



Office of Audit Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

July 6, 2005

Report Number: A-09-04-00029

Mr. Gaylan Crowell
Chief Executive Officer
Native American Air Ambulance
6402 East Superstition Springs Boulevard, Suite 224
Mesa, Arizona 85216-6069

Dear Mr. Crowell:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Review of Medicare Claims for Air Ambulance Services Paid to Native American Air Ambulance." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-09-04-00029 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Alex Trujillo
Regional Administrator
Denver Regional Office
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, Colorado 80202-4967

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE CLAIMS FOR
AIR AMBULANCE SERVICES PAID TO
NATIVE AMERICAN AIR AMBULANCE**



**Daniel R. Levinson
Inspector General**

**JULY 2005
A-09-04-00029**

Office of Inspector General

<http://oig.hhs.gov>

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

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

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health insurance coverage to people age 65 and over, the disabled, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) contracts with carriers for the administration of Medicare Part B. Part B covers a multitude of medical and other health services, including air ambulance services. Air ambulance services are provided by either a fixed wing (airplane) or rotary wing (helicopter) aircraft when the patient's medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance.

Medicare requires air ambulance suppliers to:

- document the medical necessity and appropriateness of services billed,
- transport patients to an acute care hospital for services,
- transport patients to the nearest acute care hospital with appropriate facilities,
- calculate mileage correctly, and
- submit a claim first to the primary payer when Medicare is the secondary payer and refund any Medicare payment for the services paid by another primary payer (Medicare secondary payer overpayments).

For calendar year (CY) 2002, Native American Air Ambulance (Native Air) received \$3,968,759 in Medicare payments for 1,219 air ambulance claims. Native Air is a privately held corporation, providing air medical transport services by airplane and helicopter in Arizona.

OBJECTIVE

Our objective was to determine whether Native Air claimed air ambulance services for CY 2002 pursuant to Medicare billing requirements.

SUMMARY OF FINDINGS

Contrary to Medicare billing requirements, Native Air improperly claimed air ambulance services. Of our random sample of 100 claims, 15 claims were improper:

- 1 claim was for a medically inappropriate service (transporting the patient by air ambulance when a ground ambulance would have sufficed), and
- 14 claims were for transporting patients beyond the nearest hospital with appropriate facilities.

As a result, \$10,589 of the \$330,713 reviewed was unallowable. Projecting the results of the unrestricted random sample to the population, we are 95-percent confident that at least \$62,408 of the \$3,968,759 paid to Native Air for air ambulance claims was unallowable for Medicare reimbursement. These overpayments occurred because Native Air did not ensure that:

- only medically appropriate air transport was billed to Medicare, and
- air transport was billed for the mileage to the nearest hospital with appropriate facilities and documentation in the medical records supported the reason for transporting patients beyond the nearest hospital with appropriate facilities.

RECOMMENDATIONS

We recommend that Native Air:

- refund to the Medicare program \$62,408 in overpayments for air ambulance services,
- strengthen policies and procedures to ensure that only medically appropriate air transport services are billed to Medicare, and
- strengthen policies and procedures to ensure that air transport services are billed for the mileage to the nearest hospital with appropriate facilities and that documentation in the medical records supports the reason for transporting patients beyond the nearest hospital with appropriate facilities.

NATIVE AIR’S COMMENTS

In written comments on our draft report, Native Air disagreed with our findings and the procedural recommendations. It did not comment on the recommendation for a refund of \$62,408. It stated that the physician determined the medical appropriateness of air transport, and Native Air “was not in a position to look behind the physician’s decision to determine whether, in fact, the transport was medically necessary.” Further, it “relied on the medical judgment of the physician or other trained personnel that the receiving facility was the closest appropriate facility to provide the necessary care.” Finally, Native Air stated that it established controls in CY 2003 to address the issues identified in our audit. The full text of Native Air’s comments is included as an appendix.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

We based our findings and recommendations on the Medicare billing requirements for air ambulance services and the medical reviews performed by Noridian Administrative Services, LLC (Noridian), the Medicare Part B carrier for Native Air. The medical reviewers evaluated Native Air’s documentation and determined that the air transport was not medically appropriate and that patients should have been transported to a closer hospital with appropriate facilities. Because we reviewed Medicare claims for air ambulance services provided during CY 2002, we did not review the policies and procedures developed in CY 2003.

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INTRODUCTION

BACKGROUND

Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health insurance coverage to people age 65 and over, the disabled, and people with end-stage renal disease. Administered by CMS within the Department of Health and Human Services, the program consists of four parts, including Part B – Supplemental Medical Insurance. Part B covers a multitude of medical and other health services, including air ambulance services. Part B claims are processed by carriers, which are CMS contractors. Noridian is the Medicare carrier for beneficiaries residing in Arizona.

Air Ambulance Services

Medicare reimburses air ambulance suppliers for:

- airplane or helicopter ambulance transport service, one way; and
- airplane or helicopter mileage.

Medicare Billing Requirements for Air Ambulance Services

To be covered by Medicare, ambulance services must be medically necessary and reasonable. The patient's condition should be such that use of any other method of transportation would endanger the patient's health. Air ambulance services also must be medically appropriate. The patient's condition should be such that transportation by either basic or advanced life support ground ambulance would pose a threat to the patient's survival or seriously endanger the patient's health.

Native Air

Native Air is a privately held corporation, which has provided airplane and helicopter medical transport services in Arizona since August 1995. Its main office is located in Mesa, AZ.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Native Air claimed air ambulance services for CY 2002 pursuant to Medicare billing requirements.

Scope

As part of an Office of Inspector General nationwide review of air ambulance services, we selected the air ambulance supplier that received the highest amount of Medicare payments in Arizona. Native Air received \$3,968,759 in Medicare payments for 1,219 air ambulance claims for CY 2002. We reviewed a random sample of 100 claims (a claim consisted of an air ambulance transport service and related air mileage) to determine whether Native Air:

- documented services for medical necessity and appropriateness,
- transported patients to an acute care hospital for services,
- transported patients to the nearest acute care hospital with appropriate facilities,
- calculated and billed mileage correctly, and
- received Medicare secondary payer overpayments.

We did not assess the overall internal control structure of Native Air. We limited our internal control review to obtaining an understanding of controls over the submission of claims to Medicare for air ambulance services.

We performed our review from April through October 2004 and conducted fieldwork at Native Air in Mesa, AZ, and Noridian in Fargo, ND.

Methodology

To accomplish the objective, we:

- reviewed applicable Federal regulations and Medicare requirements;
- identified the population of Medicare claims for CY 2002 air ambulance services paid to Native Air, using Medicare claims data from CMS's program safeguard contractor, Western Integrity Center;
- selected a random sample of 100 Medicare claims for air ambulance services;
- obtained medical records, patient account ledgers, insurance verification forms, and other claim-related information from Native Air for all 100 claims;
- obtained medical records from the pickup and destination facilities for certain claims;
- obtained documents related to Medicare appeal and hearing processes for certain claims;
- used medical review staff from Noridian to evaluate the 100 claims;

- obtained the air mileage chart used by Noridian during CY 2002 to determine the appropriate mileage between the pickup and destination facilities;
- obtained Medicare Common Working File data for all 100 claims to confirm that the patients were transported to an acute care hospital for services;
- reviewed Native Air's policies and procedures for billing Medicare for air ambulance services;
- interviewed Native Air officials to obtain an understanding of the Medicare billing processes for air ambulance services; and
- used a variable unrestricted appraisal program to estimate the dollar impact of overpayments identified in the population.

Details of our statistical sampling methodology are presented in Appendix A.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Contrary to Medicare billing requirements, Native Air improperly claimed air ambulance services in CY 2002. Of our random sample of 100 claims, 15 claims were improper:

- 1 claim was for a medically inappropriate service (transporting the patient by air ambulance when a ground ambulance would have sufficed), and
- 14 claims were for transporting patients beyond the nearest hospital with appropriate facilities.

As a result, \$10,589 of the \$330,713 reviewed was unallowable. Projecting the results of the unrestricted random sample to the population, we are 95-percent confident that at least \$62,408 of the \$3,968,759 paid to Native Air for air ambulance claims was unallowable for Medicare reimbursement. These overpayments occurred because Native Air did not ensure that:

- only medically appropriate air transport was billed to Medicare, and
- air transport was billed for the mileage to the nearest hospital with appropriate facilities and documentation in the medical records supported the reason for transporting patients beyond the nearest hospital with appropriate facilities.

MEDICALLY INAPPROPRIATE AIR AMBULANCE SERVICE

Medicare Billing Requirements

The Medicare Benefit Policy Manual, chapter 10.4, states that medically appropriate air ambulance services are covered only if the patient's condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Specifically, chapter 10.4.2 of the manual states, "Medical appropriateness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health."

Chapter 10.4.7 of the manual states that suppliers, when requested by the carrier to substantiate medical appropriateness, should provide documentation indicating that the air ambulance service was reasonable and necessary to treat the patient's life-threatening condition.

In addition, section 2120.4G of the Medicare Carriers Manual states that payment for the air ambulance service should be based on the amount payable for ground transport if a determination is made that ground ambulance service would have sufficed.

Air Transport Not Required

Native Air submitted one claim containing a medically inappropriate air ambulance service when a ground ambulance would have sufficed. The air transport service had related mileage of 186 miles, the distance from a hospital in Polacca, AZ, to a hospital in Phoenix, AZ.

Before our review, Noridian determined that the air transport was not medically appropriate and allowed the transport service and related mileage at ground ambulance rates. Further, Noridian allowed only 128 of the 186 claimed miles after determining that the Phoenix hospital was not the nearest hospital with appropriate facilities. However, Noridian incorrectly paid the 128 miles at an air ambulance mileage rate instead of a ground ambulance mileage rate. As a result, Native Air was overpaid \$2,845.

PATIENTS TRANSPORTED BEYOND THE NEAREST HOSPITAL WITH APPROPRIATE FACILITIES

Medicare Billing Requirements

The Medicare Benefit Policy Manual, chapter 10.4.4, states,

A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician.

Chapter 10.4.6 of the manual states that if the air transport was medically appropriate, but the patient could have been treated at a nearer hospital than the one to which he or she was transported, payment is limited to the rate for the distance from the point of pickup to the nearer hospital.

Further, chapter 10.3.6 of the manual states,

...ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities. The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have “appropriate facilities.”

Patients Not Transported to Nearest Hospital

Native Air submitted 14 claims for air ambulance services beyond the nearest hospital with appropriate facilities. As a result, Native Air was overpaid \$7,744.

For example, Native Air submitted one claim for air transport and related mileage of 149 miles for a patient with congestive heart failure. The flight was from a hospital in Lake Havasu City, AZ, to a hospital in Phoenix, AZ. The “Patient Flight Record” stated the reason for the flight as “higher level of care with cardiac intervention.” The “Consent for Transportation, Treatment, Operations and/or Anesthetics” form completed by a Native Air crewmember indicated that the hospital in Phoenix was the “closest appropriate hospital for cardiac intervention.” However, the Noridian medical review staff determined that the closest hospital with appropriate facilities to treat the patient’s condition was in Las Vegas, NV, a distance of 128 miles from the Lake Havasu hospital. Consequently, Native Air was overpaid for the difference of 21 (149 – 128) miles.

LACK OF ADEQUATE CONTROLS

Native Air did not have adequate controls to ensure that only medically appropriate air transport was billed to Medicare. It also did not have adequate controls to ensure that air transport was billed for the mileage to the nearest hospital with appropriate facilities or that documentation in the medical records supported the reason for transporting patients beyond the nearest hospital with appropriate facilities.

Native Air officials stated that the referring physicians, not its crewmembers, made the decisions to transport patients by air ambulance. During CY 2002, Native Air used the form “Documentation of Medical Necessity for Air Transport” to allow referring physicians or nurses to select reasons for requesting air transport from a predetermined list. (See Appendix B for a sample of the form.) Native Air also kept copies of patient transfer records obtained from referring hospitals. The referring physicians used the transfer records to indicate reasons for and modes of transport. Other than obtaining copies of the medical necessity form or the transfer record, Native Air did not have any other procedures for confirming whether a patient’s condition met the medical appropriateness criteria for air transport before billing Medicare.

Native Air officials also stated that referring physicians selected the hospitals to which patients were transported. Native Air used the form “Consent for Transportation, Treatment, Operations and/or Anesthetics” to document the reason for not transporting a patient to the closest hospital. However, for the 14 claims, the reasons given on the form were not sufficient to allow the mileage as billed. Other than requiring its crewmembers to document the reasons, Native Air did not have written procedures for verifying whether the destination hospital was the nearest hospital with appropriate facilities when billing Medicare. It also did not have procedures for confirming that documentation in the medical records supported the reason for transporting patients beyond the nearest hospital with appropriate facilities.

CONCLUSION

Of 100 randomly selected air ambulance claims, 15 claims did not meet Medicare billing requirements. As a result, we determined that \$10,589 of the \$330,713 reviewed was unallowable. We projected the results of the unrestricted random sample to the population and are 95-percent confident that at least \$62,408 of the \$3,968,759 paid to Native Air for air ambulance claims for CY 2002 was unallowable for Medicare reimbursement.

RECOMMENDATIONS

We recommend that Native Air:

- refund to the Medicare program \$62,408 in overpayments for air ambulance services,
- strengthen policies and procedures to ensure that only medically appropriate air transport services are billed to Medicare, and
- strengthen policies and procedures to ensure that air transport services are billed for the mileage to the nearest hospital with appropriate facilities and that documentation in the medical records supports the reason for transporting patients beyond the nearest hospital with appropriate facilities.

NATIVE AIR’S COMMENTS AND OFFICE OF INSPECTOR GENERAL’S RESPONSE

In written comments on our draft report, Native Air disagreed with our findings and recommendations. Native Air’s comments are summarized below and included in their entirety as Appendix C.

Medically Inappropriate Air Ambulance Service

Native Air’s Comments

Native Air disagreed with our finding that one claim was for a medically inappropriate service. It stated that the physician determined the medical appropriateness of air transport based upon the medical information available at the time of the transport. The 85-year-old female patient had a femur fracture, an emergent injury that could result in significant complications if the

patient was transported by ground ambulance. It further stated, “Air ambulance transports are emergency services ordered by medical decision-makers who are in the best position to know whether a patient’s current condition medically warrants the type of transport.” Therefore, Native Air “was not in a position to look behind the physician’s decision to determine whether, in fact, the transport was medically necessary.”

Office of Inspector General’s Response

We based our finding on the Medicare billing requirements for air ambulance services and the medical reviews performed by Noridian. Noridian’s reviews were based on documentation in the medical records provided by Native Air and by pickup and destination facilities for certain claims.

The Medicare Benefit Policy Manual, chapter 10.4, states that Medicare contractors, including carriers, approve claims only if the beneficiary’s medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Specifically, chapter 10.4.7 of the manual states, “In order to determine the medical appropriateness of air ambulance services the contractor will request that documentation be submitted that indicates the air ambulance services are reasonable and necessary to treat the beneficiary’s life-threatening condition.”

Further, chapter 10.2.4 of the manual states,

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier. It is important to note that neither the presence nor absence of a signed physician’s order for an ambulance transport necessarily proves (or disproves) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

Before our review, medical reviewers in Noridian’s Appeals Department evaluated Native Air’s documentation for the one claim and determined that the air transport was not medically appropriate. The documentation showed that the 85-year-old patient was stable at the time of the transport. During our review, Noridian confirmed that its original determination was correct. Then, after receiving Native Air’s comments, we requested that Noridian reevaluate the claim. Another medical reviewer in the Noridian Appeals Department reevaluated the claim and also determined that the 85-year-old patient could have been safely transported by ground to a facility that had available orthopedic surgery services. The presence of a signed physician’s order does not prove that the transport was medically necessary.

Patients Transported Beyond the Nearest Hospital With Appropriate Facilities

Native Air’s Comments

Native Air disagreed with our finding that 14 claims were for transporting patients beyond the nearest hospital with appropriate facilities. It stated that the practice during CY 2002 was to rely

on the medical judgment of the physician or other trained personnel that the receiving hospital was the closest one with appropriate facilities to provide the necessary care. Native Air also stated that it “assumed that the sending facility or physician had determined that the appropriate medical specialists or beds were not available at a closer facility.” Native Air stated that its flight crews had neither the training nor the legal authority to challenge physician orders.

Office of Inspector General’s Response

We based our finding on the Medicare billing requirements for air ambulance services and the medical review performed by Noridian. Noridian’s review was based on documentation in the medical records provided by Native Air and by the pickup and destination facilities for certain claims.

The medical reviewers examined the medical records and determined that the patients could have been transported to a closer hospital with appropriate facilities. No documentation in the medical records substantiated that “the sending facility or physician had determined that the appropriate medical specialists or beds were not available at a closer facility.”

Lack of Adequate Controls

Native Air’s Comments

Native Air disagreed that it did not have adequate controls to ensure that (1) only medically appropriate air transport was billed to Medicare and (2) air transport was billed for the mileage to the nearest hospital with appropriate facilities or that documentation in the medical records supported the reason for transporting patients beyond the nearest hospital with appropriate facilities.

Native Air stated that, in CY 2003, it established controls to address the issues identified in our audit. It developed a written policy and procedure to ensure that only medically necessary claims are billed to Medicare. It also established procedures to identify that “the destination hospital was the nearest appropriate facility and the medical record documentation supports the transport.” Native Air stated that it provides regular education and training to all crew, clinicians, coders, and billers on its policies and procedures.

Office of Inspector General’s Response

We reviewed Medicare claims for air ambulance services provided during CY 2002 and policies and procedures in existence at that time. We acknowledge that in 2003, Native Air developed new policies and procedures in an effort to comply with Medicare requirements. However, we did not validate whether the new policies and procedures were implemented because we reviewed Medicare claims for air ambulance services provided during CY 2002.

APPENDIXES

SAMPLE RESULTS AND PROJECTION

<u>Population</u>		<u>Sample</u>		<u>Errors</u>	
Items:	1,219	Items:	100	Items:	15
Payments:	\$3,968,759	Payments:	\$330,713	Payments:	\$10,589

Projection of Sample Results
(at the 90-Percent Confidence Level)

Point Estimate:	\$129,085
Lower Limit:	\$62,408
Upper Limit:	\$195,762

NATIVE AIR FORM FOR DOCUMENTATION OF MEDICAL NECESSITY

NATIVE AMERICAN AIR AMBULANCE

DOCUMENTATION OF MEDICAL NECESSITY FOR AIR TRANSPORT

I, Dr. _____ as the attending physician for _____ have referred this patient to Dr. _____ at _____ based on my assessment of this patient and the continued medical and nursing care required. Emergent transportation, including ground transport to and from appropriate airports, by a critical care team is necessary for the following reasons:

A. TIME

- The patient's condition is time critical requiring rapid transportation in order to minimize morbidity/mortality.
- The patient's condition meets established criteria for the transport based on published standards for appropriate utilization of air from the EMS, trauma, neonatal and pediatric medical communities.
- Ground transport would be hazardous due to the length of the transport.

B. FACILITY

- The receiving facility provides specialized care, treatment and diagnosis not available at the referring facility.
- The receiving facility has previous medical records where the patient has received specialized treatment in the past.
- The patient's attending physician requests transport to a specific facility based on the medical needs of the patient.

C. GENERAL CRITERIA

- The patient requires critical care life support that is beyond the scope of practice of the local ground ambulance services.
- The patient requires critical care life support and a landing facility is not available or it is unsafe to fly, so the team must go by ground ambulance.
- Distance to the closest appropriate facility is too great for safe and timely transport via ground ambulance.
- Ground ambulance transport is required due to adverse weather conditions precluding air transport.
- Critical patient with unusual circumstances that do not fit above criteria.
- Patient and/or patient's family agrees to the release of any medical records pertaining to the patient for medical and/or insurance use.
- The risks vs. benefits of air transport were explained to the patient or his/her family prior to signing this document.

PATIENT DIAGNOSIS: _____

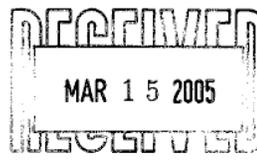
MODE OF TRANSPORT (CIRCLE) HELICOPTER FIXED WING GROUND

Referring Physician Signature Date Referring RN Signature

Patient/Family Member Signature Date Relationship to Patient



VIA OVERNIGHT DELIVERY
VIA HAND DELIVERY



Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services
Department of Health and Human Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, California 94102

Re: Review of Medicare Claims for Air Ambulance Services Paid to
Native American Air Ambulance for Calendar Year 2002: OIG
Draft Report No. A-09-04-00029

Dear Ms. Ahlstrand:

We have carefully reviewed the Office of Inspector General's ("OIG") draft report titled "Review of Medicare Claims for Air Ambulance Services Paid to Native American Air Ambulance for Calendar Year 2002" (Report No. A-09-04-00029), and appreciate the opportunity to comment on the draft report. The following is Native Air Services, Inc.'s ("Native Air") response to the specific findings and recommendations contained in the draft report.

1. Air Transport Not Required - Nonconcurrency

The report identifies one claim for an air ambulance transport that purportedly should have been billed as a ground transport service. We disagree with this finding for the following reasons:

Medicare covers transportation by air ambulance when the time required to transport the beneficiary by ground or the instability of ground transportation poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. (Medicare Benefit Policy Manual, Chapter 10, § 10.4.2.) Section 10.4.2. provides a non-exhaustive list of conditions that justify air ambulance transportation, which include intracranial bleeding (requiring neurosurgical intervention), cardiogenic shock, burns requiring treatment in a burn center, conditions requiring treatment in a hyperbaric oxygen unit, multiple severe injuries, or life-threatening trauma. As specified in the Manual, this is a non-exclusive list of possible conditions that may warrant transport by air ambulance.

In this case, the physician determined that transport by air ambulance was medically appropriate due to the beneficiary's condition at the time of the transport. The beneficiary was an 85 year-old female with a displaced left oblique distal femur fracture. This type of fracture

P.O. Box 6069 Mesa, Arizona 85216-6069

002.1357434.2 6402 E. Superstition Springs Boulevard Suite 224 Mesa, Arizona 85206 480.988.3840 Fax 480.988.3843 www.native-air.com

Ms. Lori A. Ahlstrand
March 15, 2005
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presents an emergent injury that could result in significant complications, including fat emboli, vascular compromise, pulmonary embolism, and cerebrovascular accident, if the patient was transported by ground ambulance. The patient was also in extreme pain and required a higher level of surgery and orthopedic care than was not available at the facility located in Polacca, Arizona. Consequently, transportation by ground ambulance would have seriously endangered the beneficiary's health potentially resulting in life-threatening complications. It was, therefore, medically appropriate to transport the patient by air ambulance to protect her health and minimize any further injuries or complications.

Air ambulance transports are emergency services ordered by medical decision-makers who are in the best position to know whether a patient's current condition medically warrants the type of transport.¹ As a result, "second-guessing" that decision during a post-payment audit is a faulty exercise, unless the supplier clearly should have known that the decision-maker's judgment was incorrect. Also, this approach puts the supplier in a very difficult position of having to second-guess the medical decision-makers at the time of transport, which is generally in the midst of a medical emergency or exigent circumstances, if there is concern that no Medicare payment will be made for the service. The flight crew lacks both the training and legal authority to challenge the orders of the transferring physician, and any attempt to do so would consume valuable time and endanger the health and safety of the patient. Based upon the medical information available at the time of the transport, the physician determined that it was medically necessary to transport this patient by air ambulance. At that time, Native Air was not in a position to look behind the physician's decision to determine whether, in fact, the transport was medically necessary.²

2. *Patients Not Transported to the Nearest Facility - Nonconcurrency*

The report identifies 14 claims for air ambulance services that purportedly were for services beyond the nearest hospital with appropriate facilities. We disagree with this finding for the following reasons:

In general, Medicare covers appropriate air ambulance transportation regardless of the State or region in which the service is rendered. For ambulance services, the term "locality" means "the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services." (Medicare Benefit Policy Manual, Chapter 10, § 10.3.5.) The term "appropriate facilities" means that the institution is

¹ Indeed, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Congress explicitly provided that any ambulance services, whether ground, or air, may be covered if the service is reasonable and necessary based on the health condition of the individual being transported immediately prior to the time of the transport. (MMA, Pub. L. No. 108-173, § 415, codified at 42 U.S.C. § 1395m(l)(14).) For rural air ambulance services, this requirement is met if the service is required by a physician or other qualified medical personnel who reasonably determines or certifies that transportation by ground ambulance poses a threat to the patient's survival or seriously endangers the patient's health. (*Id.*) Thus, Congress has recognized that the physician's judgment is controlling as to when air ambulance transportation is reasonable and necessary.

² As discussed below, in response to the OIG's recommendations, Native Air has developed written policies and procedures that specifically address the medical necessity requirements for Medicare air ambulance transports

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generally equipped to provide the needed hospital care and a physician or specialist is available to provide the necessary care. (*Id.* at § 10.3.6.) While a better equipped but more distant institution does not warrant a finding that a closer institution does not have “appropriate facilities,” such a finding is warranted if the beneficiary’s condition requires a higher level of trauma care or other specialized services available only at the more distant hospital. In addition, legal requirements may necessitate transporting a patient to a more distant hospital. The Medicare rules also recognize that if two or more facilities meet the destination requirement (*i.e.*, transport to a hospital, critical access hospital, skilled nursing facility, beneficiary’s home, or dialysis facility) which can both treat the patient appropriately and the locality of each facility encompasses the place where the transportation originated, then either facility is considered an appropriate destination facility, even if one facility is more distant. (*Id.* at § 10.3.)

All of the identified air transport claims met the Medicare locality and nearest appropriate facility requirements. In each case, the destination facility was best equipped to furnish the necessary care. As described above, Native Air’s practice at the time was to rely on the medical judgment of the physician or other trained personnel that the receiving facility was the closest appropriate facility to provide the necessary care. Moreover, as was likely the case for several of the transports reviewed, there were multiple hospitals equipped to care for the patient in the particular locality where the patient was picked up, in which case the Medicare rules allow transportation to a more distant facility so long as each facility meets the locality requirement. In these cases, we relied upon the physician’s medical judgment to select the most appropriate destination facility.

Several courts have recognized that in Medicare cases involving medical necessity, including air ambulance services, deference should be given to the treating physician’s opinion. While the “treating physician rule”³ expressly applies to Social Security disability cases, courts have applied it in the context of Medicare medical necessity cases. In *State of N.Y. on Behalf of Holland v. Sullivan*, a case involving denial of Medicare coverage for inpatient hospitalization services, the Second Circuit held that although “considerations bearing on the weight to be accorded a treating physician’s opinion are not necessarily identical in the disability and Medicare contexts, we would expect the [Health and Human Services] Secretary to place significant reliance on the informed opinion of a treating physician and either to apply the treating physician rule, with its component of ‘some extra weight’ to be accorded to that opinion

³ The treating physician rule, codified at 20 C.F.R. § 404.1527, generally requires an adjudicator to give controlling weight to the medical opinion of an applicant’s treating physician. As applied in the disability setting, the rule requires that:

The treating source’s opinion on the subject of medical disability--i.e., diagnosis and nature and degree of impairment--is (1) binding on the fact-finder unless contradicted by substantial evidence and (2) entitled to some extra weight, even if contradicted by substantial evidence, because the treating source is inherently more familiar with a claimant’s medical condition than are other sources. Resolution of genuine conflicts between the opinion of the treating source, with its extra weight, and any substantial evidence to the contrary remains the responsibility of the fact-finder.

(*Schister v. Bowen*, 851 F.2d 43, 47 (2nd Cir 1988).)

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or to supply a reasoned basis . . . for declining to do so." (*State of N.Y. on Behalf of Holland v. Sullivan*, 927 F.2d 57, 60 (2nd Cir. 1991).) In another case where a patient sought reimbursement for air ambulance services, the court found "no prohibition against applicability of the treating physician rule to Medicare cases," holding that substantial evidence did not support the finding that the air ambulance services were not medically necessary. (*Klementowski v. Secretary, Dept. of Health and Human Services*, 801 F. Supp. 1022, 1026 (W.D.N.Y. 1992).) (*See also Kiernan v. Shalala*, 1994 WL 637423 (D. Conn. 1994) (finding that an administrative law judge failed to accord the physician's opinion "some extra weight").)

In cases where there was another closer facility that may have been able to provide the necessary services, Native Air assumed that the sending facility or physician had determined that the appropriate medical specialists or beds were not available at a closer facility. Subsequent to when the services reviewed by the OIG were furnished, Native Air has adopted improved controls to provide education and training on the Medicare locality and appropriate facilities requirements to help ensure patients are transported to the nearest appropriate facility based on the patient's medical condition at the time of the transport. Nevertheless, based upon the physician's medical judgment at the time of these transports, we believe that all of the identified transports met the Medicare rules because they were to facilities that were best equipped to provide the necessary care and services. As discussed above, our flight crews have neither the training nor the legal authority to challenge the medical orders of a transporting physician in the midst of an emergency, and any attempt to do so, would take up valuable time and endanger the patient's health and safety.

Many of the transports were also subject to the Emergency Medical Treatment and Labor Act ("EMTALA") requirements. EMTALA requires hospitals with emergency departments to provide an appropriate medical screening examination and any necessary stabilizing treatment to any individual, regardless of ability to pay, who comes to a hospital emergency department and requests a medical examination or treatment for a medical condition. (*See* 42 U.S.C. § 1395dd.) The regulations and EMTALA Interpretive Guidelines further specify the conditions under which an EMTALA patient who has not been stabilized may be transferred. (42 C.F.R. § 489.24(e)(1), (2); State Operations Provider Certification Manual, Appendix V, Tag A409.) In such cases, a hospital may not transfer the patient unless the transfer is appropriate and the individual requests the transfer or a physician certifies the transfer.

When a physician certifies the transfer, this places a non-delegable duty on the certifying physician to determine the appropriate transportation method and destination facility. Failure to comply with the EMTALA transfer requirements subjects both the physician and transferring hospital to potential civil monetary penalties and exclusion from Medicare and Medicaid. The transporting hospital may also face a medical malpractice claim. Consequently, given that EMTALA implicitly provides the physician and transferring facility with full discretion commensurate with their liability to determine the transport method and destination of patients who have not been stabilized, it was appropriate to transport the patients to the facility ordered by the certifying physician.

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We also note that four of the claims involved transports from an Indian Health Service ("IHS") facility to a contracted IHS facility.⁴ The IHS is the primary health care provider for American Indian and Alaskan Natives and consists of tribal, urban, and federally-operated health programs. IHS beneficiaries are eligible to receive services at either IHS-operated facilities or contracted facilities. (See 42 C.F.R. Subchapter M, Part 136.) Contract health services are provided at the expense of IHS from public or private medical or hospital facilities. (42 C.F.R. § 136.21.) Such services are available as medically indicated, when necessary health services by an IHS facility are not reasonably accessible. (*Id.* at § 136.23.) For these four claims, the patients were transported to an IHS-contracted facility because it was best equipped to provide the necessary care and had available space. We believe that an IHS facility acts appropriately when it transports a patient to an IHS-contracted facility as opposed to a non-contracted facility, since this protects the IHS program from paying the higher rates it would incur for using a non-contracted facility. The Benefit Policy Manual recognizes that legal requirements may necessitate transporting a patient to a more distant hospital. (See Medicare Benefit Policy Manual, Chapter 10, § 10.3.6.) We, therefore, contend that these medically necessary transports were to the nearest appropriate facility.

Finally, even if the air transports are determined to be non-covered, the Medicare limitation on liability rules provide protection from financial liability for the non-covered services. The limitation on liability rules discharge both a beneficiary and supplier from financial liability where neither knew, or could reasonably have been expected to know, that the service was not covered by Medicare. (See 42 U.S.C. § 1395pp; 42 C.F.R. §§ 411.400-411.406.) Here, it is likely that the beneficiaries would not have known whether the air ambulance services were covered. Native Air also did not know, nor could it have reasonably been expected to know, that the services were non-covered. As explained above, at the time the transports took place, Native Air and its crew members were not in a position to nor had sufficient information to verify the medical necessity of the services. Any attempt to challenge the transferring physician's orders would have consumed valuable time that could have endangered the patient's health and safety. Therefore, under the limitation on liability rules, Native Air should not be held financially liable for any transports determined to be non-covered.

3. *Lack of Adequate Controls - Nonconcurrency*

Lastly, the report identifies certain deficiencies with respect to Native Air's internal policies and procedures. Specifically, the report claims that Native Air does not have adequate controls to ensure that only medically appropriate air transportation services are billed to Medicare. The report also finds that Native Air lacks written procedures to verify whether the destination hospital was the nearest hospital with appropriate facilities and to confirm that the

⁴ The four claims were for the following beneficiaries:



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medical record documentation supported transporting patients beyond the nearest hospital with appropriate facilities. As described below, Native Air has established adequate controls and related processes that address these identified deficiencies.

With respect to controls related to the medical appropriateness of air ambulance services, Native Air has a written policy and procedure that ensures only medically necessary claims are billed to Medicare, other government payers, and private payers. Specifically, effective April 2003, Native Air issued a written policy that addresses the medical appropriateness of air transport services. (Patient Financial Services Policy and Procedure, "Medicare Policies – ICD-9 Diagnosis Coding, Advance Beneficiary Notices, and Billing for Denials.") (Enclosure A.) This policy provides that it is Native Air's policy only to bill Medicare when the patient's condition or diagnosis indicate that the transport was medically necessary and other means of transportation are contraindicated by the patient's condition. The policy specifies the procedures to be followed for emergency transports, non-emergency or medically unnecessary transports, discharges from hospitals and nursing homes, and non-compliant transports.

Native Air also has a written policy addressing notification to patients where a transport may not be covered due to lack of medical necessity. (Patient Financial Services Policy and Procedure, "Medicare Notification Policy.") (Enclosure B.) If Native Air determines prior to a transport that the patient's condition does not meet the Medicare "reasonable and necessary" requirement for air transportation and if the patient's condition permits using an Advance Beneficiary Notice ("ABN") (*i.e.*, the patient is not under duress), it will issue an ABN and advise the patient regarding their financial responsibility. Native Air provides regular education and training to all crew, clinicians, coders, and billers on both of these policies. Documentation regarding education and training furnished to employees and others is maintained by the Human Resources Department.

In addition, in 2003, Native Air established a Quality Review process. Under this process, a registered nurse reviews the medical record documentation of all patient charts to verify there is sufficient documentation supporting the medical necessity of the transport and that the appropriate ICD-9 codes have been assigned. A designated quality assurance person for billing, who is a certified coder, then reviews the patient charts to verify that the appropriate procedure and ICD-9 codes have been assigned. The nurse reviewer and quality assurance reviewer must agree on the ICD-9 code assignment. The quality assurance reviewer also verifies that the correct units or miles have been charged and that the claim otherwise meets all Medicare coverage and billing requirements.

Native Air has also established procedures that address the report's second finding regarding adequate controls to identify that the destination hospital was the nearest appropriate facility and the medical record documentation supports the transport. To this end, Native Air provides regular education and training to all crew members and clinicians on the Medicare locality and appropriate facilities requirements.⁵ On the claims side, as described above, Native Air has established policies and procedures for informing patients when an air transport may not

⁵ As noted above, documentation related to education and training is maintained by the Human Resources Department.

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be covered by Medicare due to lack of medical necessity. This includes transports to a facility that is not considered the nearest appropriate facility.

In light of the OIG's findings, Native Air has undertaken a complete review of its policies and procedures to ensure that they adequately address the Medicare coverage and billing rules for air ambulance services. Based upon this review, if necessary, we will further revise our policies and procedures.

We hope that these comments are helpful and ask that the OIG incorporate them into its final report. If you have any questions about this letter or any other issue related to the draft report, please do not hesitate to contact me. I can be reached at (480) 988-3840.

Sincerely,



Gaylan Crowell, CEO

Enclosures (2)

cc: Jerry McGee, Audit Manager, OIG (w/enclosures)

Enclosure A

 NATIVE AIR	DATE OF ORIGIN: 4/22/2003
	REVISION:
PATIENT FINANCIAL SERVICES Policy And Procedure	EFFECTIVE DATE: 4/22/2003
Medicare Policies – ICD-9 Diagnosis Coding, Advance Beneficiary Notices, and Billing for Denials	
<small>DIRECTOR OF PATIENT FINANCIAL SERVICES</small>	<small>COMPLIANCE OFFICER</small>
<small>PRESIDENT/CEO</small>	

POLICY: It is the policy of Native Air Services Inc., to file for Medicare reimbursement only when the patient’s condition or diagnosis indicate that the transport was medically necessary and only when other means of transportation are contraindicated by the patient’s condition. Native Air Services Inc. will only include diagnoses or conditions on claim forms that are supported by documentation.

PURPOSE: This policy is intended as a guide for PFS employees.

PROCEDURE:

Medicare requires that an ambulance transport be medically necessary and that other means of transportation are contraindicated by the patient’s condition. Native Air Services Inc. will only enter diagnoses or conditions on the claims that are supported by trip documentation. The following procedures and guidelines will be used in selecting diagnoses and conditions for claim forms:

Emergency Transports – The specific current conditions or probable diagnoses identified on the patient care report will be used for all claims. They will be listed in order of severity beginning with the most severe.

Non-Emergency or Not Medically Necessary Transports – The patient’s specific and current condition that would not allow the patient to be transported by other means will be used on the claim forms. Past, or non-acute conditions and diagnoses will not be used. When possible the medical crew will obtain a signed “Advance Beneficiary Notice.” The PFS staff will bill Medicare for a “Denial” by attaching the “GZ” modifier to all HCPCS codes on the HCFA 1500 form.

Discharges from hospitals or nursing homes – Only the specific patient conditions that would require the patient to be transported only by ambulance will be documented on the claim form. These must be supported in the documentation, specifically the patient care report or Physician’s Certification Statement.

Non-compliant Transports – For all transports on which there is: Inadequate documentation of patient condition

- Lack of support for medical necessity, or

 NATIVE AIR	DATE OF ORIGIN: 4/22/2003
	REVISION:
PATIENT FINANCIAL SERVICES Policy And Procedure	EFFECTIVE DATE: 4/22/2003
Medicare Policies – ICD-9 Diagnosis Coding, Advance Beneficiary Notices, and Billing for Denials	

- Inadequate documentation of reasons why the patient could not go by other means, will be filed to Medicare with the appropriate coding (GZ) specified by the Carrier to indicate that this claim does not meet medical necessity or is not covered because the patient could go by other means. This will result in a denial of the claim. The Denial will be maintained in the patients' file, and billed to any appropriate secondary insurance.

Prior to the transport, if it is determined that the patients condition does not meet the established criteria under the Medicare guidelines for Medical Necessity, Native Air Services Inc. staff will obtain a signed Advance Beneficiary Notice, and payment will be required in advance of the transport.

Enclosure B

 NATIVE AIR	DATE OF ORIGIN: 4/22/2003	
	REVISION:	
PATIENT FINANCIAL SERVICES Policy And Procedure	EFFECTIVE DATE: 4/22/2003	
Medicare Notification Policy		
<small>DIRECTOR OF PATIENT FINANCIAL SERVICES</small>	<small>COMPLIANCE OFFICER</small>	<small>PRESIDENT/CFO</small>

POLICY: Native Air Services Inc. will expeditiously and ethically file insurance claims to all programs as a courtesy for our Patients. PFS staff will put forth its' best faith effort to maintain a working knowledge of specific rules and guidelines for each plan.

PURPOSE: This is intended as a guide for PFS team members.

PROCEDURE:

- 1) On occasion we may receive a request to transport a Medicare patient who does not meet the Medical Necessity guidelines as described by regulation. In that event:
 - a) When appropriate, we will have our crew obtain an ABN from the patient or responsible party, to demonstrate that we have informed the patient that they will be financially responsible for all or part of the flight.
 - b) As per regulation, we will file a (Claim for Denial) with Medicare using the appropriate modifier so Medicare can update and keep current its' "Common Working File." No payment is expected or requested from Medicare.
 - c) We will not attempt to file a (Claim for Reimbursement) or in any way attempt to collect money from Medicare.

- 2) On occasion we may receive a request to transport a Medicare patient beyond the closest facility. In that event"
 - a) a) When appropriate, we will have our crew obtain an ABN from the patient or responsible party, to demonstrate that we have informed the patient that they will be financially responsible for all or part of the flight.
 - b) We will not attempt to file a (Claim for Reimbursement) or in any way attempt to collect money from Medicare.

Note: It is understood that we regularly receive emergency and 911 requests to immediately transport critically ill patients. In these cases we appropriately rely on the decision of the attending/referring physician to make the determination as to the appropriateness of the medical transport.

ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX. Other principal Office of Audit Services staff who contributed include:

Jerry McGee, *Audit Manager*
Yun (Jessica) Kim, *Senior Auditor*
Dennis Ensminger, *Auditor*

Technical Assistance

Steven Wong, *Advanced Audit Techniques*

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