medicare allows at least \$104 million each year for medically unnecessary Group 7 ambulance services

Medicare allowed approximately \$9,479 for the 30-case sample, of which \$6,606 (or 70 percent) was for medically unnecessary ambulance services. Applying the same 70 percent rate to all Medicare ambulance services for the first 6 months of 1996, Medicare allowed approximately \$52.1 million for the medically unnecessary services in Group 7. If, as we believe, the last 6 months of claims in Group 7 mirror the first 6 months of claims,

then we estimate that Medicare allows as much as \$104 million each year for medically unnecessary ambulance services.⁹ (See appendix B for the explanation of the cost estimate for the allowed amounts of medically unnecessary services in Group 7.)

⁹This is a non-statistical estimate which multiplies the full-year 1996 Medicare allowance for Group 7 of \$149.28 million by the proportion of medically unnecessary services which is 0.7.

RECOMMENDATION

The HCFA should develop a prepayment edit to verify the medical necessity of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care

The OIG recommends that HCFA screen incoming ambulance claims by matching them with hospital, nursing facility, emergency room, and physician claims. This could be accomplished by means of a prepayment edit in the Common Working File database. We expect that 90 percent of ambulance claims would pass through this screen successfully and would continue toward payment. Most of the remaining claims would consist of the Group 7 claims that we described in this report. Carriers would conduct a manual review of the remaining claims to determine whether they should be paid. These claims also could be analyzed for further program vulnerabilities such as fraud or abuse by individual ambulance suppliers.

The OIG is aware that HCFA plans to work with the ambulance industry and other affected parties to establish a negotiated fee schedule effective January 1, 2000. This recommendation would provide a solution for one group of ambulance services until HCFA and the industry can better address issues of medical necessity and consistent definitions.

AGENCY COMMENTS

We received comments on the draft report from HCFA. The HCFA concurred with the need for medical review of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care. However, due to HCFA's efforts to ensure that Medicare payment systems are renovated before January 1, 2000, the agency cannot divert resources to implement a prepayment edit prior to the implementation of ambulance payment policies mandated by *The Balanced Budget Act of 1997*. In the interim, HCFA will ask its Medicare carriers to review ambulance data and decide whether edits accompanied by local medical review policies or focused medical review of potential aberrant suppliers are appropriate.

The full text of HCFA's comments appears in appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

The Office of Inspector General fully understands that HCFA is undertaking a massive

effort to ensure that all health care payment systems are fully and correctly operational before January 1, 2000. We suggest that HCFA take whatever action it can now consistent with available resources and also include the issue identified in this report on their agenda during negotiations on the ambulance fee schedule.

We also made changes based on HCFA's technical comments.

Proportion of Medically Unnecessary Services

To calculate the proportion of services that were medically unnecessary, we simply divided the number of services in our sample (30 services) by the number that the medical reviewers determined were unnecessary (20 services). The resulting estimate and 95 percent confidence interval are displayed below.

Point estimate	95 percent confidence interval	
	Lower	Upper
0.67	0.50	0.84

Cost Estimate for Allowed Amounts of Medically Unnecessary Services in Group 7

In this report, we used the more conservative of two methods for calculating the amount that Medicare allowed for medically unnecessary services in our target population. These methods, which are described in more detail below, were (1) projection of the mean and (2) ratio estimation. Both methods yielded approximately the same estimate. We used the ratio estimate method in this report because it represented the more conservative (smaller) allowed amount. From this ratio estimate, we then calculated a nonstatistical estimate for all twelve months of 1996.

Projection of the Mean

For this method, we multiplied the sample mean medically unnecessary amount (\$220 per service) by the number of services in our target population (236,800 services)¹⁰ to estimate the amount that Medicare paid for medically unnecessary services provided to our target population during January through June 1996. The resulting estimate and 95 percent confidence interval are displayed below.

Point estimate	95 percent confidence interval	
	Lower	Upper
\$52.1 million	\$36.5 million	\$67.8 million

Ratio Estimation

For this method, we calculated the ratio of (1) the medically unnecessary allowed amount for January through June 1996 (\$52.1 million, as calculated above) to (2) the total allowed amount for the same time period (\$74.8 million, as projected from our sample). The resulting ratio and 95 percent confidence interval are displayed on the next page.

¹⁰For the calculations in this appendix, we treated 1 percent-sample amounts, multiplied by 100, as if they represented population amounts. Because the one-percent sample was so large, this approximation would not have changed the 95 percent confidence intervals that we report in this appendix.

Point Estimate	95 percent confidence interval	
	Lower	Upper
0.697	0.5213	0.8725

We then multiplied this ratio by \$72.44 million, which represents the actual allowed amount for the population that we selected our sample from.¹¹ The table below shows the resulting estimate and 95 percent confidence interval.

Point Estimate	95 percent confidence interval	
	Lower	Upper
\$50.5 million	\$37.8 million	\$63.2 million

We then calculated a nonstatistical estimate for the amount that Medicare allowed for medically unnecessary services in our target population for all twelve months of 1996. We multiplied the ratio calculated earlier (0.697) by the amount that Medicare allowed for our target population during all twelve months of 1996 (\$149.28 million) to arrive at an estimated \$104.0 million for medically unnecessary services.

¹¹The \$74.8 million is a projection from our sample, while the \$72.44 million is the actual amount for the population from which that the sample was selected.

Agency Comments

The full text of comments received from the Health Care Financing Administration follows.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: SEP 24 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-A DeParle*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medical Necessity of Medicare Ambulance Services" (OEI-09-95-00412)

We reviewed the above-referenced report that examined the medical necessity of a sample of Medicare ambulance services that did not result in hospital or nursing home admissions or emergency room care. The report acknowledges the Health Care Financing Administration's (HCFA) plans to work with the ambulance industry to establish a negotiated fee schedule as mandated by the Balanced Budget Act of 1997.

This report provides the first data linking Medicare ambulance services to other associated services and we appreciate the OIG's work in this area. Our specific comments on the report recommendation follows:

OIG Recommendation

HCFA should develop a prepayment edit to verify the medical necessity of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care.

HCFA Response

We concur with the need for medical review of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care. However, with the resource demands of our aggressive efforts to ensure that Medicare payment systems are renovated so that there will be no disruption in services or payments on January 1, 2000, and the need to stabilize systems to achieve compliance, we do not believe we can implement such an edit prior to our implementation of the major overhaul of ambulance payment policies required by the Balanced Budget Act. Rather than a prepay edit across the board, we will ask our carriers to review their ambulance data and decide whether edits accompanied by local medical review policies or focused medical review of potential aberrant providers are appropriate.

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We note that while screening incoming ambulance claims by matching them with hospital, nursing facility, emergency room, and physician claims through means of a prepayment edit in the Common Working File database would be feasible, it would only serve its intended purpose if all of the associated claims are submitted for payment prior to the ambulance claim. If the ambulance claim is submitted before all other claims have been entered into the system, it would lead to manual review by carriers of more claims (involving significant time and expense) than the subset of claims envisioned by OIG.

Editorial Comments

Page 1 - The report states that "Usually, the patients are not ambulatory; that is, they are bedridden." Our understanding is that this description properly applies only to non-emergency ambulance transports. However, the paragraph makes no distinction between the use of ambulances for emergency versus non-emergency transports.

Page 2 - The report states that "Medicare ambulance costs and services are skyrocketing," which suggests that they are continuing to rise. We note that previous OIG reports have stated that ambulance payments grew by 150 percent between 1987 and 1992, while total Medicare Part B expenditures grew by only 50 percent. While ambulance payments have continued to increase in the 1990's, they have done so at a slower rate, with annual increases of 15 percent from 1992 to 1994. This slowdown of payment growth suggests that policies adopted by HCFA in the 1990's may have yielded some results. However, this report does not mention any such policies or the recent slower rate of growth.

The word "advance" should be replaced with "advanced" each time it is used to describe "advanced life support" services.