



MEDICARE APPEAL DECISION

EMERGENCY MEDICAL SERVICES
DEPT 64
P O BOX 21228
TULSA, OK 74121-1228

November 04, 2013
In Any Inquiry Refer to
4413109051000
Medicare Number of Beneficiary

Internal Control Number

Service Date(s)

Service Provided By
Emergency Medical Services
Service Provided To

* A request was sent to our office. We are sending you a copy *
* of our reply. This letter is for your records. If you have *
* any questions about this letter, please contact our *
* Customer Contact Center at 1-877-235-8073. *

Dear David M. Werfel,

This letter is to inform you of the decision on your Medicare Appeal. This appeal pertained to a refund request for Emergency Medical Services Authority in the amount of \$365,889.00. Our decision is fully favorable for Emergency Medical Services Authority. You will receive information from our overpayment and recovery department shortly.

This redetermination involved an overpayment based on an extrapolation of a statistical sample to a universe of paid claims. We have determined the statistical methodology used by the Zone Program Integrity Contractor (ZPIC) is consistent with the statistical sampling instructions provided by the Centers for



Novitas Solutions, Inc.
A CMS CONTRACTOR


PAGE 2

Werfel Werfel, Pllc

HIC NO *****
PLEASE REFER TO 4413109051000

Medicare & Medicaid Services (CMS). Please refer to CMS Manual
Publication 100-08, Chapter 03, Section 10.

Sincerely,



N. Intrieri
Novitas Solutions
Appeals

T210/R19

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**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patricia Wheeler
Regional Inspector General

November 2012
A-06-11-00050

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

The Emergency Medical Services Authority of Oklahoma City billed and Medicare Part B paid an estimated \$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. 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.

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.

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.

EMSA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

EMSA disagreed with our findings that the 10 ALS emergency transports were not medically necessary and stated that all of the transports should have been covered because they were emergencies. EMSA's comments included summary information about each of the 10 denied claims. We redacted the personally identifiable information and included EMSA's comments as Appendix D.

The information EMSA provided in its comments about the 10 denied claims was an incomplete summary of the medical records related to the transports and sometimes conflicted with the medical records. The summary information, which was taken from EMSA's medical records, was appropriately considered during TrailBlazer's medical review. As such, we stand by our reported findings and recommendations.

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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.

EMSA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

EMSA disagreed with our findings that the 10 ALS emergency transports were not medically necessary and stated that all of the transports should have been covered because they were emergencies. However, EMSA indicated that 2 of the 10 transports should have been downgraded to a lower level of ambulance transport. EMSA's comments included summary information about each of the 10 denied claims, including beneficiary names. We redacted the personally identifiable information and included EMSA's comments as Appendix D.

The information EMSA provided in its comments about the 10 denied claims was an incomplete summary of the medical records related to the transports and sometimes conflicted with the medical records. For example, EMSA stated that beneficiary No. 4 was bed-confined with acute weakness and uncontrolled diarrhea. The medical records indicated that this beneficiary was not bed-confined, but rather walked to the door and to the stretcher, and that her chief complaint was that she had diarrhea for the past 3 weeks, which is not an acute condition. The summary information, which was taken from EMSA's medical records, was appropriately considered during TrailBlazer's medical review. As such, we stand by our reported findings and recommendations.

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

APPENDIX D: EMERGENCY MEDICAL SERVICES AUTHORITY COMMENTS

WERFEL & WERFEL, PLLC
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October 15, 2012

Patricia Wheeler
Regional Inspector General
for Audit Services
DHHS Office of Inspector General
1100 Commerce Street
Room 632
Dallas, TX 75242

RE: Emergency Medical Services Authority
A-06-11-00050

Dear Ms. Wheeler:

Thank you for sharing with us the draft report concerning EMSA and allowing an opportunity for comment.

The 10 claims in issue have been denied as not medically necessary. We strongly disagree. Each transport was the result of an emergency.

Section 1861(s)(7) of the Social Security; 42 C.F.R. 410.40(d)(1) of the regulations and the CMS Manuals (in multiple places, including 100-02, Chapter 10, Sections 10.2.1, 20 and 30.1.1) all indicate that an ambulance is covered when the patient's condition is such that any other method of transportation is contraindicated.

Section 20, in giving coverage guidelines, lists the following as one example: "Was transported in an emergency situation, e.g. as a result of an accident, injury or illness".

The definitions for ALS and emergency are listed in the regulations (42 C.F.R. § 414.605), as follows:

Advanced life support, level 1 (ALS1) means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.

CMS Internet-Only Benefit Policy Manual 100-02, Chapter 10, Section 30.1.1 also defines ALS and emergency, using a similar definition that includes responding immediately based on the supplier's dispatch protocols.

An ambulance was needed for all 10 claims, as each was an emergency. These are summarized below:

1. *

This was dispatched Priority 1 (emergency, life threatening) for a patient with an altered level of consciousness. On scene, the crew also noted the patient had dizziness, decreased vital signs, with a history of multiple sclerosis. The crew provided EKG monitoring and IV.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

2.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for a fall of an 86 year old.

While the fall occurred on the prior day, she was having acute rib pain and a possible fractured rib. As it turns out, the hospital ER record confirmed a compression fracture at the endplate of L-2. Oxygen was provided by the crew.

The acute medical condition was the acute pain and possible fractured rib, not the fall.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

3.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for joint pain/foot pain.

On scene, the crew noted his left foot was swollen, he had yellow liquid leaking from the bandage, there were signs of instability, significant pain, infection and possible sepsis.

As a result, the crew provided EKG monitoring, IV and oxygen.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

***Office of Inspector General note:** We redacted the names of each of the 10 beneficiaries listed because it is personally identifiable information. We also redacted the names of two beneficiaries listed on the last page of EMSA's comments.

4.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for a sick person with defecation/diarrhea.

On scene, the crew also documented acute general weakness. The patient was bed confined.

This was an emergency due to the acute weakness and uncontrolled diarrhea.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

5.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for a fall, possibly dangerous body area. The patient was 83 years old and the fall resulted in a possible lumbar fracture.

As it turns out, the hospital ER record confirmed a compression fracture of the thoracic spine.

The crew provided spinal immobilization, EKG monitoring, IV and oxygen.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

6.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for a psych emergency. The patient was agitated, thought he was having a nervous breakdown and had a history of bi-polar schizo-affective disorder.

EKG monitoring was provided.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

7.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for an 87 year old with back pain, not relieved by pain medications.

IV was monitored en route.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED, where she was admitted for what an MRI determined was a fracture.

8.

As a result of 911 being activated, the ambulance was dispatched Priority 2 (emergency, not life threatening) for a patient who "felt like his back popped" and had back pain.

IV saline lock was started and the crew monitored the EKG.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

9.

As a result of 911 being activated, this was dispatched Priority 2 (emergency, not life threatening) for abdominal pain with a sharp burning sensation that radiates to his neck.

IV saline lock was started and the crew monitored the EKG.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

10.

As a result of 911 being activated, this was dispatched Priority 1 (emergency, life threatening) for a patient with breathing problems who was not alert. On scene, the home health nurse advised the crew of the possible blood clot in the leg and history of DVTs. The patient had sharp stabbing leg pain and swelling to her right leg.

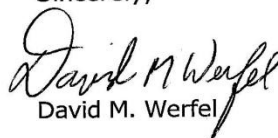
Oxygen and EKG monitoring were provided.

An ambulance was medically necessary due to the emergency, i.e. the ambulance was dispatched immediately to an acute medical condition. The patient was transported to the hospital ED.

Conclusion

For the reasons noted above, we disagree with all of the ten denials. All should have been covered as emergencies. However, we agree that two should have been downgraded to BLS emergency.

Sincerely,


David M. Werfel

DMW/te

cc: EMSA