OIG Ambulance Guidance Applies to All Healthcare Sectors

Save to myBoK

by Sue Prophet-Bowman, RHIA, CCS

The Office of Inspector General (OIG) of the Department of Health and Human Services published two more compliance program guidances in its industry-specific series this year. The guidances are aimed at ambulance suppliers and pharmaceutical manufacturers. This article will address key components of the Compliance Program Guidance for Ambulance Suppliers.

This article should be read closely by HIM professionals who work for entities that own ambulance services or are at all involved in coding or billing for ambulance services. As with previous compliance program guidances, even if you have no direct involvement with the segment of the healthcare industry directly targeted by this guidance, it is still important for HIM and compliance professionals to be familiar with the content. As the OIG gains experience with the development of each compliance program guidance, it adds or updates elements that are applicable to all segments of the healthcare industry.

Guidance Not 'One-Size-Fits-All'

The creation of compliance program guidances is a major OIG initiative that is part of its overall effort to engage the private healthcare community in preventing the submission of erroneous claims and in combating fraudulent and abusive conduct. Examples of fraudulent and abusive practices that have been identified in the ambulance industry include:

- improper transport of individuals with other acceptable means of transportation
- medically unnecessary trips
- trips claimed but not rendered
- misrepresentation of the transport destination to make it appear as if the transport was covered
- false documentation
- billing for each patient transported in a group as if he or she was transported separately
- upcoding from basic life support to advanced life support services
- payment of kickbacks

While a few of these practices are unique to the medical transportation industry, several of them, including issues related to medical necessity, false documentation, improper billing, upcoding, and payment of kickbacks, should be a familiar theme to compliance professionals in all segments of the healthcare industry. The OIG recommendations for strategies to prevent fraudulent or abusive conduct related to these practices may be applicable to all types of healthcare providers, not just ambulance suppliers.

As with past compliance program guidance documents, the guidelines described in the ambulance guidance are not mandatory, and the document does not contain all the components that should be part of an organization's compliance program.

The OIG recognizes that the ambulance industry is comprised of entities of enormous variation: large and small companies; for-profit and non-profit companies; independent companies and those that are affiliated with hospitals; and commercially owned companies as well as those operated by municipalities or counties. Therefore, compliance program guidance is not intended to be "one-size-fits-all." Rather, it is intended as a helpful tool for those entities that are considering establishing a voluntary compliance program and for those that have already established a program but are seeking to analyze, improve, or expand existing programs.

The OIG compliance program guidance should be used as a resource for ambulance suppliers to decrease the incidence of fraud and abuse as well as errors that might occur due to inadequate training or inadvertent noncompliance. Compliance programs should reflect each ambulance supplier's individual and unique circumstances.

Start with a Risk Analysis

Ambulance suppliers should conduct a risk analysis that begins by performing an evaluation of internal and external factors that affect their operations. The evaluation process may be simple and straightforward or it may be fairly complex and involved. The evaluation process should furnish ambulance suppliers with a snapshot of their strengths and weaknesses and assist providers in recognizing areas of potential risk.

Ambulance suppliers should evaluate a variety of practices and factors, including their policies and procedures, employee training and education, employee knowledge and understanding, claims submission process, coding and billing, accounts receivable management, documentation practices, management structure, employee turnover, contractual arrangements, changes in reimbursement policies, and payer expectations.

Are Policies and Procedures Accurate?

The ambulance supplier's policies and procedures should describe the normal operations of the ambulance supplier and the applicable rules and regulations. Written policies and procedures should go through a formal approval process within the organization and should be evaluated on a routine basis and updated as needed to reflect current ambulance practices. Policies and procedures should be reviewed to ensure they are representative of actual practices.

Training and Education

Ensuring that ambulance suppliers' employees and agents receive adequate education and training is essential to minimizing risk. Employees should receive training on the elements of the compliance program, the importance of the program to the organization, the purpose and goals of the program, what the program means for each individual, and the key individuals responsible for ensuring that the program is operating successfully. Compliance program education should be available to all employees, even those whose job functions are not directly related to billing or patient care.

Employees should be trained on specific areas with regard to their particular job positions and responsibilities. Training employees on the job functions of other people in the organization may also be an effective training tool. Appropriate cross training can improve employees' overall awareness of compliance and job functions, thereby increasing the likelihood that an individual employee will recognize noncompliance.

Training should be provided on a periodic basis to keep employees up to date on current requirements, such as the latest payer requirements. Employees who attend interactive training better comprehend the material presented. Because interactive, live training often requires significant personnel and time commitments, ambulance suppliers may wish to consider seeking, developing, or using other innovative training methods such as computer or Internet modules. Employees should complete a post-compliance training test or questionnaire to verify comprehension of the material presented.

Assessment of Claims Submission Process

Periodic claims reviews should be conducted to verify that a claim ready for submission, or one that has been submitted and paid, contains accurate and truthful information required by the payer. Minimally, an ambulance claims review should focus on the information and documentation in the ambulance call report (ACR), the medical necessity of the transport as determined by payer requirements, the coding of the claim, the co-payment collection process, and the subsequent payer reimbursement. The claims review may focus on particular areas of interest (for example, coding accuracy) or it may include all aspects of the claims submission and payment process.

In addition to monitoring identified errors, the source or cause of the errors should also be evaluated. It is the ambulance supplier's responsibility to identify weaknesses and correct them promptly. A detailed and logical analysis of errors and their causes will make claims reviews useful tools for identifying risks, correcting weaknesses, and preventing future errors.

Claims reviews should be conducted by individuals with experience in coding and billing and familiar with the different payers' coverage and reimbursement requirements for ambulance services. The reviewers should be independent and objective in their approach. Claims reviewers who analyze claims that they prepared or supervised often lack sufficient independence to accurately evaluate the claims submission process and accuracy of individual claims.

Consider using a baseline audit to develop a benchmark against which to measure performance. Comparing audit results from different audits will generally yield useful results only when the audits analyze the same or similar information and when matching methodologies are used. In addition to using internal benchmarks, external information should also be used.

Claims should be reviewed on a pre-billing basis to identify errors before claims are submitted. If there is insufficient documentation to support the claim, it should not be submitted. If, as a result of the pre-billing claims review process a pattern of claim submission or coding errors is identified, a responsive action plan should be developed to ensure that overpayments are identified and repaid.

A review of paid claims may be necessary to determine error rates and quantify overpayments or underpayments. The post-payment review may help identify billing or coding software system problems.

Claims denials should be reviewed periodically to determine if denial patterns exist. If a pattern is detected, it should be evaluated to determine the cause and appropriate course of action. Employee education regarding proper documentation, coding, or medical necessity may be appropriate.

System Reviews, Safeguards

Periodic review and testing of coding and billing systems are essential to detect system weaknesses. One reliable systems review method is to analyze in detail the entire process by which a claim is generated, including how a transport is documented and by whom; how that information is entered into the supplier's automated system (if any); coding and medical necessity determination protocols; billing system processes and controls, including any edits or data entry limitations; and the claims generation, submission, and subsequent payment tracking processes.

Ambulance suppliers should ensure that their electronic or computer billing systems do not automatically insert information that is not supported by the documentation of the medical or trip sheets. If information is automatically inserted into a claim submitted for reimbursement and that information is false, the ambulance supplier's claims will be false. If a required field on a claim form is missing information, the system should flag the claim prior to its submission.

A systems review is especially important when documentation or billing requirements are modified or when an ambulance supplier changes its billing software or claims vendors.

Identify, Address Risk Areas

To stay abreast of risks affecting the ambulance and other healthcare industries, OIG publications, including advisory opinions, fraud alerts, bulletins, and reports from the Office of Evaluation and Inspections and the Office of Audit services should be reviewed. Compliance program guidance documents do not identify all risks applicable to a particular segment of the healthcare industry.

A reasonable response should be developed to address identified risk areas, including written protocols and reasonable time frames for specific situations. Developing timely and appropriate responsive actions demonstrates the organization's commitment to address problems and concerns. Determining whether identified problems respond to corrective actions may require continual oversight.

Medicare Fraud, Abuse Hazards

Medical Necessity

Medically unnecessary transports have formed the basis of a number of Medicare and Medicaid fraud cases. Medicare Part B covers ambulance services only if the beneficiary's medical coverage contraindicates another means of transportation.

Upcoding

Ambulance suppliers should be careful to bill at the appropriate level for services actually provided. The federal government has prosecuted a number of ambulance cases involving upcoding from basic life support to advanced life support related to

both emergency and non-emergency transports.

Documentation, Billing, Reporting Risks

Inadequate or faulty documentation is a key risk area for ambulance suppliers. The compilation of correct and accurate documentation (whether electronic or hard copy) is generally the responsibility of all ambulance personnel, including the dispatcher who receives a request for transportation, the personnel transporting the patient, and the coders and billers submitting claims for reimbursement.

When documenting a service, ambulance personnel should not make assumptions or inferences to compensate for a lack of information or contradictory information on a trip sheet, ACR, or other medical source documents. To ensure that adequate and appropriate information is documented, an ambulance supplier should gather and record, at a minimum, the following:

- dispatch instructions, if any
- reasons why transportation by other means was contraindicated
- reasons for selecting the level of service
- information on the status of the individual
- who ordered the trip
- time spent on the trip
- dispatch, arrival at scene, and destination times
- mileage traveled
- pickup and destination codes
- appropriate zip codes
- services provided, including drugs or supplies

The appropriate Healthcare Common Procedure Coding System (HCPCS) codes should be used when submitting claims for reimbursement. The HCPCS codes reported on the ambulance trip sheets or claim forms should be selected to most accurately describe the type of transport provided based on the patient's illness, injury, signs, or symptoms at the time of the ambulance transport.

HCPCS codes should not be selected based on information relating to the patient's past medical history or prior conditions, unless such information also specifically relates to the patient's condition at the time of transport. Ambulance suppliers should use caution not to submit incorrect HCPCS codes on trip sheets or claims to justify reimbursement.

Reference

The OIG Compliance Program Guidance for Ambulance Suppliers is available at http://oig.hhs.gov/fraud/docs/complianceguidance/032403ambulancecpgfr.pdf.

Sue Prophet-Bowman *(sue.prophet@ahima.org) is AHIMA's director of coding policy and compliance.*

Article citation:
Prophet-Bowman, Sue. "OIG Ambulance Guidance Applies to All Healthcare Sectors." *Journal of AHIMA* 74, no.7 (July/August 2003): 66-69.