



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
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December 22, 2004

Report Number: A-02-04-01013

Gloria M. Lebron
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Dear Ms. Lebron:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "*Review of New Payment Provisions for Ambulance Suppliers in Puerto Rico*". The audit covered the period of April 1, 2002 through December 31, 2003. Should you have any questions or comments concerning the matters commented on this report, please direct them to the HHS official named below.

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To facilitate identification, please refer to Report Number A-02-04-01013 in all correspondence relating to this report.

Sincerely,


Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
NEW PAYMENT PROVISIONS
FOR AMBULANCE SUPPLIERS
IN PUERTO RICO
APRIL 1, 2002 TO DECEMBER 31, 2003**



**December 2004
CIN A-02-04-01013**

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

In accordance with the Balanced Budget Act of 1997, the Centers for Medicare & Medicaid Services (CMS) implemented a national ambulance fee schedule outlining five levels of service intensity for ground transport, and two for air transport. The fee schedule, which is being phased-in over a five-year period, applies to all ambulance services rendered since April 1, 2002. During this five-year transition period, payments consisted of a “blended” figure, representing the ambulance fee schedule and a reasonable charge for independent suppliers. The percentages for the blended rate during the transition period are:

Phase-In Period	Fee Schedule %	Reasonable Charge %
Year One (4/1/2002-12/2002)	20	80
Year Two (CY 2003)	40	60
Year Three (CY 2004)	60	40
Year Four (CY 2005)	80	20
Year Five (CY 2006)	100	0

To accomplish its mission, CMS contracts with carriers to process Medicare Part B claims submitted by health care practitioners, including ambulance suppliers. Triple S serves as the Medicare carrier for the Commonwealth of Puerto Rico and U.S. Virgin Islands.

OBJECTIVE

Our objective was to determine whether Triple S complied with the new Medicare fee schedule provisions for the payment of ambulance services.

SUMMARY OF FINDINGS

Triple S complied with the new Medicare fee schedule provisions for payment of ambulance services rendered between April 1, 2002 and December 31, 2003. Accordingly, we have no recommendations.

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INTRODUCTION

BACKGROUND

Medicare Carriers and Fiscal Intermediaries

The Social Security Amendments of 1965 established the Medicare program under Title XVIII of the Social Security Act (Act). Medicare is a health insurance program providing health coverage for people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. At the Federal level, Medicare is administrated by CMS. To accomplish its mission, CMS contracts with fiscal intermediaries and carriers to process Medicare claims submitted by health care practitioners. A Medicare carrier is responsible for adjudicating Medicare Part B claims submitted by authorized practitioners, in accordance with the provisions of the Act, Federal regulations, and guidelines issued by CMS. Triple S serves as the Medicare carrier for the Commonwealth of Puerto Rico and U.S. Virgin Islands.

New Medicare Payment Policy for Ambulance Services

In accordance with the Balanced Budget Act of 1997, the CMS implemented a national ambulance fee schedule outlining five levels of service intensity for ground transport, and two for air transport. The fee schedule, which is being phased-in over a five-year period, applies to all ambulance service rendered since April 1, 2002. During this five-year transition period, payments consisted of a “blended” figure, representing the ambulance fee schedule and the reasonable charge for independent suppliers. The percentages for the blended rate during the transition period are:

Phase-In Period	Fee Schedule %	Reasonable Charge %
Year One (4/1/2002-12/2002)	20	80
Year Two (CY 2003)	40	60
Year Three (CY 2004)	60	40
Year Four (CY 2005)	80	20
Year Five (CY 2006)	100	0

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Triple S complied with the new Medicare Fee Schedule provisions for the payment of ambulance services.

Scope

The scope of our audit was limited to the specific objective. Our audit universe consisted of 827,357 ambulance services paid by Triple S that were rendered between April 1, 2002 and December 31, 2003, totaling \$58,468,318.

We reviewed a simple random sample of 100 ambulance services totaling \$6,294 paid by Triple S for services rendered during our audit.

We did not review the reasonableness or medical necessity of the services nor did we assess the overall internal controls of Triple S. Our internal control review was limited to gaining an understanding of those controls related to the processing of ambulance service claims under the first two fee schedule phase-in periods.

Methodology

To accomplish our objective, we:

- reviewed Medicare regulations, manuals, and guidelines pertaining to ambulance services
- consulted CMS regional representatives and Triple S personnel responsible for processing ambulance service claims
- reviewed policies and procedures followed by Triple S for reimbursing ambulance service claims pursuant to the new fee schedule
- obtained copies of fee schedules for ambulance services for the period between April 2002 and December 2003
- requested that Triple S provide Primary History Detail and Pricing Inquiry documents detailing payment computation for 100 sample services, and
- analyzed supporting documentation for sample ambulance services to evaluate compliance with new Medicare fee schedule provisions

Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Triple S complied with the new Medicare fee schedule provisions for payment of ambulance services rendered between April 1, 2002 and December 31, 2003. Accordingly, we have no recommendations.

During our audit period, Triple S reimbursed suppliers in Puerto Rico and U. S. Virgin Islands \$58,468,318 for 827,357 ambulance services.

The chart below represents our findings, organized by billing code:

Procedure Code	Description	Number of Services	Amount Reviewed	Amount Allowed
	Non-Emergency Transport			
AO428	Ambulance service, basic life support	38	\$4,497	\$4,497
	Emergency Transport			
AO429	Ambulance service, basic life support	6	\$822	\$822
AO427	Ambulance service, advanced and specialized life support	2	\$365	\$365
	Mileage			
AO425	Ground ambulance mileage, per statute mile	54	\$610	\$610
	Total	100	\$ 6,294	\$ 6,294

To ensure suppliers receive proper reimbursement, CMS issues a yearly fee schedule, and posts it on the CMS Web site. According to relevant excerpts from the Medicare Claims Processing Manual- Chapter 15 – Ambulance, Section 20.1.6:

For implementing the transition to the fee schedule, the reasonable charge for each supplier is the reasonable charge for 2000 (e.g., the lowest of the customary charge, the prevailing charge, or the inflation indexed charge previously determined for 2000) adjusted for each year of the transition period by the ambulance inflation factor, as published by CMS.

The reasonable charge portion of the blended rate was set at 80 percent for the first transition period, and applied to the lowest customary, prevailing, or inflation indexed charge. The reasonable charge portion was then combined with the fee schedule portion to compute the allowable ambulance service charge. This allowable charge was

compared to the charge submitted by the supplier, and the lower of the two figures was selected as the final allowed charge.

According to transition rules, the reasonable charge portion for each supplier is partly a function of particular payment methodology, even though the actual fee schedule portion of the payment is identical for all suppliers. Until full implementation of the new fee schedule, payments for identical services within one locality will differ among various suppliers.

Non-Emergency and Emergency Transport

Since implementation of the new fee schedule on April 1, 2002, payment for ambulance transport is based on the actual level of service provided, which includes payment for all ambulance supplies and services, except for mileage that is separately payable from the base rate.

Any vehicle used as an ambulance must be appropriately designed and equipped to respond to medical emergencies, and be equally suitable for transporting beneficiaries with acute, but non-emergency, medical conditions. In this regard, the fee schedule outlines seven categories of ground ambulance service. The Medicare Claims Processing Manual, Chapter 15, *Ambulance*, Section 10.3, details specific applications of each category. Our sample review included three of the seven categories, as follows:

1 - Basic Life Support (Non-Emergency) Transport Procedure Code A0428

Thirty-eight of 100 services in our sample concerned basic life support transport, classified by suppliers as non-emergencies.

Basic life support (BLS) consists of transportation by ground ambulance, including medically necessary supplies and services, as well as all other elements of “BLS Ambulance Service” as defined by the State. The ambulance must be staffed by a qualified individual, defined by State and local law as an Emergency Medical Technician-Basic (EMT-Basic).

For the transition period between April 1, and December 31, 2002, CMS set the supplier fee schedule for A0428 Ambulance Service Transport in Puerto Rico at \$136.16. During this transition period, the fee schedule portion was set at 20 percent of the blended rate, yielding a uniform amount per allowed charge of \$27.23 (20 percent of \$136.16) for all suppliers. The remaining 80 percent of the blended rate incorporated each supplier’s reasonable charge, based, either on the customary or prevailing charge, whichever was lower.

The following typical examples illustrate various situations addressed by the fee schedule for establishing allowed ambulance service charges during the first year of the transition period.

- A blended amount of \$153.61, consisting of a \$27.23 fee schedule portion (20 percent of \$136.16) and a \$126.38 reasonable charge portion (80 percent of \$157.98, the inflation indexed charge). A comparison of this amount to the

submitted charge yielded an allowed charge reflecting the lower of these two figures.

- A blended amount of \$130.98, comprising a \$27.23 fee schedule portion (20 percent of \$136.16) and a \$103.75 reasonable charge portion (80 percent of \$129.69, the customary fee). A comparison of this amount to the submitted charge yielded an allowed charge reflecting the lower of these two figures.

We determined that Triple S properly paid these 38 BLS-non-emergency services in our sample, in compliance with relevant provisions of the new Medicare fee schedule.

2 - Basic Life Support – Emergency Transport Procedure Code A0429

Six of 100 services in our sample concerned basic life support transport, classified by suppliers as medical emergencies.

When medically necessary, BLS service, as defined above, is considered to be within the scope of “emergency response.” An emergency response is defined as one that, at the time of ambulance supplier notification, requires an “immediate response.” An immediate response is defined as one requiring the ambulance supplier to initiate elements of its response procedure as quickly as possible upon notification.

We determined that Triple S properly paid these six BLS-Emergency services in our sample, in compliance with relevant provisions of the new Medicare fee schedule.

3 - Advanced Life Support, Level 1 – Emergency Transport Procedure Code A0427

Two of 100 services in our sample concerned advanced life support emergency transport, requiring specialized life support services.

Advanced life support, Level 1 (ALS1) is defined as transportation, by ground ambulance, including medically necessary supplies and services, requiring at least one ALS assessment or intervention.

We determined that Triple S properly paid these two ALS-1 emergency services in our sample, in compliance with relevant provisions of the new Medicare fee schedule.

Ground Ambulance Mileage Procedure Code A0425

Fifty-four of the 100 services in our sample were for ground ambulance mileage.

The CMS Medicare Claims Processing Manual, Chapter 15, *Ambulance*, Section 20.4 states that charges for mileage must be based on loaded mileage only, e.g., from the point of pickup of a patient to his/her arrival at destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes the basic charge for ambulance services and the rate for loaded mileage. Any separate charges for unloaded mileage are denied.

The new ambulance fee schedule provides a separate payment amount for mileage in addition to the base rate. The mileage rate per statute mile applies for all types of ground ambulance services, except Paramedic Intercept, and is provided to all Medicare contractors electronically by CMS as part of the ambulance fee schedule. Suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

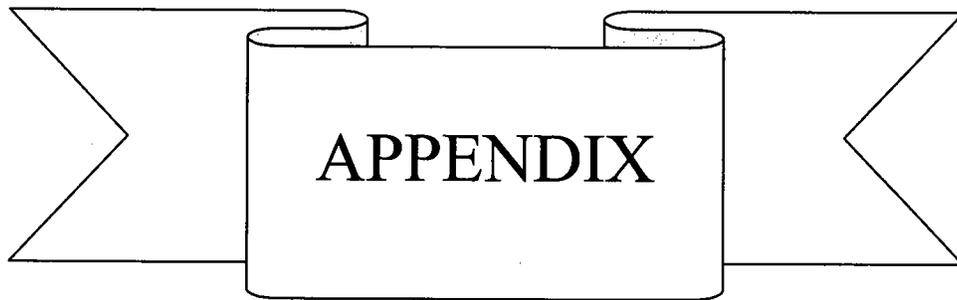
In general, during the transition period, ambulance service claims are paid based on a blended rate that consists of both the fee schedule and the reasonable charge rates. In Puerto Rico, with the implementation of the new ambulance payment provisions, the mileage reimbursement is based only on the fee schedule portion of the blended rate because there is no reasonable charge. The reason for this is that under the previous billing methodology, ambulance suppliers were paid an “all-inclusive” rate, which covered reimbursement for both the ground transportation and the mileage. Therefore, the reasonable charge portion, which includes customary or routinely billed amounts for procedure codes that the supplier is eligible to bill, is not applied. As the transition period progresses, the fee schedule portion will increase to reach the 100 percent of the mileage reimbursement.

The amount reimbursed to the supplier is calculated as follows: Step 1, the number of loaded miles on the service is multiplied by a yearly rate listed in the mileage fee schedule. Step 2, the result is multiplied by the fee schedule percentage for the corresponding transition year to obtain the fee schedule amount. Step 3, this amount is compared to the submitted charge and the lower of the two becomes the allowed amount. Finally, Medicare pays to the supplier 80 percent of this allowed amount.

The table below illustrates an example of the mileage reimbursement under the new Medicare fee schedule provisions for ambulance services for the first two years of the transition period.

Transition Year	Loaded Miles	Mileage Rate per Fee Schedule	Fee Schedule Transition Period %	Subtotal	Submitted Charge	Allowed Charge	Medicare Paid to Supplier (80% of allowed)
Apr/2002-Dec/2002	14	\$5.47	20%	\$15.32	\$20	\$15.32	\$12.26
Jan/2003-Dec/2003	20	\$5.53	40%	\$44.24	\$35	\$35	\$28

We determined that Triple S properly paid all 54 ground ambulance mileage services in our sample, in compliance with relevant provisions of the new Medicare fee schedule.



AMBULANCE SERVICE UNIVERSE

The ambulance services in our universe reference nine procedure codes, including five for ground ambulance, two for air ambulance, and two for mileage reimbursement.

Procedure codes, number of services, and amounts paid are detailed below.

Procedure Code	Description	Number of Services	Amount Paid	Percent of Total Paid
AO425	Ground ambulance mileage, per statute mile	379,616	\$ 4,822,375	8.2%
AO426	Ambulance service, Advanced life support, non-emergency transport, specialized ALS service rendered.	1,194	\$ 179,816	.3%
AO427	Ambulance service, Advanced life support, emergency transport, specialized ALS service rendered.	11,403	\$ 1,957,966	3.3%
AO428	Ambulance service, Basic life support, non-emergency transport	395,368	\$ 46,049,741	79%
AO429	Ambulance service, Basic life support, emergency transport	39,561	\$ 5,199,058	8.9%
AO430	Ambulance service, conventional air services, one-way transport (fixed wing)	2	\$ 1,329	.001%
AO431	Ambulance service, conventional air services, one-way transport (rotary wing)	93	\$ 203,025	.3%
AO434	Ambulance service, specialty care transport	29	\$ 9,454	.02%
AO436	Air mileage (rotary wing) per statute mile	91	\$ 45,554	.08%
	Total	827,357	\$ 58,468,318	

ACKNOWLEDGEMENTS

This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services. Other contributing principal Office of Audit Services staff include:

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