Medicare's $30M ambulance-ride mystery
29 September 2015, by Ricardo Alonso-Zaldivar

Medicare paid $30 million for ambulance rides for which patients got no other medical services either at the place they were picked up or at their destination. The mystery ambulance rides are part of a bigger problem with Medicare payments for transporting patients, according to a federal audit being released Tuesday. (AP Photo/Pat Sullivan)

Medicare paid $30 million for ambulance rides for which no record exists that patients got medical care at their destination, the place where they were picked up or other critical information.

The mystery ambulance rides are part of a bigger problem with Medicare payments for transporting patients, according to a federal audit being released Tuesday.

The Department of Health and Human Services' inspector general's office also found that some urban ambulance services got paid for an average distance of more than 100 miles per ride. That contrasts with a national average of just 10 miles for urban ambulance rides.

Four major metro areas seemed to be breeding grounds for ambulance schemes. Philadelphia, Los Angeles, New York and Houston accounted for about half of the questionable rides and payments. Medicare has barred new ambulance companies from joining the program in Houston and Philadelphia, and the report recommends a similar approach in certain other places.

Across the country, 1 in 5 ambulance companies had at least some questionable billings.

"Medicare payments for ambulance transports have increased in recent years, and investigators have uncovered a variety of fraud schemes involving ambulance suppliers," the report said.

The audit involves medical claims dating to the first six months of 2012, but the inspector general's office said it believes the findings reflect continuing weaknesses in Medicare's efforts against fraud. A Medicare spokesman says the agency has taken action since the auditors privately shared their findings last year.

Investigators went to great lengths to try to explain the $30 million in mystery ambulance rides.
The audit scrutinized 7.3 million ambulance rides in the first half of 2012. In addition to the mystery transports, investigators found that Medicare paid $24 million for ambulance rides that didn't meet program requirements for payment.

In its formal response, Medicare said it has developed a comprehensive strategy to combat ambulance fraud and abuse.

A spokesman said separately that Medicare is now requiring prior approval for repeat non-emergency ambulance rides in New Jersey, Pennsylvania and South Carolina. Next year that requirement will be extended to Delaware, Maryland, North Carolina, Virginia and West Virginia, plus Washington, D.C.

Medicare is also considering barring new ambulance companies from joining the program in fraud-prone areas.

Fraud costs the health care system tens of billions of dollars a year. Medicare is especially vulnerable because Congress requires the program to pay claims promptly in most cases. That has given rise to the frustrating condition that law enforcement officials call "pay and chase."

The inspector general recommended that Medicare use its existing legal authority to require more documentation from ambulance companies and to give its billing contractors additional options to hold off paying claims that don't seem to meet basic requirements.

More information: Inspector General's report—
http://oig.hhs.gov/oei/reports/oei-09-12-00351.pdf

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