

industry. This voluntary compliance program guidance should assist ambulance suppliers and other health care providers in developing their own strategies for complying with federal health care program requirements.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

Background

The creation of compliance program guidances (CPGs) is a major initiative of the OIG in its effort to engage the private health care community in preventing the submission of erroneous claims and in combating fraudulent and abusive conduct. In the past several years, the OIG has developed and issued CPGs directed at a variety of segments in the health care industry. The development of these CPGs is based on our belief that a health care provider can use internal controls to more efficiently monitor adherence to applicable statutes, regulations, and program requirements. Copies of these CPGs can be found on the OIG Web site at <http://oig.hhs.gov>.

Developing Compliance Program Guidance for Ambulance Suppliers

Having experienced a number of instances of ambulance provider and supplier fraud and abuse, the ambulance industry has expressed interest in protecting against such conduct through increased guidance to the industry. To date, the OIG has issued several advisory opinions on a variety of ambulance-related issues (see endnote 13 in this compliance program guidance) and has published final rulemaking concerning a safe harbor for ambulance restocking arrangements (66 FR 62979; December 4, 2001).

To provide further guidance, the OIG published a **Federal Register** notice (65 FR 50204; August 17, 2000) that solicited general comments, recommendations, and other suggestions from concerned parties and organizations on how best to develop compliance guidance for ambulance suppliers to reduce the potential for fraud and abuse. On June 6, 2002, the OIG published a Draft Compliance Program Guidance to afford all interested parties a further opportunity to provide specific comments in the development of this final CPG (67 FR 39015; June 6, 2002). In response to that notice, the OIG received three public comments, collectively representing a variety of outside sources. We have carefully considered those comments, as well as previous OIG publications, and

have consulted with the Centers for Medicare and Medicaid Services (CMS) and the Department of Justice in developing final guidance for ambulance suppliers. This final guidance outlines some of the most common and prevalent fraud and abuse risk areas for the ambulance industry and provides direction on how to: (1) Address various risk areas; (2) prevent the occurrence of instances of fraud and abuse; and (3) develop corrective actions when those risks or instances of fraud and abuse are identified.

This CPG is divided into the following five separate sections, with an appendix:

- Section I is a brief introduction.
 - Section II provides information about the basic elements of a compliance program for ambulance suppliers.
 - Section III discusses various fraud and abuse and compliance risks associated with ambulance services covered under the Medicare program.
 - Section IV briefly summarizes compliance risks related to Medicaid coverage for transportation services.
 - Section V discusses various risks under the anti-kickback statute.
 - The appendix provides relevant statutory and regulatory citations, as well as brief discussions of additional potential risk areas to consider when developing a compliance program.
- Under the Social Security Act (the Act), ambulance “providers” are Medicare participating institutional providers that submit claims for Medicare ambulance services (*e.g.*, hospitals, including critical access hospitals (CAHs) and skilled nursing facilities (SNFs); the term “supplier” means an entity that is other than a provider. For purposes of this document, we will refer to both ambulance suppliers and providers as ambulance “suppliers.”

Compliance Program Guidance for Ambulance Suppliers

I. Introduction

The OIG recognizes that the ambulance industry is comprised of entities of enormous variation: some ambulance companies are large, many are small; some are for-profit, many are not-for-profit; some are affiliated with hospitals, many are independent; and some are operated by municipalities or counties, while others are commercially owned. Consequently, this guidance is not intended to be a one-size-fits-all guide. Rather, like the previous CPGs, this guidance is intended as a helpful tool for those entities that are considering establishing a voluntary

compliance program and for those that have already done so and are seeking to analyze, improve or expand existing programs. As with the OIG’s previous guidance, the guidelines discussed in this CPG are not mandatory, nor is the CPG an all-inclusive document containing all the components of a compliance program. Other OIG outreach efforts, as well as other federal agency efforts to promote compliance, can and should also be used in developing a compliance program tailored to an entity’s particular structure and operations.

This guidance focuses on compliance measures related to services furnished primarily under the Medicare program and, to a limited extent, other federal health care programs. (See, *e.g.*, section IV for a brief discussion of Medicaid ambulance coverage.) Suppliers are free to address private payor claims and services in their compliance programs.

As in other sectors of the health care industry, most ambulance suppliers are honest suppliers trying to deliver quality services. However, like other health care industry sectors, the ambulance industry has seen its share of fraudulent and abusive practices. The OIG has reported and pursued a number of different fraudulent and abusive practices in the ambulance transport field. Examples 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/she was transported separately;
- Upcoding from basic life support to advanced life support services; and
- Payment of kickbacks.

To help reduce the incidence and prevalence of fraudulent or abusive conduct, an ambulance supplier should consider the recommendations in this guidance.

This final CPG has been modified from the draft CPG to take into further consideration CMS’s adoption of a new fee schedule for payment of ambulance services. The CMS’s ambulance fee schedule is the product of a negotiated rulemaking process and will replace (over a five-year transition period) the retrospective, reasonable cost reimbursement system for providers, and the reasonable charge system for suppliers of ambulance services. As the government and the industry gain more experience under the new fee schedule,