Office of Audit Services
Region I
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Boston, MA 02203
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December 14, 2004

Report Number: A-01-04-00520

Ms. Delia O'Connor
President
Caritas Norwood Hospital
800 Washington Street
Norwood, MA 02062

Dear Ms. O'Connor:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Ambulance Charges Claimed By Caritas Norwood Hospital – Fiscal Years 2002 and 2003." Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

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To facilitate identification, please refer to report number A-01-04-00520 in all correspondence.

Sincerely,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures - as stated

HHS Action Official:
Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services, Region I
JFK Federal Building
Room 2325
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF AMBULANCE CHARGES CLAIMED BY CARITAS NORWOOD HOSPITAL FISCAL YEARS 2002 AND 2003

DECEMBER 2004
A-01-04-00520

Office of Inspector General

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) administers Part A and Part B of the Medicare program through contracts with private organizations called fiscal intermediaries (FIs) and carriers to process and pay claims. Part B generally covers all medically necessary ambulance services, except for transfers of patients between hospitals, when Part A pays for the services under a diagnosis related group. Ambulance services fall into the categories of emergency or non-emergency. Emergency related services do not require a statement of medical necessity to support Federal reimbursement since the beneficiary's condition requires both the ambulance transportation itself and the level of service provided. However, non-emergency ambulance transports require ambulance suppliers to obtain, from the beneficiary's attending physician or other appropriate health care professional, a written physician statement certifying the medical necessity of requested ambulance transports for Federal reimbursement.

Caritas Norwood Hospital (the Hospital) is a 295-bed community hospital that serves patients in and around Norwood, Massachusetts. The Hospital is an acute care facility, and provides area residents with emergency medical and transport services through the Caritas Norwood Emergency Medical Services. The Hospital submitted 3,515 ambulance claims to the FI under Medicare Part B, totaling approximately $1.1 million in ambulance services for fiscal year (FY) ended September 30, 2002. For calendar years (CYs) 2002 to 2005 Medicare pays hospital suppliers for ambulance services using a blended rate. This rate includes a segment based on a fee schedule and another segment based on reasonable costs as reported on the Medicare cost report.

OBJECTIVE

The objective of our review was to determine whether the Hospital claimed ambulance charges in accordance with Medicare regulations.

SUMMARY OF FINDINGS

The Hospital was generally in compliance with Medicare regulations for claiming ambulance services costs. However, we identified internal control weaknesses for completing medical necessity forms and allocating ambulance costs between Part A and Part B on the cost reports.

Completing Medical Necessity Forms

Medicare requires a written physician statement certifying the medical necessity of non-emergency ambulance transports. Our analysis of the medical necessity forms for the 67 non-emergency claims selected in our sample disclosed that 19 were incomplete. Although the forms were signed and dated by the physician, the medical reason for the trip was not provided. The Hospital had not established adequate procedures to ensure that the physician completed the entire medical necessity form.

Without proper documentation, there is a risk that claims for non-emergency transports may not meet the Medicare reimbursement criteria. The hospital did provide additional medical record documentation to support the services in question.

Allocating Ambulance Costs

Medicare Part B covers all ambulance services, except for transfers of inpatients, when Medicare Part A pays for the services directly or indirectly under a diagnosis related group (DRG). The Hospital charged all of its Medicare ambulance service costs to Part B even though a small percentage of the ambulance services were provided to beneficiaries in a Medicare Part A stay. This occurred because the software used to prepare the Medicare cost report did not allocate ambulance costs to Part A. As a result, the Hospital overstated Part B costs and understated Part A costs on the cost reports for FYs 2002 and 2003.

RECOMMENDATIONS

We recommend that the Hospital:

- develop written policies and procedures for completing medical necessity forms including regular training of physicians and other appropriate individuals on the Medicare requirements for establishing medical necessity

- establish procedures to allocate ambulance costs related to inpatient transfers to Part A inpatient services.

HOSPITAL MANAGEMENT COMMENTS

In its response, dated December 6, 2004 (See Appendix), the Hospital agreed with and has adopted corrective actions for each of our recommendations.

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INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) administers Part A and Part B of the Medicare program through contracts with private organizations called fiscal intermediaries (FIs) and carriers to process and pay claims. Part B generally covers all medically necessary ambulance services, except for transfers of patients between hospitals, when Part A pays for the services under a diagnosis related group (DRG).

Caritas Norwood Hospital (the Hospital) is a 295-bed community hospital that serves patients in and around Norwood, Massachusetts. The Hospital is an acute care facility, and provides area residents with emergency medical and transport services through the Caritas Norwood Emergency Medical Services. The Hospital submitted 3,515 ambulance claims to the FI under Medicare Part B, totaling approximately $1.1 million in ambulance services for fiscal year (FY) ended September 30, 2002. For calendar years (CYs) 2002 to 2005 Medicare pays hospital suppliers for ambulance services using a blended rate. This rate includes a segment based on a fee schedule and another segment based on reasonable costs as reported on the Medicare cost report.

Medical Necessity

Medicare covers emergency and non-emergency ambulance services only if transportation in any other vehicle could endanger the beneficiary's health. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Emergency transports do not require a statement of medical necessity. However, non-emergency transports require ambulance suppliers to obtain from the beneficiary's attending physician or other appropriate healthcare professional, a written physician statement. The written physician statement must be signed and dated by the physician or appropriate health care professional and provide adequate information on the transport provided for each individual beneficiary to verify that the transport was medically necessary. Appropriate documentation must be kept on file and upon request presented to the contractor.

Allocation of Cost

Hospital-based ambulance suppliers bill their FIs under Medicare Part B, unless the service was provided for an inpatient beneficiary. If the beneficiary was an inpatient, the DRG payment includes a provision for the ambulance services provided during an inpatient stay and related costs are allocated to Part A on the Medicare cost report.

For calendar years (CYs) 2002 to 2005 Medicare pays hospital suppliers for ambulance services using a blended rate. This rate includes a segment based on a fee schedule and another segment based on reasonable costs as reported on the Medicare cost report.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine whether the Hospital claimed ambulance charges in accordance with Medicare regulations.

Scope

Medical Necessity

From a population of 3,515 ambulance claims, we reviewed a statistically valid sample of 100 claims for ambulance services rendered in FY 2002, which included 33 emergency and 67 non-emergency ambulance transports.

Cost Reports

We reviewed ambulance costs recorded to the Medicare cost reports for FYs ended September 30, 2002 and 2003.

Internal Controls

We did not review the overall internal control structure of the Hospital. Our internal control review was limited to obtaining an understanding of the process used to claim ambulance costs for program reimbursement and to report ambulance costs on the Medicare cost reports.

Our fieldwork was performed at Caritas Norwood Hospital in Norwood, Massachusetts, from June 2004 through August 2004.

Methodology

To accomplish our objectives, we:

- reviewed applicable Medicare laws and regulations
- interviewed hospital officials
- examined ambulance claim information related to sample items
- tested the medical necessity and extent of supporting documents related to sampled items
- tested ambulance costs reported in Medicare cost reports to source documents.

Our review was performed in accordance with generally accepted government auditing standards. On December 6, 2004 the Hospital responded to our draft report (See Appendix).

FINDINGS AND RECOMMENDATIONS

The Hospital was generally in compliance with Medicare regulations for claiming ambulance services costs. However, we identified internal control weaknesses for completing medical necessity forms and allocating ambulance costs between Part A and Part B on the Medicare cost report.

Incomplete Medical Necessity Forms

CRITERIA

Under Code of Federal Regulations, Title 42, Section 410.40(d), Medicare covers emergency and non-emergency ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation could endanger their health. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Section 410.40(d)(1) states that non-emergency transportation by ambulance is appropriate if the beneficiary is bed-confined and it is documented that the beneficiary's medical condition is such that other methods of transportation would endanger the beneficiary's health; or if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

For non-emergency transports, Sections 410.40(d)(2) and (d)(3) require ambulance suppliers to obtain a written physician statement signed by the physician or appropriate health care professional providing adequate information on the transport provided for each individual beneficiary to verify that the transport was medically necessary. Appropriate documentation must be kept on file and upon request presented to the contractor. The statement can be obtained from the beneficiary's attending physician or the following: a physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the attending physician, hospital or facility where the beneficiary is being treated and who has personal knowledge of the beneficiary's condition at the time the transport is ordered.

CONDITION

The 100 ambulance services claimed in FY 2002 included 33 emergency and 67 non-emergency ambulance transports. Our analysis of the medical necessity forms for the 67 non-emergency claims selected in our sample disclosed that 19 were incomplete. Although the forms were signed and dated by the physician, the medical reason for the trip was not provided.

CAUSE

The physicians did not in all cases complete the medical necessity forms because the Hospital did not develop written policies and procedures for completing medical necessity

forms including regular training of physicians and other appropriate individuals on the Medicare requirements for establishing medical necessity.

EFFECT

Without proper documentation, there is a risk that claims for non-emergency transports may not meet the Medicare reimbursement criteria. The hospital did provide additional medical record documentation to support the services in question.

Allocation of Ambulance Costs

CRITERIA

Under 42 CFR § 410.40, Medicare Part B covers all ambulance services, except for transfers of inpatients, when Medicare Part A pays for the services directly or indirectly under a diagnosis related group (DRG). The DRG payment for inpatient services includes non-physician outpatient services rendered during an inpatient stay. These outpatient services include, among other things, costs for transportation of a hospital inpatient by ambulance to and from another hospital or freestanding facility to receive specialized services not available at the hospital where the beneficiary is an inpatient.

Under 42 CFR § 414 the fee schedule for ambulance services will be phased in over 5 years beginning April 1, 2002. Payment for services furnished during the transition period is made based on a combination of the fee schedule payment for ambulance services and the amount the program would have paid absent the fee schedule for ambulance services… The reasonable charge or reasonable cost portion of payment … is equal to the supplier's reasonable charge allowance or provider's reasonable cost allowance for the prior CY, multiplied by the statutory inflation factor for ambulance services.

CONDITION

The Hospital charged all of its ambulance service costs to Part B even though about 3,500 Medicare ambulance transports related to Part A each year as follows:

- 23 ambulance transports (.7%) during FY 2002
- 43 ambulance transports (1.2%) during FY 2003.

CAUSE

The software used by the Hospital and FI did not allocate ambulance costs to Part A.

EFFECT

As a result, the Hospital overstated Part B costs and understated Part A costs on the cost reports for FYs 2002 and 2003.

RECOMMENDATIONS

We recommend that the Hospital:

- develop written policies and procedures for completing medical necessity forms including regular training of physicians and other appropriate individuals on the Medicare requirements for establishing medical necessity

- establish procedures to allocate ambulance costs related to inpatient transfers to Part A inpatient services.

HOSPITAL MANAGEMENT COMMENTS

The Hospital agreed with our findings and has developed the following:

- a written policy and procedure for completing medical necessity forms including regular training of physicians and other appropriate individuals on the Medicare requirements for establishing medical necessity

- a procedure to allocate ambulance costs related to inpatient transfers to Part A inpatient services.

APPENDIX

Caritas Norwood Hospital

800 Washington Street
Norwood, MA 02062
tel: 781•278•6001
www.caritasnorwood.org

Delia O'Connor
President

December 6, 2004

Mr. Michael J Armstrong
Regional Inspector General
For Audit Services
Department of Health & Human Services
Office of Audit Services
Region 1
John F Kennedy Federal Building
Boston, MA 02203

Common Identification Number A-01-04-00520

Dear Mr. Armstrong:

Pursuant to the recommendations established by the Office of Inspector General (OIG) for Caritas Norwood Hospital to develop the following:

1. A written policy and procedure for completing medical necessity forms including regular training of physicians and other appropriate individuals on the Medicare requirements for establishing medical necessity.

2. A procedure to allocate ambulance costs related ti inpatient transfers to Part A inpatient services.

The attached policy and procedures represents a formal response to the Office of Inspector General recommendations to the draft report entitled "Review of Ambulance Charges Claimed by Caritas Norwood Hospital for Fiscal Years 2002 and 2003.

Sincerely

Delia O'Connor

Attachment

Caritas Norwood Hospital
OIG Corrective Action – Cost Reporting

Background Per OIG Report

Hospital-based ambulance suppliers bill their FIs under Medicare Part B, unless the service was provided for an inpatient beneficiary. If the beneficiary was an inpatient, the DRG payment includes a provision for the ambulance services provided during an inpatient stay and related costs are allocated to Part A on the Medicare cost report.

For calendar years (Cys) 2002 to 2005 Medicare pays hospital suppliers for ambulance services using a blended rate. This rate includes a segment based on a fee schedule and another segment based on reasonable costs as reported on the Medicare cost report.

OIG Recommendation

Establish procedures to allocate ambulance costs related to inpatient transfers to Part A inpatient Services.

Cost Reporting Methodology

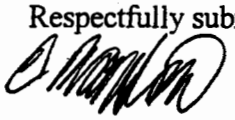
1. The Hospital uses the same cost reporting software as the Fiscal Intermediary (FI).
2. Ambulance charges are segregated between inpatient and outpatient services depending on the service type billed to Medicare.
3. The FI accumulates said charges in the Provider Statistical & Reimbursement (PS&R) system based on billings submitted to the FI.
4. At year-end, the FI sends to providers the PS&R, which accumulates charges based on submitted bills by department (O.R., Radiology, etc.) and type (Inpatient, Psych, Outpatient, etc.).
5. Medicare departmental costs are determined by multiplying the Ratio of Cost-to-Charge (RCC) by PS&R departmental charges.
6. The RCC is determined by taking fully loaded cost (direct cost +or- recoveries & adjustments + overhead cost by department) divided by total departmental charges.

Conclusion

The PS&R accumulates Medicare revenue based on billed charges for service types (inpatient, outpatient, etc.). When inpatient charges are billed, it is accumulated in the inpatient portion of the PS&R and reported on the cost report as such; the same is true for outpatient charges.

Therefore, only outpatient cost (Medicare outpatient charges x RCC) is allocated to outpatient, and inpatient Medicare cost is not allocated to outpatient services by virtue of the PS&R accumulation.

Respectfully submitted,



Edward A. Namenson, Director of Finance

CARITAS NORWOOD HOSPITAL

MANUAL Clinical Practice
SECTION 3 POLICY NO. 14
DATE WRITTEN 12/04
LAST REVIEW
LAST REVISION

TITLE: Documenting Evidence of Medical Necessity for Ambulance Transfers

PURPOSE:

To outline the hospital's responsibilities for verifying and documenting that a medical reason exists to support transferring patients via ambulance.

POLICY:

1. Documented evidence of medical necessity must be included as part of the medical record for all patients where an ambulance is needed to transfer a patient (non-emergency) from the emergency department or any inpatient unit.

2. Evidence of medical necessity must be documented in the appropriate form prior to Emergency Medical personnel (EMS) transporting patient via ambulance.

PROCEDURE:

A. Emergency Department Transfers

When an ambulance is needed for Non-Emergency Transfers from the Emergency Department

- Physician documents the order. For patients with Medicare, the physician documents on the "Emergency Department Physician Record" (see attachment #1). For patients with Medicaid/Mass Health, the physician documents on the distinct "Ambulance Medical Necessity Form" (see attachment #4).
- Physician checks off the box labeled Ambulance Medical Necessity box and signs and dates the order.
- EMS dispatch is contacted to request an ambulance.
- The nurse, in the final step in the discharge, must review the form and check the box, if it has not been previously checked.

B. Inpatient Unit Transfers

When an ambulance is needed for Non-Emergency Transfers from an Inpatient Unit.

- Physician documents the order on the "Referral Discharge Order Form" (See attachment # 2).
- Physician will check off the "Ambulance Medically Necessary" box in section 8 of the form, and signs and dates the order (designee/Case Manager).
- EMS dispatch is contacted to request an ambulance.
- The nurse, in the final step in the discharge, must review the form and check the box, if it has not been previously checked.

C. Other Outpatient Areas

When an ambulance is needed for non-Emergency transfers from other Outpatient Areas.

- Physician will document the order and evidence of medical necessity in an appropriate section of the patient record.

D. The hospital must ensure that appropriate documentation of evidence of Medical Necessity is maintained as part of the permanent medical record.

- A copy of the completed form must be given to the Caritas Norwood Hospital EMS personnel.
- EMS personnel will not transfer patients via ambulance without a completed form.
- The completed Medical Necessity form, either ED or Referral/discharge form and the ambulance run report must be given to Paramedic Services for billing.
- Completed form and ambulance run report is sent to Medical Records.
- Medical Record personnel will file the medical necessity and ambulance run sheet in the patient's medical record according to protocol.

E. Education

- Education and training is required of all physicians and other selected individuals and will be included as part of all new orientations.
- Documentation of this education will be maintained through the medical staff office.

Mary Ann Glynn, MBA, RN
Vice President, Patient Care Services

J Richard Young, MD
Vice President, Medical Affairs

Stfdev/Pol.Clin./Ambulance Necessity/12/04/cam