Questions and Answers
INSPECTOR GENERAL'S REPORT: MEDICAL NECESSITY OF MEDICARE AMBULANCE SERVICES
Final HCFA Press Office DRAFT -- December 8, 1998
For Internal Use Only

Background: The cost of Medicare ambulance services more than tripled between 1987 and 1996, from $602 million annually to almost $2.1 billion, prompting the Administration to request legislative authority to change ambulance payment policies. Additionally, HCFA issued a proposed regulation in 1997 to revise ambulance coverage policies. However, in a recent report, the HHS Inspector General examined 1 percent of all Part B ambulance claims paid between January and June 1996. Of this universe of 37,520 claims, 6.3 percent, or 2,368, were claims for beneficiaries who received ambulance services that did not result in hospital or nursing home admissions or emergency care on the same date the ambulance service was provided.

It's important to note that the Inspector General found that in 93 percent of the cases reviewed there was an admission to a hospital or nursing home, emergency care provided, or some other service provided that would warrant the use of ambulance services. The Inspector General then selected 30 cases from the group where no admissions or emergency care were provided for medical review, and found that in 20 of the 30 cases, the ambulance claims were medically unnecessary because alternative transportation would not have endangered the patient's health. Based on the extrapolation of only 20 cases, the Inspector General's report estimated that Medicare spends about $104 million annually for these kinds of medically unnecessary ambulance services.

The Inspector General has recommended that HCFA 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.

Q: **Medicare has been criticized repeatedly for overpaying ambulance providers. Why can't you correct these problems that have been cited repeatedly by the Inspector General?**

A: This Inspector General's report looked at ambulance claims from the first half of 1996. ~~Since 1995, and~~ It's important to note that the Inspector General found that in 93 percent of the cases reviewed there was an admission to a hosptial or nursing home, emergency care provided, or some other service provided that would warrant the use of ambulance services. It's also important to note that since 1996 we've taken a number of steps to ensure that ambulance companies bill Medicare properly, that Medicare pays correctly and, most importantly, that beneficiaries get appropriate ambulance services. For example, we issued a fraud alert in 1996 to put ambulance providers and Medicare carriers on notice about questionable practices, including billing for medically unnecessary and non-covered ambulance services.

Also, as the Inspector General's report notes, we issued a proposed regulation in June

1997 to overhaul and update Medicare coverage policies for ambulance services. The final regulation scheduled for publication in early 1999 will (1) tighten requirements for determining medical necessity, (2) require better documentation from ambulance companies, and (3) require physician certification for non-emergency ambulance services. We believe the adoption of the final rule will clarify the definition of medical necessity and cut down significantly on improper payments for ambulance services.

Additionally, under the Balanced Budget Act of 1997, Medicare will move to an ambulance fee schedule, meaning ambulance companies will be paid according to the service provided, instead of the current system, in which they are reimbursed based on their charges, which gives them little incentive for efficiency. HCFA has set up a negotiated rulemaking process, which brings government and private sector expertise to the table to develop this fee schedule. The negotiated rulemaking committee will begin work in early 1999, and use of the ambulance fee schedule will begin as soon as possible after Jan. 1, 2000 once Y2K concerns are addressed.

In fact, as early as 1995, we instructed Medicare carriers to assign new codes for ambulance services to show whether emergency or non-emergency services were provided, whether basic or advanced-life support services were provided and whether an all-inclusive payment rate or base rate with mileage and supplies billed separately were used. These changes created a consistent method to process claims and allowed us to collect specific information about what kinds of ambulance services were being provided to Medicare beneficiaries.

Q: **Why has it taken you so long to overhaul ambulance coverage and payment rules to correct these problems?**

A: It hasn't. In overhauling the coverage rules, we wanted to make sure that the fixes will enable beneficiaries to get appropriate services and that Medicare pays ambulance companies fairly. In developing new coverage regulations, we wanted input from outside experts, so we consulted with groups such as the American Ambulance Association and the American College of Emergency Physicians. We issued the propose dregulation in 1997, and we're on track to issue the final ambulance coverage regulation in early 1999.

On the payment issue, some members of Congress raised concerns in late 1997 that the coverage regulation overlapped with ambulance payment issues in the Balanced Budget Act, and they told us to remove these provisions from the proposed coverage rule and include them in the negotiated rulemaking for the fee schedule. We agreed. But we will begin work on this second effort early next year and use of the ambulance fee schedule will begin as soon as possible after Jan. 1, 2000 once Y2K computer work is complete.

Q. **Is that all you've done to correct these problems? It doesn't seem like very much.**

A. Since 1995, we've given more and more scrutiny to ambulance services being provided to Medicare beneficiaries, issued a fraud alert on questionable billing practices, issued a

proposed rule outlining a major overhaul of ambulance coverage policies, and we're now ready to sit down at the table with the private sector to hammer out the remaining coverage and payment issues.

Q: **The Inspector General has recommended that HCFA 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 report says HCFA can't implement the Inspector General's recommendation because of Year 2000 computer problems. Aren't you just blaming your inability to correct problems with ambulance overpayments on your Year 2000 work, which is behind schedule, too?**

A: First of all, we have taken steps to correct Medicare ambulance payments and agree with the Inspector General about the need for more prepayment scrutiny of ambulance claims. Once we have completed our Y2K work to make sure Medicare claims are paid promptly come Jan. 1, 2000, we will take action on the Inspector General's recommendation. It's important to us that our Y2K renovation and testing of systems is more than 90 percent complete and on track for the federal government's deadline.

In the meantime, we do believe that our contractors can perform more intense reviews of ambulance claims. We will send instructions to our contractors in early 1999 on how to scrutinize ambulance claims more closely.

[**BACKGROUND:** ~~In developing the prepayment edits,~~ HCFA's comments on the IG report note that screening incoming ambulance claims by matching them with hospital, nursing facility, emergency room and physician claims through a prepayment edit is feasible, but it would only serve its intended purpose if all of the associated claims are submitted prior to the ambulance claim. If the ambulance claim is submitted before all other claims have been entered in the system, it would lead to manual review by carriers of more claims and involve significant time and expense than the subset of claims envisioned by the Inspector General.]

Q. **What are you doing to stop ambulances from being used to transport seniors to fireworks displays and concerts?**

A. Medicare does not pay for ambulances to transport Medicare beneficiaries to these kinds of events. The Inspector General's report notes that ambulance providers said their non-emergency transports include standby time for community events such as sporting events, fireworks and concerts. These costs are included in an ambulance company's overhead costs. By law, Medicare payments to ambulance providers by law are based on their reasonable charges, which include a share of overhead costs.

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Comments:

As discussed - please let me know later today.

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