DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT 21 1992

From Bryan B. Mitchell
Principal Deputy Inspecto General
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Subject Review of Medical Necessity For Ambulance Services (A-01 -91-00513)

To Toby, Jr.
Acting Administrator
Health Care Financing Administration

Attached is our final audit report which presents the results of our nationwide review of medical necessity for ambulance services. Our review shows that, from 1986 to 1989, the number of trips by Medicare beneficiaries in advanced life support (ALS) ambulances increased by 131 percent while the number of trips in basic life support (BLS) ambulances increased by only 14 percent. Further, allowed charges for ALS and BLS ambulances increased by $72 million from 1988 to 1989. Of this amount, $53 million or 73 percent was attributable to increased utilization of ALS ambulances.

In our opinion, the increase in ALS utilization is due, in large part, to Health Care Financing Administration (HCFA) policies which base payment on the mode of transportation rather than the medical necessity for the level of service. Based on our sample of ALS claims, we estimate that $15.95 million would be saved annually, $12.76 million by the Medicare Part B program and $3.19 million by beneficiaries, if payment were based on the medical need of the beneficiary. We are recommending that HCFA modify its Medicare Carriers Manual to allow payment for nonemergency ALS services only when medically necessary at that level of service. We are also recommending that HCFA instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary and that HCFA closely monitor carrier compliance.

Based on the comments received from your office, HCFA has generally concurred with our recommendations and has agreed to take corrective action. We appreciate the cooperation given us in this review.

Please advise us, within 60 days, on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant inspector General for Health Care Financing Audits at-(41 0) 966-7104. Copies of this report are being sent to other interested top Departmental officials.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAL NECESSITY FOR AMBULANCE SERVICES

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SUMMARY

Effective March 1, 1982, the Health Care Financing Administration (HCFA) instructed carriers to permit separate reimbursement rates for basic life support (BLS) and advanced life support (ALS) ambulances. Data obtained from HCFA shows that, from 1986 to 1989, the number of trips in ALS ambulances increased by 131 percent while the number in BLS ambulances increased by only 14 percent. Further, allowed charges for base rate ALS and BLS ambulance services (exclusive of associated services which are separately billed) increased by $72 million from 1988 to 1989. Of this amount, $53 million or 73 percent was attributable to increased utilization of ALS ambulances. In our opinion, the increase in ALS utilization is due, in large part, to HCFA policies which base payment on the mode of transportation rather than the medical necessity for the level of service.

Section 5116.1 of the Medicare Carriers Manual (Carriers Manual) defines the types of services provided by BLS and ALS ambulances. Both types of ambulances are equipped for BLS; however, ALS ambulances are equipped with more complex life sustaining equipment. Although the Carriers Manual requires the use of an ALS ambulance for the supplier to obtain reimbursement at the ALS rate, it does not require the provision of ALS level services. The Carriers Manual only requires that transportation by ambulance be medically necessary. The requirement for determining medical necessity was established before HCFA instructed carriers to permit separate reimbursement rates for BLS and ALS ambulances. The Carriers Manual does not require medical justification nor does it establish medical criteria considered necessary for payment at the ALS level of service. Since carriers are required to establish medical necessity only for an ambulance, not for a BLS or an ALS ambulance, the level of service provided seldom enters into the payment decision.

Section 5246.4 of the Carriers Manual requires reduction in payment to the lowest level necessary to meet the patient's medical need. However, the Carriers Manual does not require certification nor does it contain specific guidelines for carriers to evaluate medical necessity at the ALS level. Rather, the Carriers Manual and HCFA guidance allows payment at the ALS level when claimed by suppliers or mandated by local ordinance. In 18 percent of the cases we reviewed for ALS services, we found that the beneficiary's medical condition supported a BLS level of service. As a result, carriers are sometimes paying the ALS rate for ambulance services when, in our opinion, the less costly BLS level of service would ensure the beneficiary's safety.

We believe that the Medicare Part B program should contain specific controls to ensure that reimbursement for ambulance services at the ALS level is justified. We estimate that the Medicare program allowed $15.95 million for nonemergency ALS services for Calendar Year (CY) 1989 which, in our opinion, were not necessary at the ALS level of service and for which BLS services were available in the same city'or town. We recognize that in some rural areas it may be impractical or uneconomical to

provide both the ALS and BLS levels of service. Therefore, in calculating our projected savings, we considered a lower level of service as appropriate only when we could determine that a BLS level of service was available in the same city or town and sufficient to ensure the beneficiary's safety.

Our review also noted significant differences between carriers in allowed charges for the ALS level of service. Based on information obtained from the carriers, we found that similar items, such as oxygen and disposable supplies, were treated differently for reimbursement purposes. However, we could not explain the variances in allowed amounts for ALS services between carriers solely on the observed differences in the carrier treatment of various items. We believe that these variances occurred, to some extent, because HCFA guidelines did not establish a uniform listing of items for carriers to use when establishing ALS rates. The effect is that rates were not uniformly established and cannot be easily compared. Uniform HCFA guidelines, delineating which items are reimbursable under the base ALS rate, would enable an equitable comparison of rates between carriers and show whether corrective action is needed to resolve apparent inequities.

We recommend that HCFA revise its Carriers Manual to require that payment for nonemergency ambulance services at the ALS level be allowed only when medically necessary and not be impacted by local ordinances mandating ALS services. In this regard, HCFA should consider the use of physician certifications to authenticate the need for the ALS level of service. Further, we are recommending that carriers be instructed to institute controls to ensure that payments for ALS services are based on the medical need of the beneficiary and that HCFA closely monitor carrier compliance. We estimate that $15.95 million would be saved if payment was based on the medical need of the beneficiary. Of these savings, we estimate that $12.76 million would accrue annually to the Medicare Part B program and $3.19 million would accrue annually to beneficiaries. These allocations of savings are based on the beneficiary co-payment requirement of 20 percent of allowed charges but do not consider any annual deductible. We are also recommending that HCFA revise its guidelines to carriers to specify the items to be included in the all-inclusive ALS rate. Uniform HCFA guidelines would enable an equitable comparison of rates between carriers and show whether corrective action is needed to resolve apparent inequities in reimbursement rates.

In response to our draft report, HCFA officials expressed general agreement with the report and stated they would propose regulatory changes to implement our recommendations. We agree with HCFA's desire to provide the public and affected ambulance companies the opportunity to comment through the regulatory process. The HCFA's comments are presented in their entirety as Appendix II to this report.

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INTRODUCTION

This report presents the results of our nationwide review of medical necessity for ambulance services furnished by suppliers under Part B of title XVIII (Medicare) of the Social Security Act. The objective of our review was to analyze ambulance utilization, payments, and policies to determine methods for controlling Medicare Part B ambulance costs. Our review included dates of service from January 1, 1989 to December 31, 1989 extracted from HCFA's Part B Medicare Annual Data (BMAD) System files as of June 7, 1991. In 1989, Medicare Part B base rate allowed charges were $557 million; $170 million for ALS ambulance services and $387 million for BLS ambulance services.

BACKGROUND

The Social Security Act, section 1861 (s) (7), provides for coverage of ambulance service where the use of other methods of transportation is contraindicated by the individual's condition. The limitations for coverage of ambulance services are specified in title 42 of the CFR, section 410.40, and include the requirement that the services be medically necessary, specifically that other means of transportation would endanger the beneficiary's health.

The Emergency Medical Services Systems (EMSS) Act of 1973, which amended the Public Health Services Act by adding title XII, provided for grants to assist geographic areas which demonstrated a need for establishment or improvements of EMSS. The intent of the EMSS Act was to encourage, in part, more sophisticated levels of ambulance services. In rural areas, nonprofit or public agencies furnishing ambulance services were targeted for improvements. The EMSS Act required that an Emergency Medical Services (EMS) plan include a central communications system and an adequate emergency medical transportation system. The EMSS Act also required that the plan include an adequate number of ground and other vehicles to meet the individual characteristics of the system's service area. Effective March 1, 1982, HCFA instructed the carriers to permit separate reimbursement rates for BLS and ALS ambulances. These instruct&s are contained in section 5116.1 of the Carriers Manual. Both types of ambulances are equipped for basic services such as control of bleeding, treatment for shock, cardiopulmonary resuscitation, etc. However, ALS ambulances have complex life sustaining equipment and radio/telephone hookups for patient evaluation and monitoring by a physician or hospital emergency staff. In locations where both types of service are available, the established ALS rate is allowable when an ALS ambulance is used. Similarly, the established ALS rate is allowed in locations where only ALS services are available.

Sections 5116.1 and 5246.4 of the Carriers Manual advise carriers to monitor suppliers to ensure that they practice economical care. The Carriers Manual advises that reimbursement should be limited to the less expensive level of service when suppliers repeatedly use ALS ambulances and less expensive BLS ambulances are available that would have met the patient's need, or when suppliers actually furnish a less expensive level of service.

Section 2120 of the Carriers Manual establishes the criteria for medical necessity. It contains the same requirements as published in the Social Security Act and the Federal Regulations. The requirement for determining medical necessity was established before HCFA allowed separate reimbursement rates for BLS and ALS ambulances. Consequently, the Carriers Manual does not contain specific guidelines for carriers to evaluate medical necessity for reimbursement at the ALS level of service.

SCOPE

We conducted our review in accordance with generally accepted government auditing standards. The objective of our review was to analyze ambulance utilization, payments, and policies to determine methods for controlling payments for ambulance services under Medicare Part B. Our review included dates of service from January 1, 1989 to December 31, 1989. Allowed payments for these dates of service were extracted from HCFA's BMAD files as of June 7, 1991. In 1989, Medicare Part B allowed charges were $557 million; $170 million for ALS ambulance services and $387 million for BLS ambulance services. These allowed amounts are exclusive of associated ambulance services which are separately billed.

To accomplish our objective we:

- reviewed and evaluated Carriers Manual guidelines regarding payment for ambulance services;
- extracted ambulance statistics from HCFA's BMAD file to perform a trend analysis on ALS and BLS payments for ambulance services and utilization over a 4-year period ended December 31, 1989;
- verified survey data and procedures for the Massachusetts carrier;
- selected a random sample of 8 carriers and 50 ALS services claimed from each carrier for CY 1989;
- reviewed the allowed charges and supporting documentation to determine whether carrier requirements relating to medical necessity were met;

- solicited and reviewed each sampled carrier's procedures for determining medical necessity for ALS and BLS ambulance services;

- reviewed State and local licensing and certification requirements for ALS and BLS ambulances for the States in which carriers were selected:

- utilized the Department of Commerce, Bureau of the Census' Geographic Identification Scheme; Census of Population and Housing, issued April 1983, classifications of supplier locations as urban or rural;

- utilized carrier and State EMS agencies' classifications of ambulance suppliers to determine the availability of level of services in cities and towns; and

- utilized a multi-stage variable appraisal of our statistical sample to estimate the savings that would have accrued if medical necessity at the ALS level was a factor in determining payment.

To select the carriers for our study, we utilized a two-stage sample based on probability proportional to size, whereby the relative sizes of the sampling units are considered when selecting primary units to include in the sample. The first stage consisted of the random selection of eight Part B Medicare carriers. The relative size of the carriers was based on dollar amounts allowed for 1989 ALS base rate ambulance services. The selected carriers represented Arkansas, California, Florida, Texas, Georgia, Oregon, Missouri, and West Virginia. Our review did not include the carriers for Kentucky, Puerto Rico, and Rhode Island because BMAD data was not available for CY 1989. In addition, our review did not include carriers for the States of New Jersey, Maryland, and part of New York because the level of activity did not warrant their inclusion. Therefore, these six carriers were not included in our projected cost savings.

The second stage of our sample consisted of the selection of 50 ALS base rate line item charges allowed for each carrier. The 50 line item charges were randomly selected from a computer file of 1989 ALS ambulance services extracted from HCFA's BMAD beneficiary file. We recognize that in rural areas targeted by the EMSS Act of 1973, it may be impractical or uneconomical to provide both the ALS and BLS levels of service. Therefore, in calculating our savings, we included the difference between the amounts allowed for ALS and BLS levels of service only when we could determine that BLS services were available in that city or town and sufficient to ensure the beneficiary's safety. We considered a service as available if the supplier offered BLS services or a BLS supplier was located in the same city or town in which the ALS supplier was located. Details of the methodology used in selecting and appraising the sample are included as Appendix I to this report.

Our review of internal controls at the carriers was limited to the portion of ambulance service claims processing that dealt with determinations of medical necessity for ALS and BLS levels of service. Testing was limited to a review of ALS base rate ambulance services provided to Medicare beneficiaries during 1989 and did not include amounts billed separately such as mileage or disposable supplies.

We performed our review between April and October 1991. During this period we were in contact with officials at HCFA central and regional offices, the eight carriers included in our review, State and local licensing and certification authorities, State EMSS agencies, and members of the American Ambulance Association.

FINDINGS AND RECOMMENDATIONS

We found that 18 percent (71 claims) of the 400 claims reviewed were for services which were not medically necessary at the ALS level of service and not in response to an emergency situation. In addition, we determined that the BLS level of service was available in that city or town and would have been sufficient to ensure the beneficiaries' safety for each of the 71 questioned claims. The 71 claims included 52 prescheduled patient transfers and 19 nonemergency transports for treatment of chronic medical conditions. As a result of our tests, we believe that suppliers are sometimes paid at the higher ALS rate for ambulances used to transport patients needing only a BLS level of service.

We believe that savings of $15.95 million could be realized annually if HCFA allowed payment for nonemergency services at the ALS level only when medically necessary. We do not believe that Medicare payment should be impacted by local ordinances mandating ALS services. Further, carriers should be instructed to institute controls to ensure that payments for ALS services are based on the medical need of the beneficiary. Carrier compliance should be closely monitored by HCFA.

HCFA POLICY

Section 5246.4 of the Carriers Manual requires a reduction in payment to the lowest level necessary to meet the patient's medical need. This section states:

> "When the level of service reported on a claim is not reasonable and necessary; i.e., when it has been determined either by you or by a peer review organization pursuant to a contract with the Secretary that a less expensive level of the service would have met the patient's medical need; or when a less expensive level of the service was actually furnished, reimbursement must be based on the reasonable charge for the less expensive level of the service."

Section 5116.1 also advises carriers to monitor suppliers to ensure that they practice economical care. The repeated use of ALS ambulances in situations when carriers should have known that less expensive BLS ambulances were available and medically "appropriate" constitutes uneconomical practices by suppliers. It is also uneconomical for suppliers to limit the availability of BLS ambulances so that ALS ambulances

must be substituted when a BLS ambulance would have been sufficient. If the carrier becomes aware of such practices, the carrier should limit allowed charges to the lower reasonable charge established for BLS ambulances.

However, section 5116.1 of the Carriers Manual allows carriers to pay ALS rates when an ALS ambulance is used even if only a BLS level of service is necessary. This is supported by HCFA guidance sent on February 5, 1990 to the Associate Regional Administrator for Medicare in Seattle. The memo states in part:

> "With regard to your first question of whether or not ambulance coverage is based on the individual patient's need for specific services, HCFA does not, at this time, make a coverage distinction between ALS and BLS services. The instructions at the Medicare Carriers Manual (MCM) section 5116FF do allow a higher payment for ALS ambulances. As the first paragraph of MCM section 5116.1 indicates, the instructions are specifically intended to recognize-the increasing.-use. of more sophisticated ambulances, and the high costs associated with them.. Generally, these payments are for the: ambulance transportation furnished to patients, and' not for any specific service."
>
> "While Congress made a distinction between "transportation. by ambulance" and "normal transportation," there is nothing in the law or committee reports which would preclude higher Part B reimbursement for ambulance services furnished by specialized types of ambulances. Since the specialized ambulances are more expensive for ambulance companies to acquire and operate, we see no reason, why. the programs allowances should not be responsive to the resulting charging practices."

The requirement for determining medical necessity was established before HCFA instructed carriers to pay for ambulances at the ALS or BLS level. Further, requirements for suppliers to provide claims data that would allow carriers to determine the level of service required were not instituted. Section 2125 of the Carriers Manual does not contain specific guidelines for carriers to evaluate medical necessity at the ALS level. Since carriers are required to establish medical necessity only for an ambulance, not for a BLS or an ALS ambulance, the level of service required seldom enters the payment decision.

In practice, some carriers have required justification for the level of service provided while others are reluctant to reduce an ALS claim to the BLS allowed amount based solely on information provided on the claim. For example, in Massachusetts, the

carrier will pay for **ALS** services only if a physician certifies that transportation at that level was medically necessary. The Massachusetts carrier provides a distinct medical necessity form for the ALS level of service and will only allow payment for ALS services if the need for ALS service is authorized by a physician. The procedures used by this carrier were reviewed as part of our survey of ambulance services allowed under the Medicare Part B program, although the carrier was not selected in our random sample.

In contrast, other carriers' policies differed from those in Massachusetts. We found that the carrier in California pays the ALS rate when billed because it questions whether claims examiners possess the medical qualifications necessary to reduce the ALS claim to the BLS allowed amount based solely on information provided on the claim. The Georgia carrier recently instructed its claims processors to assume that all requests for payment at the ALS level were for emergencies and, therefore, allowable at that level.

INCREASED USE AND COST OF ALS SERVICES

Medicare Part B allowed charges for ALS ambulance base rate services rose from $66.5 million in CY 1986 to $170 million during CY 1989. This represents an increase of 156 percent. Over the same period, allowed charges for BLS base rate services increased by only 24 percent. Allowed charges for ALS and BLS ambulance services increased by $72 million from 1988 to 1989. Of this amount, $53 million or 73 percent was attributable to increased utilization of ALS ambulances. Also, the number of trips in ALS ambulances increased by 131 percent from 1986 to 1989, while the number of trips in BLS ambulances increased by only 14 percent.

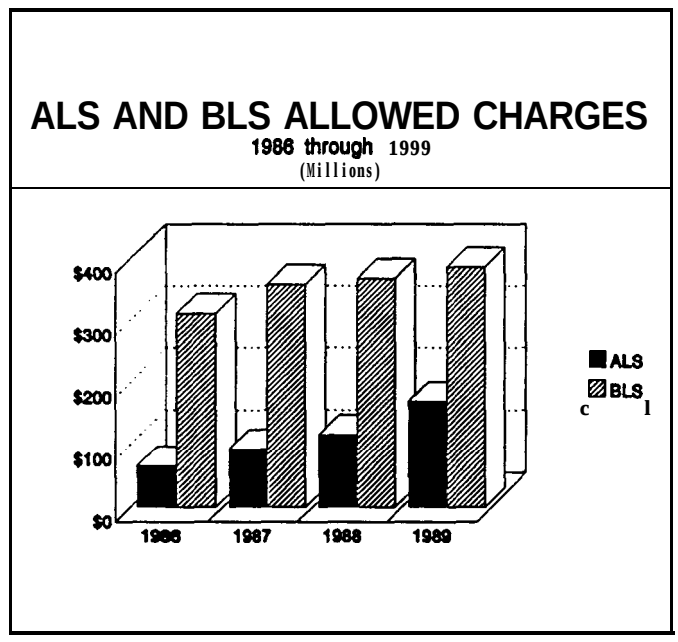

Figure 1

This increase in utilization is significant when coupled with the differences in payment rates between ALS and BLS services. The average price differential in 1989 between ALS and BLS base rate services for the eight carriers reviewed ranged from $31 to $226 as shown in the following table:

1989 AVERAGE ALLOWED CHARGES

CARRIER	ALS	BLS	DIFFERENCE
BS of Arkansas/AR	$224	$ 89	$135
BS of California	284	140	144
BS of Florida*	128	73	55
BS of Texas	160	90	70
Aetna/Georgia	129	65	64
Aetna/Oregon	365	139	226
General American Life/MO*	108	77	31
Nationwide/WV	157	60	97

* Since the period of our review, carriers for Florida and Missouri established statewide rates for ALS services of $215 and $175, respectively.

As shown in the above table, significant differences in allowed charges exist between the ALS and BLS levels of service. Further, there does not appear to be any consistency among carriers in either the amounts they allow for ALS or BLS services or the differences between ALS and BLS allowed charges.

We could not make a meaningful comparison of carriers' reimbursement rates because of the lack of uniformity in the reimbursement computations. Analysis of these differences was not an objective of this review. However, we obtained documentation from the carriers in our sample advising providers which items were included and excluded in determining reimbursement under the all-inclusive ALS service rates. The following chart shows that some of the carriers in our review included certain items in the all-inclusive base rate for ALS services while other carriers allowed the same item as a separate payment.

CARRIER ALL-INCLUSIVE ALS RATE

ALS Items	AR	CA	FL	TX	GA	OR	MO	WV
Oxygen	S	S	S	S	S	S	S	I
EKG Monitoring	I	I	I	I	I	I	S	I
Administration IV	I	I	I	I	I	I	S	I
Disposable Supplies	I	S	I	S	I	I	S	S
Drawing of Blood	I		I	-	-	I	S	I
Night Shift Differential		S	I	U	I	I	-	I
Wait Time	U+1/2 hr.	I	S	S+1/2 hr.	S	S+1 hr.	S	I
Mileage	U	S	S	S	S	S	S	S
Avg. ALS Rate Allowed	$224	$284	$128	$160	$129	$365	$108	5157

Legend:
U = allowed under certain circumstances
S = separately reimbursed
I = included in ALS all-inclusive rate
- = could not determine from carrier information

While the above chart does not include all of the items in an all-inclusive reimbursement rate, it shows how similar items are treated differently by our sampled carriers for reimbursement purposes. We recognize that reasonable charge screens formed the basis for the carriers' computation of BLS and ALS rates and that some items will be treated differently from one carrier to another. However, we could not explain the variances in allowed amounts for ALS services between carriers solely on the observed differences in the treatment of various items. We believe that these variances occurred, to some extent, because HCFA guidelines asking carriers to establish BLS and ALS rates did not establish a uniform listing of items for carriers to include or exclude. The effect is that rates were not uniformly established and cannot be easily compared. Uniform HCFA guidelines, delineating which items are included under the base ALS rate, would enable an equitable comparison of rates between carriers after allowing for geographic or other differences. Comparison of rates would also show whether corrective action is needed to resolve apparent inequities in reimbursement rates between carriers.

As shown in Figure 2, suppliers have increased their utilization of more expensive vehicles equipped with ALS systems. In 1986, the proportion of ALS allowed trips to total ambulance trips ranged from 4 percent to 28 percent for the eight carriers sampled. In 1989, however, the proportion of ALS allowed trips to total ambulance trips ranged from 18 to 48 percent for those same carriers.

PROPORTION OF ALS TRIPS TO TOTAL TRIPS

CARRIER/STATE	1986	1989
BS OF ARKANSAS/AR	11%	48%
BS OF CALIFORNIA	24%	37%
BS OF FLORIDA	17%(1987)	28%
BS OF TEXAS	20%	33%
AETNA/GEORGIA	4%	26%
AETNA/OREGON	28%	40%
GENERAL AMERICAN LIFE/MO	16%	23%
NATIONWIDE/WV	11%	18%

Figure 2

Our review found that only two of the eight carriers, West Virginia and Missouri, had procedures in place to evaluate medical necessity for ALS services. During 1989, the West Virginia and Missouri carriers exhibited the lowest ALS utilization in proportion to total ambulance services, 18 percent and 23 percent, respectively.

Currently, the carriers for Georgia and Florida accept ALS claims as submitted without review for level of service. The Georgia carrier instructs claims processors to assume ALS ambulance claims are emergencies. Therefore, these claims are not reviewed to determine whether they were, in fact, emergencies or otherwise supported at the ALS level of service. Correspondingly, ALS utilization in Georgia rose from 4 percent of total ambulance services in 1986 to 26 percent in 1989. During the period of our review, Florida required suppliers to include "run" reports with the claim to describe the services provided. These "run" reports were used to determine the necessity for the ALS level of service. In that State, ALS utilization went from 17 percent in 1987 to 28 percent in 1989. In 1990, the Florida carrier initiated an electronic billing system which no longer allows claims to be screened against the "run" reports.

The four remaining carriers (Arkansas, California, Texas, and Oregon) did not have criteria to evaluate the medical appropriateness of the ALS level of service. They exhibited the highest ALS utilization in proportion to total ambulance services. We found that ALS trips to total trips for these four carriers ranged from 33 percent to . 48 percent.

REVIEW OF MEDICAL NECESSITY FOR ALS CLAIMS

We reviewed claims documentation to determine the extent that carriers allowed ALS rates for ambulance transportation which could have been safely and more economically provided at the BLS level. However, because information on medical necessity by level of service was not available, we could not identify all ALS submissions for which the BLS level of service would have been appropriate. We also found that descriptive information regarding patient condition and symptoms was often insufficient to provide definitive proof of medical necessity for a particular level of ambulance service. Accordingly, we classified sampled claims as not medically necessary for the ALS level of service only when we could determine that the BLS level of service would be appropriate. Those services were for prescheduled and nonemergency transport of patients for treatment of chronic medical conditions. This is similar to the Oregon carrier's acceptance of a local ordinance which allows the BLS service level for prescheduled nonemergency transportation of nursing home residents but requires ALS ambulances for all other ambulance requests. Prescheduled nonemergency patient transport included hospital discharges to residences, scheduled hospital admissions for elective procedures, transfers to other medical facilities for specialized services, and nonemergency nursing home transfers for treatment of conditions and symptoms which would not require an ALS level of care.

The following list shows the number of ALS services per carrier for which the ALS level of service would not be considered medically necessary if HCFA required certification at the ALS level and not merely certification that an ambulance was necessary.

50 ALS CLAIMS PER CARRIER	ALS NOT MEDICALLY NECESSARY
BS of Arkansas/AR	29 claims
BS of California	7 claims
BS of Florida	3 claims
BS of Texas	15 claims
Aetna/Georgia	6 claims
Aetna/Oregon	4 claims
General American Life/MO	0 claims
Nationwide/WV	7 claims
TOTAL	71 claims

In calculating our savings, we included the difference between the amounts allowed for ALS and BLS levels of service for the 71 questioned claims only when we could determine that BLS services were available in that city or town. We considered a service as available if the supplier offered BLS services or a BLS supplier was located in the same city or town in which the ALS supplier was located. We utilized a multi-stage variable appraisal methodology which estimated savings of $15.95 million. Since this report is designed to estimate savings, not to recover costs, we have reported the point estimate as our savings. Details of the methodology used in selecting and appraising the sample are included as Appendix I to this report. Of the $15.95 million estimated savings in allowed payments for nonemergency ALS ambulance services, about $12.76 million would accrue annually to the Medicare Part B program and $3.19 million would accrue annually to the beneficiaries. These allocations of savings are based on the beneficiary co-payment requirement of 20 percent of allowed charges, but do not consider any annual deductible requirement.

CRITERIA FOR ALS SERVICES

State and local requirements for ALS services sometimes vary from the Carriers Manual requirements for the same service. Section 5116.1 of the Carriers Manual describes typical ALS ambulances as mobile coronary care units and other ambulance vehicles that are appropriately equipped and staffed by personnel trained and authorized to administer intravenous therapy, provide anti-shock trousers, establish and maintain a patient's airway, defibrillate the heart, relieve pneumothorax conditions, and perform other advanced life support procedures or services, such as, electrocardiogram (EKG) monitoring.

State Requirements

Six of the eight States included in our review require that suppliers, approved to provide ALS services, equip and staff their vehicles in accordance with the Carriers Manual. The remaining two States have two categories of ALS services, full ALS in accordance with the Carriers Manual and an intermediate ALS level which grants ALS status to suppliers who can furnish intravenous therapy. The intermediate level is not authorized to perform EKG monitoring, defibrillate the heart, or administer drugs. For payment purposes, however, the carriers in these States do not distinguish between the two ALS service levels. In these two States, both service levels are allowed the-full ALS rate even though the intermediate level does not meet HCFA's minimum requirements for an ALS service.

Local Ordinances

Five carriers (Georgia, Florida, California, Oregon, and Arkansas) are aware of local ordinances within their jurisdictions governing the level of ambulance services. These carriers allow the ALS rate on all ALS submissions governed by these local ordinances. They believe that where local ordinances require ALS transport, the carrier must allow the ALS rate for all ambulance claims submitted under the ALS codes. In this regard, guidance from the HCFA Regional Administrator on August 12, 1991, to the carrier in Oregon states:

> "After talking with HCFA Central Office and reviewing several memos issued during the past several years, the only conclusion drawn from the facts you presented, is that HCFA must pay for the Advanced Life Support (ALS) level when such level is required by government ordinance. As this is the case in Eugene, Oregon, we find no other option, such as a differentiation of the level of care provided, to develop a payment methodology."

Based on HCFA guidance, some carriers allow requests for payment at the ALS level when required by government ordinance. In Georgia, for example, the carrier recently instructed its claims processors to assume that all requests for payment at the ALS level were for emergencies and, therefore, allowable at that level. Only Arkansas and Oregon, however, maintained information on how and which suppliers were affected by local ordinances. In these two States, ALS to total ambulance trips were 48 and 40 percent, respectively. Carriers for Georgia, California, and Florida do not maintain similar listings of localities with such ordinances.

Our review found that the ALS level of service was not medically necessary for 29 of the 50 Arkansas ALS claims. These 29 claims were for prescheduled nonemergency transports, the majority of which were provided in the cities of Little Rock (13 transports) and Pine Bluff (7 transports). Section 5-58 of Article III, Ambulance Service of the Little Rock Code, mandates the ALS level of service for ambulances operating within city limits. Pine Bluff had a similar ordinance during the period of our review. Although the Pine Bluff ordinance was repealed, it is currently under consideration for reinstatement.

The significant impact of local ordinances on ALS services to the Medicare program in Arkansas is illustrated in Figure 3. It shows the rise in ALS services since 1986 and the corresponding decrease in BLS services. Correspondingly, the shift to the higher priced ALS services is shown in Figure 4. It illustrates the increase in allowed charges for ALS services in Arkansas since 1986.

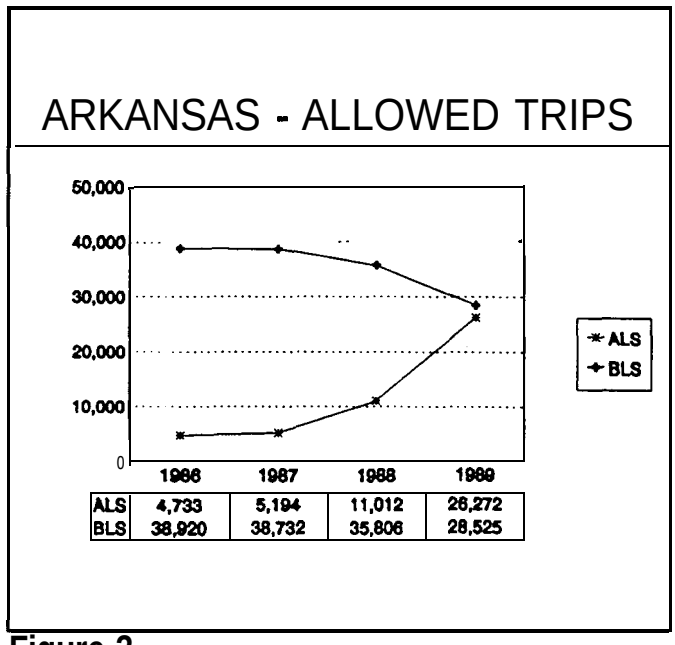

Figure 3

We also identified local ordinances mandating ALS services in Oregon. The State of Oregon Revised Statutes outline the minimum vehicle and staffing requirements for licensing ambulances at the ALS and BLS levels of service. These regulations do not mandate ALS as the minimum standard of patient transport for localities. However, Oregon State regulations allow cities and towns to mandate the level of service requirements for ambulances operating within their borders as long as they are not less than the State requirements. City ordinances in Springfield and Eugene require the ALS level of service for all ambulance services. These cities also require ALS staff and equipment for ambulance transport in accordance with State definitions except for transport of nonemergency nursing home patients. The cities' rules allow an emergency medical technician (EMT) qualified at the BLS level during nonemergency transport of nursing home patients. According to State authorities, transport of a patient attended by an EMT not qualified or licensed to perform ALS procedures constitutes transport at the BLS level.

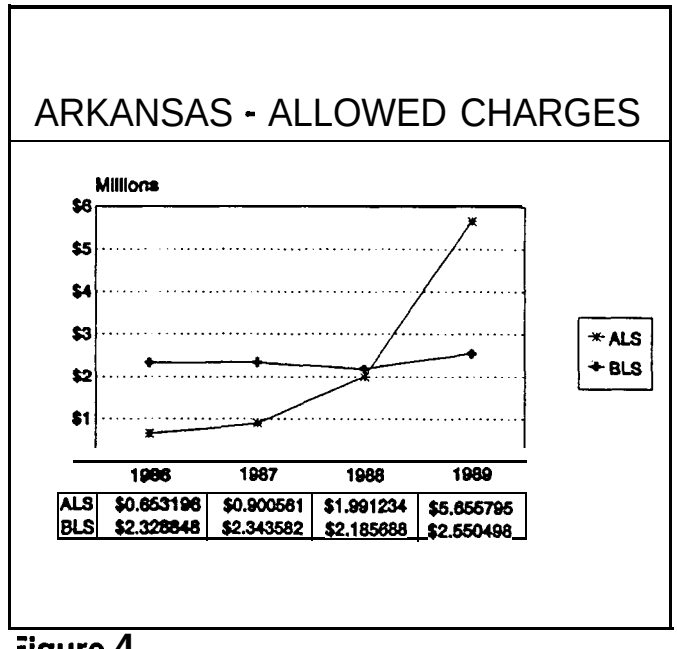

Figure 4

POST-PAYMENT REVIEW

In the case of California, the carrier relies on post-payment provider audits to identify inappropriate ambulance claims including ALS submissions which are not medically necessary. The carrier officials do not believe that claims processors can appropriately evaluate claims information to determine whether the ALS level of service was warranted. In addition, the California carrier determined that information submitted on claims by suppliers is often less than accurate. Information from the carrier's post-payment reviews performed in 1989 exemplify some of the misinformation contained in supplier statements regarding patients' symptoms and conditions. Claims were identified by carrier reviews where supplier descriptions of symptoms (the basis of medical necessity evaluations) were not substantiated in the ambulance "run" reports or emergency room records. For example, patients described on ambulance claims as being nonambulatory actually walked from the ambulances into the hospitals.

It would appear that post-payment audits could be effective in identifying ALS ambulance claims for which medical necessity is not substantiated. However, post-payment audits are labor intensive and infrequently performed. Over a 2-year period, the California carrier was able to audit fewer than 4 percent of the ambulance suppliers submitting claims. For this reason, post-payment audits by themselves are ineffective in controlling costs.

CONCLUSIONS

We believe that methods must be found to ensure that the rise in ambulance allowed charges at the ALS level of service is justified. In this regard, the Carriers Manual requires reduction in payment to the lowest level necessary to meet the patient's medical need. However, other portions of the Carriers Manual and HCFA guidance allow payment at the ALS level when mandated by local ordinance or when claimed by suppliers. As a result, carriers' requirements vary for payment of the ALS level of service.

We believe that the Medicare Part B program should contain sufficient controls to ensure that reimbursement for ambulance services at the ALS level is justified. Therefore, we believe that reimbursement of ALS ambulance services should be based on medical necessity in accordance with section 5246.4 of the Carriers Manual and should not be impacted by local ordinances mandating ALS services. We also believe that the Carriers Manual should be revised to require medical necessity at the ALS level of service for payment of nonemergency transport to be allowed at the ALS

level. This requirement would not prevent communities from mandating an ALS response to emergency ambulance requests. It would, however, allow the carriers to pay claims for ALS services at the BLS rate when the less expensive level of service would have met the patient's medical need.

RECOMMENDATIONS

We recommend that HCFA revise its Carriers Manual to require that payment for nonemergency ambulance services at the ALS level be allowed only when medically necessary and not be impacted by local ordinances mandating ALS services. In this regard, HCFA should consider the use of physician certification to authenticate the need for the ALS level of service. Further, controls should be established at the carriers to ensure that reimbursement for ALS services is based on the medical need of the beneficiary. The effectiveness of these controls should be closely monitored by HCFA. We estimate that savings of $12.76 million could be realized annually by the Medicare Part B program if HCFA instituted these recommendations. In addition, we estimate that savings of $3.19 million could be realized annually by beneficiaries.

We are also recommending that HCFA revise its guidelines to carriers to specify the items to be included in the all-inclusive ALS rate. Uniform HCFA criteria would enable an equitable comparison of rates between carriers and show whether corrective action is needed to resolve apparent inequities in reimbursement rates between carriers.

HCFA COMMENTS

In commenting on our draft report, HCFA officials were in general agreement with the report's recommendations. They agreed with the need to revise the Medicare Carriers Manual instructions on reimbursement for ALS ambulance services. However, HCFA believes that proposed changes to ambulance reimbursement policy should be established by regulation and that the public and the affected ambulance companies should have the opportunity to comment on the proposed changes. In addition, HCFA concurs with our recommendation that controls be established at the carriers to ensure that reimbursement for ALS services is based on the medical need of the beneficiary and stated it would consider including our recommendation to use physician certification to authenticate that need in its proposed regulation. The HCFA agreed that the effectiveness of controls at the carrier level should be closely monitored.

While HCFA Concurs in principle with our recommendation to revise its guidelines to carriers to specify the items to be included in the all-inclusive rate, it points out that

there are a number of issues that must be addressed prior to rebundling of ALS services. The HCFA states that it has been actively engaged in a nationwide campaign to ensure more uniform coding practices among carriers and will continue to examine issues with the goal of developing new guidelines.

OIG RESPONSE

We concur with HCFA's position and approach concerning the recommendations contained in this report. Where appropriate, the final report has been revised to reflect HCFA's comments. We have included HCFA's comments in their entirety as Appendix II to this report.

APPENDICES

MEDICAL NECESSITY FOR AMBULANCE SERVICES

SAMPLE METHODOLOGY

Our sample methodology used the Office of Audit Services (OAS) statistical sampling program - RHC TWO STAGE SAMPLE SELECTION (Rao-Hartley-Cochran), dated May 1990. The first stage consisted of the random selection of eight Part B Medicare carriers with probability of selection proportional to dollar amounts allowed for CY 1989 dates of service for ALS ambulance services. The primary unit was selected by placing the primary units in eight random groups and then selecting one primary unit from each group using probability proportional to size sampling. The second stage consisted of 50 line item charges per carrier for an ALS rate service randomly selected from a computer file of 1989 ALS ambulance services extracted from HCFA's BMAD file.

The BMAD file contains a 5 percent sample of all Part B beneficiary claims and 100 percent of end stage renal disease (ESRD) beneficiary claims. This 5 percent judgmental sample selects all Part B beneficiary claims with Health Identification Code Numbers (HICN) last digits of 05, 20, 45, 70, and 95. Our extracts from the BMAD file include only those ESRD beneficiary claims for ALS services which would be included in the 5 percent sample based on claims with HICN last digits 05, 20, 45, 70, or 95. This made the basis for ESRD sampled items similar to the other ALS claims included in HCFA's sample.

On a scientific random selection basis, we examined 400 transactions from a population of 1,016,958 transactions with a total value of $169,901,876. The population of transactions that we sampled pertains to the period from January 1, 1989 to December 31, 1989. Extrapolating the results of our statistical sample to the population of $170 million in ALS allowed charges, we estimate savings of $15.95 million if carriers and HCFA required proof of medical necessity for ALS services. Since this report is designed to estimate savings, not to recover costs, we have reported the point estimate as our savings in accordance with the OAS policy. Our projection has a precision of plus or minus 67.32 percent at the 90 percent confidence level.

The following chart provides the sample size, the value of the examined items, the number of errors (nonzero differences) and their value and the total adjusted value of the examined items.

TWO STAGE RHC PROCEDURE

PU NBR	SAMP SIZE	EXAMINED VALUE	NONZERO DIFFS	TOTAL OF DIFF VALUES	TOTAL ADJ VALUES
1	50	4,738.68	0	0.00	4,738.68
2	50	11,798.87	29	3,510.66	8,288.21
3	50	6,170.44	3	178.05	5,992.39
4	50	15,892.04	4	457.59	15,434.45
5	50	14,258.78	7	926.10	13,332.68
6	50	6,474.56	7	378.28	6,096.28
7	50	7,305.81	15	1,179.70	6,126.11
8	50	5,238.00	6	318.36	4,919.64
TOTAL	400	71.877.18	71	6,948.74	64,928.44

Three of the eight carriers had less than six errors and were projected as zero errors in accordance with the OAS policy.

The 400 items selected had a value of $71,877.18. However, there were 71 items where a BLS level of service would have been sufficient to ensure the beneficiaries' safety. These items had a value of $6,948.74. This value represents the difference between the allowed ALS rate and the BLS rate which could have been allowed. As a result, the examined items had an adjusted value of $64,928.44.

The attached schedule provides a listing of the carriers and their carrier number, as well as, their allowed charges and allowed units for ALS ambulance services. The schedule is limited to those carriers for which BMAD showed ALS ambulance activity in 1989.

SCHEDULE OF ALLOWED CARRIER CHARGES AND SERVICES

	CARRIER - 1989 ALS	ALLOWED CHARGES	ALLOWED UNITS
542	BS OF CALIFORNIA	$31,520,653	111,006
900	BS OF TEXAS	13,873,292	100,385
865	BS OF PENNSYLVANIA	13,127,651	77,264
590	BS OF FLORIDA	12,515,256	97,804
16360	NATIONWIDE/OHIO	9,361 ,125	35,645
710	BS OF MICHIGAN	8,137,313	50,817
621	HEALTH CARE SVCE/IL	5,803,079	49,527
520	ARKANSAS	5,655,795	26,272
2050	TRANSAM OCC/CA	5,623,298	28,831
1370	AETNA/OKLAHOMA	5,126,467	17,807
528	ARKANSAS BS/LA	4,890,402	21,983
1380	AETNA/OREGON	4,708,869	15,042
1040	AETNA/GEORGIA	3,627,467	35,955
1030	AETNA/ARIZONA	3,601,689	21,316
801	WESTERN BS/NY	3,508,903	22,929
930	WASH PHYS SVCE/WA	3,433,973	17,573
630	BS OF INDIANA	3,227,744	24,777
740	BS OF KANSAS CITY/MO	3,160,550	11,323
550	BS OF COLORADO	2,798,050	15,136
1290	AETNA/NEVADA	2,381,698	9,078
5440	EQUITABLE/TENNESSEE	2,162,378	24,052
11260	GEN AM LIFE/MO	1,687,120	18,286
16510	NATIONWIDE/WV	1,657,226	12,684
803	EMPIRE BS/NY	1,590,459	8,639
700	BS OF MA/MA	1,478,140	10,655
510	BS OF ALABAMA	1,380,282	17,706
5535	EQUICOR/NC	1,355,033	24,477
10230	TRAVELERS/CT	1,141,693	16,918
1360	AETNA/NM	1,118,610	5,446
10240	TRAVELERS/MN	1 ,108,811	4,804
650	BS OF KANSAS	1,073,306	11,372
951	WISCONSIN PHYS SVCE	999,008	5,633
720	BS OF MINNESOTA	924,662	2,983
880	BS OF SO CAROLINA	899,728	17,412
640	BS OF IOWA	793,983	7,221
10490	TRAVELERS/VA	750,436	7,206
820	BS OF NORTH DAKOTA	742,482	5,421
21200	BS OF MA/MAINE	554,474	5,305

SCHEDULE OF ALLOWED CARRIER CHARGES AND SERVICES

	CARRIER - 1989 ALS	ALLOWED CHARGES	ALLOWED UNITS
5130	EQUITABLE/IDAHO	484,574	3,144
10250	TRAVELERS/MS	484,224	4,907
655	BS OF KANSAS/NE	354,635	2,192
780	BS OF MA/NH & VT	328,198	3,690
751	BS OF MONTANA	141,526	882
1020	AETNA/ALASKA	135,800	778
910	BS OF UTAH	130,349	784
580	BS OF PENN/DC	129,216	2,245
1120	AETNA/HAWAII	112,053	805
5530	EQUITABLE/WYOMING	89,451	701
570	BS OF PA/DELAWARE	10,745	140
TOTAL		$169,901,876	1,016,958

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date AUG 4 1992

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Audit Report: "Review of Medical Necessity for Ambulance Services," A-01-91-00513

To Inspector General
Office of the Secretary

We have reviewed the subject draft audit report which presents the results of OIG's nationwide review of medical necessity for ambulance services. Effective March 1, 1982, the Health Care Financing Administration (HCFA) instructed carriers to use separate reimbursement rates for basic life support (BLS) ambulance services and advanced life support (ALS) ambulance services. The focus of OIG's review was the difference in the level of medical necessity for ALS and BLS ambulance services.

OIG found that the number of trips in ALS ambulances increased by 131 percent between 1986 and 1989. The number of trips for the less expensive BLS ambulances increased by only 14 percent. In 18 percent of the reviewed ALS ambulance claims paid by HCFA, the beneficiary's medical condition did not support receiving the ALS service. OIG estimates that if reimbursement for ambulance services was based on the medical need of the beneficiary, the Medicare program could save $12.76 million per year and beneficiaries would save about $3.19 million.

OIG recommends that HCFA revise the instructions in the Medicare Carriers Manual to require, except in those rural areas where BLS services are not available, that payment for nonemergency ambulance services at the ALS level be allowed only when medically necessary and not be affected by local ordinances mandating ALS services. HCFA should also consider the use of physician certification to authenticate the need for the ALS level of service. Also, OIG recommends that HCFA establish controls at the carriers to ensure that reimbursement for ALS services is based on the medical need of the beneficiary. The effectiveness of these controls should be closely monitored by HCFA. Finally, OIG recommends that HCFA revise its instructions to carriers to specify the items to bc included in the all-inclusive ALS rate.

HCFA is in general agreement with the report's recommendations. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft audit report. Please let us know if you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG)
Draft Audit Report: "Review of Medical
Necessity of Ambulance Services."
A-01-91-00513

Recommendation

HCFA should revise its Carriers Manual to require, except in those rural areas where basic life support (BLS) ambulance services arc not available, that payment for nonemergency ambulance services at the advanced Iife support (ALS) ambulance level bc allowed only when medically necessary and not be impacted by local ordinances mandating ALS services. In this regard, HCFA should consider the use of physician certification to authenticate the need for the ALS level of service.

HCFA Response

HCFA partially agrees with the recommendation. We agree that both the regulations and the Medicare Carriers Manual instructions should be refined to make more explicit the conditions under which a patient is to bc appropriately transported by ambulance, for both BLS and ALS transportation.

Section 1861(s)(7) of the Social Security Act (the Act) provides that ambulance services bc covered only where other methods of transportation are contraindicated by the individual's condition, to the extent provided in regulations. We believe that it was Congress' intent that the level of ambulance services received by Medicare beneficiaries be appropriate for the beneficiaries' medical conditions. Therefore, based on current law and regulations, Medicare coverage of AU services should be dependent upon the patient's medical condition, regardless of the type of vehicle furnishing the service, and not be dependent upon local ordinances mandating ALS servicer.

However, we are concerned about the financial impact of this policy on ambulance companies who provide services in areas with local ordinances mandating ALS level services. We believe that the proposed changes to HCFA's ambulance reimbursement policy should be established by regulation, giving the public and the affected ambulance companies the opportunity to comment on the proposed changes. Because of this, we do not believe that we should change the Medicare Carriers Manual instructions prior to publishing the proposed regulation changes in the Federal Register.

Ambulance Services in Rural Areas

OIG states that it may be impractical or not economical to provide both ALS and BLS levels of services in rural areas. Thus, OIG believes that an exception to the general policy to accommodate rural areas should be promulgated. Clear documentation for this recommendation is not provided in the report.

We do not agree that rural areas should be excepted from the proposed regulatory and manual changes. Excepting rural area ambulance services would be inconsistent with section 1861(s)(7) of the Act,

Further, the Office of Technology Assessment indicated in a Report to Congress, "Rural Emergency Medical Services (EMS)," (November 1989), that most rural EMS ambulance services are providing a BLS level of care using a BLS level of equipment. The report states that rural ambulance services suffer from EMS personnel shortages, inadequate training opportunities for personnel, lack of medical supervision of local EMS operations, and antiquated equipment

Medical Documentation for ALS Services

HCFA will consider OIG's proposal that Medicare cover ALS services only when such services are ordered by a physician. We may include this proposni in our proposed regulation. This would provide us with the opportunity td'rcccivc comments from the ambulance industry and the general public about the feasibility of such a requirement.

Obviously, HCFA would not support a requirement that beneficiaries receive prior authorization from their physician to use an ambulance for urgent or critical situations. We believe that such a requirement would be inappropriate when bcncficiarics need immediate ambulance transportation, such as in the cases of trauma or cardiac arrest.

Recommendation

Controls should be established at the carriers to ensure that reimbursement for ALS services is based on the medical need of the beneficiary. The effectiveness of these controls should be closely monitored by HCFA.

HCFA Response

HCFA concurs with the recommendation. After the proposed changes have been made in the regulations regarding ambulance services and in the corresponding Medicare Carriers Manual instructions, controls will be established at the carriers to ensure that reimbursement for ALS services is based on the medical need of the beneficiary regardless of the type of vehicle furnishing the service.

Recommendation

HCFA should revise its guidelines to carriers to specify the items to be included in the all-inclusive ALS rate.

HCFA Response

HCFA concurs in principle with the recommendation. We agree that the lack of uniformity in supplier billing practices and Medicare payment screens makes it very difficult to compare variances in allowable ALS amounts among carriers. For 3 years, HCFA has been actively engaged in a nationwide campaign to ensure more uniform coding practices among carriers.

As an outgrowth of the Project Hope study on Medicare payment for ambulance services, we recently began examining the possibility of rebundling ALS services to minimize the number of services for which separate payments are made. We also note that a number of carriers have already chosen to rebundle these services due to administrative and programmatic concerns, such as the unwieldiness of an excessive number of payment screens for ambulance services.

However, there are a number of issues that must be addressed by HCFA prior to implementing the rcbundling of AU services. These issues include the standardization of the terminology describing various ambulance services and supplies, the corresponding adjustments that would be necessary in Medicare rates, policy decisions concerning the infl ation-indexed charge and inherent reasonableness, and rulemaking to make major changes in the longstanding Medicare policy for individual ambulance suppliers. We will continue to examine these issues with the goal of developing new guidelines for carriers.