



Effective Ambulance Service Auditing: A Suggested Approach

By R. Michael Scarano, Jr.

Executive Summary

Because the Medicare rules governing ambulance services are complex and unique, providers should implement an effective audit program to assure they meet the applicable requirements. This article identifies the most important issues to be addressed in an ambulance service audit and summarizes the applicable rules. The issues that should be addressed include determining whether: services are medically necessary and billed at the correct level of service; a physician certification statement is properly procured, when necessary; only covered mileage is billed for; the requirement for a beneficiary signature is met; and a health facility or hospice, rather than Medicare, has been billed when required under Medicare rules. Providers should also assure their crews and vehicles meet applicable coverage requirements; their Enrollment Applications (Form 855) are up to date; and their financial relationships with referral sources comply with the Anti-kickback Statute.

Introduction

The Medicare rules governing ambulance reimbursement are unique and complex. As a result, the OIG, CMS and its contractors frequently find deficiencies in ambulance provider¹ billing practices, resulting in denials, recoupment or, in extreme cases, actions under the False Claims Act² or other fraud statutes. Recent enforcement actions have also focused on alleged kickbacks by ambulance service providers in the form of commercially unreasonable discounts provided to health facilities on transports for which they are financially responsible. The government has alleged that these discounts were provided in exchange for referrals of transports paid for under Medicare Part B.

In light of these risks, ambulance service providers should ensure they have an effective audit program in place addressing claims, financial relationships with referral sources and other issues. This article provides a framework for establishing an effective ambulance

audit program, focusing on the delivery of ground ambulance services. A future supplement to this article will address the special additional audit issues raised by air ambulance services.

Rules governing ambulance services are complex and unique.

Sources of Applicable Rules

Medicare provides reimbursement for air and ground ambulance services under Medicare Part B. The applicable rules are found in Title 42 of the Code of Federal Regulations³, Chapter 10 of the Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 15 of the Medicare Claims Processing Manual (CMS Pub. 100-04), and the applicable ambulance billing guides of the various carriers.⁴ Except for

a difference in the beneficiary signature requirement discussed below the same rules apply to both provider-based and independent (supplier) ambulance services. (Suppliers and providers will collectively be referred to in this article as “providers.”) Another valuable resource for ambulance auditors is the OIG’s Compliance Program Guidance for Ambulance Suppliers.⁵

Overview of Claims Issues

Effective auditing of Medicare ambulance claims requires, at a minimum, reviewing the issues of whether:

- The services performed are medically necessary and appropriate.
 - The requirements for the level of service billed are met.
 - The transport is to a covered destination.
 - Physician certification requirements are met, when applicable.
 - All the mileage billed for is covered and accurate.
 - The appropriate codes and modifiers are used.
 - The requirement for the signature of a patient or representative is satisfied.
 - Medicare has been billed for services that should have been billed to a health facility under the PPS payment rules applicable to hospitals and nursing homes, or to a hospice under the hospice benefit rules.
- In addition to the foregoing claims issues, auditors should review whether:
- The vehicles and crews meet applicable coverage requirements.

¹ Some ambulance services are operated by Part B suppliers and some are operated by Part A providers. We will refer to both collectively as “providers.”

² 31 U.S.C. § 3729.

³ See 42 CFR §§ 410.40, 410.41, 410.601 et seq. 424.124.

⁴ See, e.g., National Heritage Insurance Company’s Ambulance Billing Guide, May 2007

⁵ 68 FR 14245 (March 24, 2003); published on the OIG’s Web site at <http://oig.hhs.gov/fraud/docs/complianceguidance/032403ambulancecpgr.pdf>

- The provider's Enrollment Application is up to date.
- All the provider's financial relationships with referral sources, including discounts it provides to health facilities, comply with the Anti-kickback Statute⁶.

The Claims Audit Process

Documentation Needed

In performing the audit, a sufficient sample of claims should be reviewed, either prior to submission or afterwards, to assure all personnel who prepare patient care documentation and claims are correctly following the applicable rules. In addition to the claims themselves, pertinent back-up documentation must be collected and reviewed.

Patient care documentation in the ambulance setting is usually called the patient care report (or PCR, trip ticket or run sheet). Because the condition of the patient as reported at the time of dispatch helps determine the level of service that can be billed, it is also necessary to collect and review dispatch records. These are often called the 'CAD notes', with CAD referring to the computer aided dispatch system used by most ambulance services. If a physician certification statement (PCS) is obtained for the transport, the PCS also constitutes a critical part of the billing documentation. Finally, hospital or nursing home face sheets or similar documentation, if obtained by the provider, should also be reviewed in the audit.

Reviewing Claims

Armed with the claims to be audited and the foregoing documentation, the following questions should be asked for each claim billed to Medicare.

1. Do the services meet medical necessity requirement?

Transport Requirement. As a threshold requirement, Medicare coverage does not apply unless the patient is actually transported. An exception to this rule applies if the patient dies after dispatch of the ambulance, but before the patient is loaded into the ambulance. In that circumstance, Medicare pays for the service based on the non-emergency basic life support, or 'BLS' base rate (without mileage or rural adjustment), even though there is no transport. The QL-modifier should be used for such transports.

Medical Necessity Criteria. The fact that the patient is transported, by itself, is not sufficient to establish coverage. Like

other services, Medicare only covers ambulance transportation when it is medically necessary and reasonable. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. In any case where some other means of transportation could be used without endangering the individual's health, whether or not such other transportation is actually available, this coverage condition is not satisfied.

Medical necessity may be presumed by Medicare intermediaries and carriers under certain circumstances, including when the patient:

- Is transported in an emergency situation, e.g., as a result of an accident, injury or acute illness.
- Needs to be restrained to prevent injury to the patient or others.
- Is unconscious or in shock.
- Requires oxygen or other emergency treatment during transport.
- Exhibits signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain.
- Exhibits signs and symptoms that indicate the possibility of acute stroke.
- Has to remain immobile because of a fracture that has not been set or the possibility of a fracture.
- Is experiencing severe hemorrhage.
- Can only be moved by stretcher.
- Is bed confined at the time of transport (subject to the additional considerations below).

For non-emergency transports, bed confinement is frequently the primary criterion establishing medical necessity. A beneficiary is bed confined if he or she is unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair. However, the fact that the patient is not bed-confined does not necessarily mean that ambulance transport is not medically necessary. A patient who is not bed-confined may nevertheless require medical monitoring or assistance for a condition such as those listed above. Such monitoring generally cannot be provided in a wheelchair van or other type of non-ambulance transport. Conversely, the fact that a patient is bed confined does not necessarily establish medical necessity. For example, if a



bed-confined patient is transported for a reason other than to receive medically necessary and appropriate services at a covered destination, or as a result of an evacuation or similar unusual circumstances, the transport is generally not medically necessary.

Reasonableness Requirement. In addition to the medical necessity requirement, ambulance transports must be 'reasonable'. This means it is reasonable, under the circumstances, to transport the beneficiary to another covered destination to receive the medically necessary services for which the patient was transported. The contractor may find that a transport is not 'reasonable' if it would have been less expensive to bring the services to the patient's bedside than to transport the patient to another site to receive those services. As a practical matter, it is extremely difficult for an ambulance provider to apply this requirement and contractors rarely deny on this basis.

2. Is the Transport Billed at the Correct Level of Service?

There are seven levels of ground ambulance services, with different payment amounts for each category. The seven levels are described below:

Basic Life Support ("BLS") – Non-Emergency (HCPCS AO428): This is defined as ambulance transportation, including the provision of necessary supplies and services, performed by at least one individual who is qualified in accordance

⁶ 42 USC § 1320a-7(b)b.

with state and local laws as an emergency medical technician-basic (“EMT-Basic”).

BLS Emergency (AO429): This is defined as the delivery of BLS services, as defined above, in the context of an emergency response, as defined below:

- An ‘emergency response’ means that, at the time the ambulance provider is called, it responds immediately. An ‘immediate response’ is one in which an ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call. An emergency response can occur either as a result of a call to the local ‘911’ or similar emergency response system, or to the ambulance service directly through its seven-digit number. The determination to respond emergently must be in accord with the local 911 or equivalent service dispatch protocol. If the call comes in directly to the ambulance provider through its seven-digit number, then the ambulance services’ dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service.

Advanced Life Support, Level 1 (ALS1), Non-Emergency (HCPCS A0426): This is defined as ambulance transportation and the provision of medically necessary supplies and services by ALS personnel, including at least one ALS intervention.⁷

- ‘ALS personnel’ is defined as an individual trained to a level above EMT-B. This would include an EMT-paramedic (paramedic) or emergency medical technician-intermediate (EMT-I).
- An ALS intervention is defined as a procedure that, in accordance with state or local laws, is required to be performed by personnel above the EMT-B level, such as a paramedic or EMT-I.

ALS1-Emergency (HCPCS A0427): This is defined as ambulance transportation, and the provision of medically necessary supplies and services, including an ALS assessment by ALS personnel or at least one ALS intervention, following an emergency response as defined above.

- An *ALS assessment* is an assessment performed by an ALS crew member as part of an emergency response (as defined above) that was necessary because the patient’s reported

condition at the time of dispatch was such that only ALS personnel were qualified to perform the assessment. An ALS assessment need not result in a determination that the patient requires an ALS intervention in order to justify billing at this level. The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. When the dispatch is inconsistent with the standard of protocol, including situations where no protocol was used, the transport may be billed as ALS1 only if the beneficiary’s condition (e.g., symptoms) at the scene require an ALS level of service.

Advanced Life Support, Level 2 (ALS2)(HCPCS A0433): This is defined as ambulance transportation and the provision of medically necessary supplies and services, including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) the provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical air way
- Intraosseous line

Note that the monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS procedure.

Specialty Care Transport (SCT) (HCPCS A0434): This is defined as inter-facility ambulance transportation of a critically injured or ill patient, including the provision of medically necessary supplies and services, at a level of service beyond the scope of what a paramedic with standard training may perform. Medical necessity for SCT is established when a beneficiary’s condition requires ongoing care and must be furnished by one or more health professionals above the level of a paramedic with standard training. This would include nursing care, respiratory care, cardiovascular care, or services provided by a paramedic with additional training recognized by a state or local

agency as qualifying the paramedic to perform this level of transport.

Paramedic Intercept (HCPCS A0432): This is defined as ALS services provided by an entity that does not provide ambulance transport, when certain special conditions are satisfied. In order to be covered, paramedic intercept services must be furnished in a rural area, under contract with one or more volunteer ambulance services which are prohibited by state law from billing any one for any service. New York is currently the only state where these services are covered.

3. Is the Patient Transport to a Covered Destination?

Medicare covers ambulance transports only to the following destinations: a hospital; critical access hospital; skilled nursing facility; beneficiary’s home; or a hospital-based or free-standing dialysis for an ESRD patient. A physician’s office is not a covered destination, except when it is necessary to stop at a physician’s office during an emergency transport. Two single-digit modifiers should be used with the ambulance service code to identify both the point of origin and the destination. The first single-digit modifier indicates the point of origin. The second digit modifier indicates the destination.

4. When Required, Is the Physician Certification Statement (PCS) Requirement Met?

Applicable Transports. Certain non-emergency ambulance transports require a certification by a physician (or, for some of these transports, by certain other licensed personnel), documenting the need for ambulance transportation. Specifically, a physician certification statement or PCS is required for: non-emergency repetitive scheduled transports; non-emergency non-repetitive scheduled transports; and non-emergency, non-scheduled transports. Notwithstanding the foregoing, a PCS is not required for non-repetitive transports of patients residing in a facility or at home who are not under the direct care of a physician.

A ‘repetitive’ ambulance transport is defined as ambulance transport that is furnished three or more times during a ten-day period, or at least once per week for at least three weeks, to receive services such as dialysis, respiratory therapy or other types of repetitive services. A ‘scheduled’ transport is defined as a

⁷ Although an ALS assessment may also be performed during an ALS non-emergency transport, the performance of an ALS assessment alone is insufficient to bill at this level. On the other hand, an ALS assessment is sufficient to bill for an ALS emergency transport, if the requirement for an “emergency response” is met, as discussed below.

transport arranged more than 24-hours in advance. A 'non-scheduled transport' is defined as transport scheduled less than 24-hours in advance.

Requirements. There is no required format for a PCS, so long as it documents the medical necessity for ambulance service and is signed by an appropriate individual. The PCS for a non-emergency repetitive transport must be signed by the patient's attending physician within the 60 days prior to the transport. A single PCS for a repetitive patient may be used for multiple transports, provided there is no material change in the patient's condition justifying transport. For other transports requiring a PCS, a PCS pertaining to each specific transport may be signed by either: the patient's attending physician; a physician assistant; nurse practitioner; critical nurse specialist; registered nurse; or discharge planner employed by the hospital or facility where the beneficiary is treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service is rendered. Except for repetitive transports, in the event the ambulance service is unable to obtain a PCS, it may nevertheless submit the claim after 21 days if acceptable documentation of attempts to obtain the PCS exists. Such documentation must include a signed return-receipt from the U.S. Postal Service or other similar delivery service.

5. Is All of the Mileage Covered?

Loaded Mileage. Medicare makes separate payment for mileage. Only the number of miles for which the beneficiary is transported in the ambulance (i.e., loaded mileage) may be billed. If the number of covered miles is in excess of a whole number, the provider may round up. For example, if the patient was transported 2.1 miles, the provider may bill for 3 miles. Miles may either be taken from the ambulance odometer readings recorded by the crew or may be calculated using MapQuest or a similar program.

Transports within the Locality. Only covered mileage may be billed. As a general rule,

only mileage for transportation to the closest appropriate facility is covered. However, if two or more facilities can treat the patient appropriately, and the locality of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of these facilities is covered if the patient is transported there.

'Locality' means the service area in which individuals normally travel, or are expected to travel, to receive hospital or skilled nursing services. An example is as follows: a beneficiary becomes ill at home and requires ambulance service to the hospital. The small community in

which he lives has a small hospital. Two large metropolitan hospitals are located some distance from the beneficiary's community and both regularly provide hospital services to the community's residents. The community is within the locality of both metropolitan hospitals and transport to either of these (as well as to the local community hospital) is covered.

Transports Outside the Locality. Medicare will cover mileage outside the locality only in exceptional situations where a facility outside the locality of the point or origin was the nearest appropriate facility under the circumstances. An "appropriate facility" means an institution that is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the care required to treat the patient's condition. The fact that a particular physician does not have staff privileges at a hospital is not a consideration in determining whether the hospital has appropriate facilities, provided there is

another qualified physician or specialist available at that facility. Therefore, transport to a more distant hospital solely to avail a patient of the services of a specific physician or specialist does not make that facility the nearest appropriate facility. A facility is not considered 'appropriate' if there is no bed available.

In the event a beneficiary is transported outside of the locality, as defined above, to a facility which is further away than the closest appropriate facility within the locality, then the mileage is not covered and may not be billed to Medicare. It may, however, be billed to the beneficiary, subject to other payment rules.

“Another valuable resource is the *OIG's Compliance Program Guidance for Ambulance Suppliers*.”

6. Is the Correct Zip Code Used for the Point of Pickup?

Medicare pays an additional amount if the point of pickup is in a rural area or a so-called 'super rural area'. Whether a transport qualifies for one of these designations depends on the zip code indicated for the point of pickup. It is therefore important that the zip code be accurate. CMS has posted zip codes, along with their rural or super rural designation, on its website at www.cms.hhs.gov/center/ambulance.asp.

7. Are the Correct Codes and Modifiers Used?

As with all Medicare services, it is important to assure that all correct codes and modifiers are used. A list of modifiers and codes specific to ambulance services is found in the Medicare Claims Processing Manual, Chapter 15, Section 30.

8. Is the Beneficiary Signature Requirement Satisfied?

New Rule. The rules governing Medicare requirements for beneficiary signatures for ambulance providers have been changed, effective January 1, 2008, by



a controversial rule issued by CMS on November 1, 2007 (the 'new rule').⁸ The following discussion reflects these changes:

General Requirement. Medicare requires the signature of the beneficiary on the ambulance provider's documentation, reflecting the beneficiary's request that payment be made to the ambulance provider, if the patient is able to sign. If the beneficiary is physically or mentally unable to sign, a representative may sign on his/her behalf. An acceptable representative includes a legal guardian, representative or other person who receives benefits on the beneficiary's behalf, or who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs; or a representative of an institution (other than the provider) that has provided care to the beneficiary. The documentation should state why the beneficiary is unable to sign and the representative's relationship to the beneficiary. The signature of the beneficiary or representative should be dated.

Special Rule for Emergency Transports. Pursuant to the new rule, if the patient is unable to sign and there is no representative available to do so, a claim may nevertheless be submitted for *emergency transports only* if the following additional documentation is obtained by the provider:

- (1) A contemporaneous statement, signed by an ambulance employee present during the trip to the receiving facility, that at the time of service, the beneficiary was physically or mentally incapable of signing the claim and that no representative is available or willing to sign the claim on behalf of the beneficiary.
- (2) Documentation with the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary.
- (3) One of the following:
 - A signed contemporaneous statement from a representative of the facility that received the

beneficiary, which documented the name of the beneficiary and the date and time the beneficiary was received by that facility; 'or, secondary verification' containing the name of the beneficiary and the date and time the beneficiary was received by the facility. This secondary verification may take the form of a copy of any of the following documents: (1) the patient care or trip report signed by a representative of the receiving hospital; (2) the hospital's registration/admissions sheet, (3) the patient's medical record, (4) the hospital's log, or (5) other internal hospital records. The "secondary verification" may be obtained after the transport but must be obtained before submission of the claim.

Non-emergency Transports. The new rule does not provide any alternative mechanism for submitting a claim without a beneficiary or representative signature for Part B suppliers. Therefore, unless the beneficiary is deceased, it will apparently be necessary for Part B suppliers to obtain the signature in each instance. However, CMS points out that in the event the signature is not obtained at the time of transport, it may be obtained at any time prior to the filing of the claim. CMS also points out that in the event a claim cannot be filed due to lack of cooperation by the beneficiary or representative, the beneficiary or a financially responsible party can be billed directly by the provider.

Additional Exception for Part A Providers. The new rule gives additional latitude to ambulance services rendered by Part A providers in obtaining signatures. If the patient is unable to sign, these providers may submit a claim for either emergency or non-emergency transports if the provider creates and signs documentation indicating that it has made reasonable efforts to locate and obtain the signature of a permitted representative. The unavailability of a patient or representative signature at the time of transport

will generally not be sufficient. Part A providers will be required to make reasonable efforts to obtain a patient or representative signature after the transport and prior to submitting a claim. The rule does not specify how long these attempts must be made or what they must entail but Part A providers should at a minimum, send out one or two letters seeking signature before relying on this exception.

Lifetime Signatures. Historically, it has not been necessary to obtain a patient or representative signature for a transport if the patient already has a "lifetime signature" on file. This is defined as a signature by the patient or legal representative of the patient, as specified by state law, authorizing the submission of claims on the patient's behalf for future or indefinite periods. Since nothing in the new rule changes this, possession of a prior signature on file appears to satisfy the signature requirement.

If the signature requirement is satisfied through any of the mechanisms above, the provider may answer "Yes" to the question on the Medicare claims form asking whether the provider has a beneficiary signature on file.

9. Is the transport the financial responsibility of the hospital, nursing home, or hospice?

Certain ambulance transports performed for hospital, nursing home and hospice patients are the financial responsibility of the originating health facility or hospice, and may not be billed to the Medicare carrier. The OIG has documented in a series of reports that this is an area of concern and ambulance services should be vigilant in monitoring compliance with these rules.

SNF Patients During a Covered Part A Stay: Under the prospective payment system (PPS) and consolidated billing rules applicable to skilled nursing facilities (SNFs), payment for certain transports are made to the SNF as part of Medicare's bundled payment for patients during a stay covered by Medicare Part A. Ambulance providers must bill the SNF, rather than Medicare, for these transports. Information regarding which transports are covered by this requirement and must therefore be billed to the facility, and which transports are outside the scope of

⁸ See Final Rule with Comment [CMS-1385-FC], RIN 0938-AO65, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions, scheduled to be published in the Federal Register November 27, 2008. As of the date this article went to press, the ambulance industry was objecting strongly to the new beneficiary signature provisions in this rule. If CMS revises or rescinds these provisions, an update will be published in a future edition of this Journal.

the SNF's PPS payment and may be billed to the carrier can be found in Section 30.2.3 of Chapter 15 of the Medicare Claims Processing Manual.

Hospital Inpatients: Under the PPS rules applicable to hospitals, payment for transports of hospital inpatients is included in Medicare's DRG payment to the hospital. Ambulance providers must therefore bill the hospital, rather than Medicare, for these transports. These include round-trip transports of hospital inpatients to receive services which are not available at the facility where the patient is admitted, as well as transports of an inpatient between separate campuses of the same hospital (i.e., two facilities of a health system which share the same provider number).

Repeat Admissions and Interrupted Stays. In addition, CMS has taken the position that an ambulance transport provided following discharge from a general acute care hospital but prior to a 'repeat admission' constitutes the hospital's responsibility. A 'repeat admission' occurs when the patient is discharged from an acute care hospital and returns to the same hospital on the same day (before midnight) for treatment of the same condition. Similarly, under the rules governing 'interrupted stays' applicable to long-term care hospitals (LTCHs), acute psychiatric hospitals or rehabilitation hospitals, transports of patients who are discharged and then readmitted within a specified period of time constitute the financial responsibility of the hospital. For LTCHs this rule applies if the patient is readmitted before midnight within three days of discharge, while for psychiatric and rehabilitation hospitals the rule is limited to readmissions before midnight on the same day as discharge.

Hospice Patients: Transports provided to patients who have elected to receive the hospice benefit, for a condition related to their terminal illness, must be billed to the hospice and may not be billed to Medicare Part B.

Other Important Audit Issues

The foregoing discussion addresses the most important issues to be evaluated in reviewing claims on a pre- or post submission basis. In addition, any audit of an ambulance provider should include certain other key issues, identified below:

1. Do the vehicles and crews meet coverage requirements?

Ambulances and crews used to provide ambulance services must comply with state and local laws governing their licensure and certification. Depending on the jurisdiction, ambulances and crews may be subject to both state and local requirements. Verification of ambulance licensure can be accomplished by checking to assure the provider has a valid license on file. Verification of crew members' licensure or certification can be accomplished by checking the records of the applicable state and/or local agency. In addition, crew members should be screened to assure they are not excluded from federal health care programs using the OIG's Provider Exclusion website.

2. Is the provider enrollment form on file with the Medicare contractor up to date?

Providers are required to have an Enrollment Application (Form 855) on file with the contractor. The form includes detailed information regarding the provider, and registrations of the ambulances used by the provider must be included as an attachment to the form. When new vehicles are placed in service, existing vehicles are taken out of service, or other information required on the 855 form changes, an amended 855 form must be filed with the contractor within 90 days of such change. Therefore, the 855 should be reviewed as part of the audit to make sure it is current. The 855 does not require a list of the crew members or their credentials.

3. Does the ambulance service have any financial relationships with the referral sources that violate the Anti-Kickback Statute?

The Anti-Kickback Statute makes it unlawful to provide or receive anything of value, in cash or in kind, as an inducement for the referral of federal fee for service business. Providers should review their financial relationships with referral sources, such as referring physicians, hospitals, and SNFs, to make sure there is no unlawful remuneration imbedded in those relationships.

'Remuneration' can include commercially unreasonable discounts provided by an ambulance company to a hospital or nursing home on PPS transports if the discount is intended to induce the referral by the facility of Medicare Part B referrals.

Recent enforcement actions reflect that the government may be focusing on this issue. In guidance documents addressing this issue,⁹ the OIG has indicated that it will view as 'suspect' any arrangements in which a health facility or other customer which refers Part B business is given a price which is either (1) below the ambulance provider's fully loaded costs, including its labor, overhead, equipment, etc; or (2) lower than prices the provider would charge a customer with a comparable or higher volume of business for which it is financially responsible and no federal health care program referrals. In other words, the OIG will view as suspect any discounted rates for PPS or bundled transports which do not reflect fair market value in an arms-length transaction, without taking into account the volume or value of existing or potential Medicare fee for service referrals. The OIG also recommends that for each discount arrangement, the ambulance provider carefully and accurately document how fair market value is determined. For example, to the extent that part of a discount is attributable to factors such as the expected volume of PPS business, or lower billing costs and bad debt attributable to such business, the provider's reliance on these factors should be documented.

Conclusion

The foregoing provides a roadmap for conducting an effective ambulance service audit program. While an attempt has been made to identify the most important issues to be addressed, it is not intended to be exhaustive. Providers are encouraged to review the OIG's Compliance Program Guidance for Ambulance Suppliers and the other sources listed in the Introduction so that they may be apprised of all potential risk areas, and can tailor an audit program to their own needs and capabilities. **NP**

R. Michael Scarano, Jr. is a partner with Foley & Lardner LLP, with offices throughout the United States. He is a nationally recognized expert on emergency medical services law and represents some of the largest ground and air ambulance providers in the nation. Mr. Scarano was selected for inclusion in the 2008 and 2007 editions of The Best Lawyers in America®. He can be reached at mscarano@foley.com or 858-847-6712.

⁹ See, e.g., Supplemental Compliance Program Guidance for Hospitals; 70 Federal Register 4858 (January 31, 2005); available on the OIG's website at <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>