DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VI
1100 COMMERCE STREET, ROOM 632
DALLAS, TX 75242

September 28, 2012

Report Number: A-06-11-00050

Mr. H. Stephen Williamson, MPH
President and Chief Executive Officer
Emergency Medical Services Authority
1111 Classen Drive
Oklahoma City, OK 73103

Dear Mr. Williamson:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *The Emergency Medical Services Authority of Oklahoma City Billed and Was Paid for Advanced Life Support Transports That Were Not Medically Necessary*. This draft report is subject to further review and revision. Please safeguard it against unauthorized use.

To properly consider your views on the validity of the facts and reasonableness of the recommendations in this report, we request that you provide us with written comments within 30 days from the date of this letter. Your comments should include a statement of concurrence or nonconcurrence with each recommendation.

- For each concurrence, please include a statement describing the nature of the corrective action taken or planned.

- For each nonconcurrence, please include specific reasons for the nonconcurrence and a statement of any alternative corrective action taken or planned.

Your written comments will be summarized in the body of our final report and included as an appendix. Please mail a paper copy of your comments to the address provided above.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, the final report will be posted at http://oig.hhs.gov. To reduce the risk of identity theft, please send us, in addition to the paper copy of your comments, an electronic copy with /Your Name/ typed in place of your written signature. The electronic copy should be in Microsoft Word/Corel WordPerfect format or a PDF converted from a Microsoft Word/Corel WordPerfect file. Providing an electronic copy also will

assist OIG in ensuring that your comments will be accessible to individuals with disabilities, as required by section 508 of the Rehabilitation Act of 1973, P.L. No. 93-112, as amended by P.L. No. 105-220.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414, or contact Warren Lundy, Audit Manager, at (405) 605-6183 or through email at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-11-00050 in all correspondence.

Sincerely,

for Patricia Wheeler
Regional Inspector General
for Audit Services

Enclosure

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

THE EMERGENCY MEDICAL SERVICES AUTHORITY OF OKLAHOMA CITY BILLED AND WAS PAID FOR ADVANCED LIFE SUPPORT TRANSPORTS THAT WERE NOT MEDICALLY NECESSARY

Patricia Wheeler
Regional Inspector General

September 2012
A-06-11-00050

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

EXECUTIVE SUMMARY

We estimate that the Emergency Medical Services Authority of Oklahoma City billed and Medicare Part B paid at least $365,889 for advanced life support emergency transport claims that did not meet Medicare coverage requirements.

WHY WE DID THIS REVIEW

Medicare Part B covers ambulance transports when a beneficiary's medical condition, at the time of transport, is such that any other type of transportation would endanger the beneficiary's health. The Office of Inspector General has identified ambulance transports as vulnerable to fraud, waste, and abuse. We conducted this review because the Emergency Medical Services Authority of Oklahoma City (EMSA) was one of the top billers of advanced life support (ALS) emergency transports in 2010.

Our objective was to determine whether ALS emergency transports billed by EMSA during 2010 met Medicare coverage requirements.

BACKGROUND

Medicare pays for different levels of ambulance transports. These levels of transport are differentiated by the qualifications and training of the crew and the equipment and supplies available on the ambulance. In Oklahoma, a paramedic emergency medical technician must be on the ambulance during an ALS transport.

For ambulance transports to be covered by Medicare, the beneficiary must be transported, the transport must be medically necessary, and the condition of the beneficiary would not allow transportation by other means. Medicare covers an emergency ambulance transport when provided after the sudden onset of a medical condition with acute symptoms of such severity that the absence of immediate medical attention could place the beneficiary's health in serious jeopardy.

In Oklahoma, ambulance suppliers are required to respond when called. If a transport does not meet Medicare coverage requirements, ambulance suppliers may seek payment from the beneficiary or a secondary insurance payer. These other payers may require a denial from Medicare before paying for a transport. Ambulance suppliers can seek denial of Medicare payment by adding modifier GY on the Medicare claim to denote that the transport was for a noncovered service.

EMSA was established in Tulsa, Oklahoma, in 1977 and began providing service to Oklahoma City, Oklahoma, in 1990. EMSA is Oklahoma's largest provider of prehospital emergency medical care, providing ambulance transports to residents in central and northeast Oklahoma.

TrailBlazer Health Enterprises, LLC (TrailBlazer), is a Medicare administrative contractor (MAC) that administers the Medicare program under contracting arrangements with the Centers for Medicare & Medicaid Services. TrailBlazer is the Medicare Part B MAC for Oklahoma and other States.

HOW WE CONDUCTED THIS REVIEW

Our review focused on 21,855 Medicare Part B ALS emergency ambulance claims with dates of service during 2010. In total, EMSA billed for and was paid $7,435,749 for these claims. We selected a simple random sample of 100 claims and requested that TrailBlazer perform a medical review to determine if the claims met Medicare coverage requirements. We used the medical review results to estimate the number of improperly billed and paid claims and the associated overpayment.

WHAT WE FOUND

EMSA billed and Medicare paid for ALS emergency transports that did not meet Medicare coverage requirements. Of the 100 claims in our random sample, EMSA appropriately billed and was paid for 90 of the claims. However, EMSA inappropriately billed and was paid for 10 ALS emergency transports that were not medically necessary, and EMSA did not include the GY modifier on the claims. Based on the sample results, we estimated that EMSA improperly billed for at least 1,210 ALS emergency transports with an associated overpayment of at least $365,889.

WHAT WE RECOMMEND

We recommend that EMSA:

- refund $365,889 to the Federal Government,
- strengthen its policies and procedures to ensure compliance with Medicare coverage requirements, and
- use modifier GY on Medicare claims for ambulance transports that do not meet Medicare coverage requirements.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare Part B covers ambulance transports when a beneficiary's medical condition, at the time of transport, is such that any other type of transportation would endanger the beneficiary's health. The Office of Inspector General has identified ambulance transports as vulnerable to fraud, waste, and abuse. We conducted this review because the Emergency Medical Services Authority of Oklahoma City (EMSA) was one of the top billers of advanced life support (ALS) emergency transports in 2010.

OBJECTIVE

Our objective was to determine whether ALS emergency transports billed by EMSA during 2010 met Medicare coverage requirements.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services. Medicare Part B covers medically necessary services such as doctors' services, outpatient care, home health services, and other medical services, including ambulance transports.

Levels of Ambulance Transport

Medicare pays for different levels of ambulance transports. These levels of transport are differentiated by the qualifications and training of the crew and the equipment and supplies available on the ambulance. For example, to provide an ALS-level service, an ambulance must be equipped with specialized equipment, such as a defibrillator, intravenous administration equipment, and certain medication. In Oklahoma, a paramedic emergency medical technician must be on the ambulance during an ALS transport.

Medicare Requirements for Ambulance Transports

For ambulance transports to be covered by Medicare, the following requirements must be met:

- the beneficiary must be transported,
- the transport must be medically necessary and reasonable for the condition of the beneficiary, and
- the condition of the beneficiary would not allow transportation by other means.

Medicare covers emergency ambulance transports, which should be provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- place the beneficiary's health in serious jeopardy,
- result in serious impairment of bodily functions, or
- result in serious dysfunction of any bodily organ or part.

In addition, the mileage for ambulance transports is covered when the transport is to the nearest appropriate facility.

Medicare Payments for Ambulance Transports

Suppliers of ambulance transports submit claims for payment to Medicare administrative contractors (MAC). Claims contain information such as beneficiary identifiers (e.g., name and Medicare number), the origin and destination of the ambulance transport, mileage, beneficiary diagnosis, and type of service provided (e.g., ALS).

In Oklahoma, ambulance suppliers are required to respond when called. If a transport does not meet Medicare coverage requirements, ambulance suppliers may seek payment from the beneficiary or a secondary insurance payer. These other payers may require a denial from Medicare before paying for a transport. Ambulance suppliers can seek denial of Medicare payment by adding modifier GY on the Medicare claim to denote that the transport was for a noncovered service.

The Emergency Medical Services Authority of Oklahoma City

EMSA was established in Tulsa, Oklahoma, in 1977 and began providing service to Oklahoma City, Oklahoma, in 1990. EMSA is Oklahoma's largest provider of prehospital emergency medical care. It provides ambulance transports to residents in central and northeast Oklahoma. EMSA is operated as a public trust authority of Oklahoma City government.

TrailBlazer Health Enterprises, LLC

TrailBlazer Health Enterprises, LLC (TrailBlazer), is an MAC that administers the Medicare program under contracting arrangements with CMS. TrailBlazer is the Medicare Part A and Part B Jurisdiction 4 MAC for Colorado, New Mexico, Oklahoma, and Texas.

HOW WE CONDUCTED THIS REVIEW

Our review focused on 21,855 Medicare Part B ALS emergency ambulance claims with dates of service during 2010. In total, EMSA billed for and was paid $7,435,749 for these claims, including the mileage. We selected a simple random sample of 100 claims and requested that TrailBlazer perform a medical review to determine if the claims met Medicare coverage

requirements. We used the medical review results to estimate the number of improperly billed and paid claims and the associated overpayment.

We assessed the reliability of the data from CMS's National Claims History file by electronically testing required data elements and by checking the basic reasonableness of the data against another source. We determined that these data are sufficiently reliable for the purposes of this report.

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 objective.

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

EMSA billed and Medicare paid for ALS emergency transports that did not meet Medicare coverage requirements. Of the 100 claims in our random sample, EMSA appropriately billed and was paid for 90 of the claims. However, EMSA inappropriately billed and was paid for 10 ALS emergency transports that were not medically necessary, and EMSA did not include the GY modifier on the claims. Medicare paid EMSA $3,349 for the 10 ALS emergency transports that were not medically necessary. Based on the sample results, we estimated that EMSA improperly billed for at least 1,210 ALS emergency transports with an associated overpayment of at least $365,889.

Section 1861(s)(7) of the Social Security Act states that when other means of transport can be utilized without endangering the individual's health (whether or not such other transportation is actually available), no payment may be made for ambulance service. Regulations (42 CFR § 410.40(d)) state that Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. 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. Failure to meet coverage requirements means that the beneficiary's condition did not warrant transportation by ambulance; rather, the beneficiary could have safely been transported by other means, such as taxi, private car, wheelchair van, or other type of vehicle.

RECOMMENDATIONS

We recommend that EMSA:

- refund $365,889 to the Federal Government,
- strengthen its policies and procedures to ensure compliance with Medicare coverage requirements, and
- use modifier GY on Medicare claims for ambulance transports that do not meet Medicare coverage requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

Scope

Our review focused on 21,855 Medicare Part B ALS emergency ambulance claims with dates of service during calendar year 2010. EMSA was paid a total of $7,435,749 for these claims, including the mileage.

We limited our review of EMSA's internal controls to those that were applicable to the sampled ALS emergency claims because our objective did not require an assessment of all internal controls related to EMSA.

We conducted our fieldwork at EMSA offices in Oklahoma City, Oklahoma, from December 2011 through June 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with EMSA personnel, CMS headquarters staff, and TrailBlazer medical review officials to gain an understanding of the Medicare ambulance benefit;
- used CMS's National Claims History file to identify Medicare Part B claims for which EMSA was paid for ALS emergency transports during our audit period;
- identified 21,855 Medicare Part B ALS emergency ambulance claims for which EMSA received $7,435,749 in payments, which included the related mileage payment for the transports;
- selected a simple random sample of 100 paid ALS emergency claims;
- obtained and reviewed records from EMSA that supported the 100 sampled claims;
- requested that TrailBlazer perform a medical review to determine whether the claims met Medicare coverage requirements and sent to TrailBlazer the records we obtained from EMSA; and
- used the results of TrailBlazer's medical review to estimate the number of improperly billed and paid claims and the associated overpayment.

We assessed the reliability of the data from CMS's National Claims History file by electronically testing required data elements and by checking the basic reasonableness of the data against

another source. We determined that these data are sufficiently reliable for the purposes of this report.

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 objective.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of EMSA's ALS emergency ambulance services and related mileage during calendar year 2010.

SAMPLING FRAME

We removed from the population 48 ALS emergency claims that we reviewed during survey work. The sampling frame consisted of the remaining 21,855 ALS emergency claims and the related mileage with Medicare payments to EMSA totaling $7,435,749.

SAMPLE UNIT

The sample unit was a paid ALS emergency ambulance claim for ambulance services.

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 with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number of ALS emergency claims billed inappropriately and the associated overpayment.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Medically Unnecessary Ambulance Claims	Value of Medically Unnecessary Ambulance Claims
21,855	$7,435,749	100	$33,836	10	$3,349

Estimated Value of Medically Unnecessary Ambulance Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$731,946
Lower Limit	$365,889
Upper Limit	$1,098,002

Estimated Number of Medically Unnecessary Ambulance Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	2,186
Lower Limit	1,210
Upper Limit	3,574