News & Publications

Federal Regulators Target Ambulance Service Providers

By Ely Goldin – 06/10/2011

Government investigation into alleged fraud and abuse by ambulance service providers is at an all-time high. According to one study commissioned by the Office of Inspector General (OIG), "25 percent of ambulance transports did not meet Medicare's program requirements, resulting in an estimated $402 million in improper payments." In response to what is perceived as an over-billing crisis, the federal government set up special task forces whose primary mission is to fight Medicare fraud and abuse. These task forces are extremely well-funded and have initiated thousands of investigations throughout the country, leading to numerous indictments in virtually every Medicare region. According to a press release issued by the Department of Justice (DOJ) and U.S. Department of Health and Human Services (HHS), efforts to combat healthcare fraud are actually turning a significant profit for the U.S. government. At least one report suggests the government's efforts are yielding a 6:1 return on investment, meaning the government recoups as much as six dollars for every dollar spent on enforcement.

In recent months, Philadelphia has seen its share of ambulance-related prosecutions. On February 10, 2011, the U.S. Attorney for the Eastern District of

Pennsylvania unsealed an indictment against three individuals associated with Philadelphia-based Advantage Ambulance Company. The indictment alleged that Advantage overbilled Medicare by $1,268,000 over the course of six years by transporting patients who did not require ambulance transport. In a similar case, the U.S. attorney charged the owner of Gray Eagle Ambulance in Philadelphia with Medicare fraud for transporting patients who were able to walk or travel by paratransit van.

Enforcement aimed at combating fraud and abuse in the ambulance industry is by no means limited to federal criminal indictments. Medicare intermediaries have launched countless investigations into billing practices and coding errors. Ambulance service providers suspected of improper billing practices are being routinely placed on prepayment reviews, which can last up to 18 months, during which time cash flow to the ambulance provider is effectively cut off. More importantly, the reviews are often a precursor to formal administrative action or even criminal referrals.

Ambulance service providers also face potential exposure from a new breed of "ambulance chasers." Under federal whistle-blower laws, private litigants are allowed to bring qui tam actions alleging Medicare fraud for the benefit of the U.S. government. Whistle-blower law firms are specifically targeting the ambulance industry and spending big money on marketing efforts to bring in clients with knowledge of fraudulent ambulance billing practices. The whistle-blowers are often former employees, billing personnel, nursing home and/or dialysis staff or, in some cases, someone affiliated with a competitor in the industry. These whistle-blowers and the law firms that represent them receive a portion of any recovery obtained. One particular law firm boasts recoveries in excess of $40 million against ambulance providers, with nearly $8 million in qui tam "rewards" paid to the whistle-blowers.

But wait … there's more. On February 2, 2011, the Centers for Medicare and Medicaid Services (CMS) published a new Final Rule that significantly expands

the federal government's ability to combat suspected fraud and abuse in the ambulance industry. Under the Final Rule, which took effect on March 25, 2011, all new Medicare providers and existing providers that reapply for Medicare eligibility are automatically sorted into three risk categories: limited, moderate and high. Pursuant to the new criteria established by CMS, government-affiliated ambulance providers and ambulance companies operated by companies traded on the New York Stock Exchange or NASDAQ are considered to pose a limited risk of fraud. However, any privately owned ambulance company is automatically presumed to pose at least a moderate risk of fraud and abuse.

What does this mean? Under the new Rule, CMS is authorized to carefully scrutinize all new applications and requests for Medicare re-enrollment. As part of the process, Medicare intermediaries are authorized to conduct unannounced site visits to providers, both before and after the enrollment process. These visits go beyond merely verifying that a Medicare provider is actually operating out of the physical address listed on the application. Medicare contractors are expressly permitted to conduct unannounced reviews of an ambulance company's supplier standards, performance standards and controls in place for billing practices, as well as other more traditional conditions of participation.

In addition, the Final Rule ratchets up the right to cut off funding by allowing CMS to suspend payment to a provider pending an investigation into a "credible allegation of fraud." The Rule defines a "credible allegation of fraud" as "an allegation from any source, including but not limited to fraud hotline complaints, claims data mining, patterns identified through provider audits, civil False Claims Act, and law enforcement investigations." Allegations are deemed credible when they have the "indicia of reliability." The suspension can last for 180 days while the Medicare contractor conducts the investigation; however, if the contractor is unable to complete the examination, an additional 180-day extension may be afforded. In certain cases, if the contractor contacts OIG or law enforcement during the 360-day period, the suspension can be extended for an additional 180 days. If, during this 18-month period, the Medicare contractor refers the

investigation to the DOJ, the suspension can be extended indefinitely pending formal charges. As CMS puts it, the new regulations are designed to "help us move away from the ‘pay and chase' approach."

In this new climate, the stakes for private ambulance service providers are higher than ever. Coding errors, billing shortcomings and insufficient paperwork can no longer be treated as routine operational hiccups. Medicare is cracking down, and sloppy operations can easily translate into payment suspensions, administrative actions, civil monetary penalties or even criminal referrals. Private ambulance service providers concerned about potential enforcement issues are considering voluntary operational, billing and legal audits in an effort to identify shortcomings and stave off possible enforcement. Providers already contacted by a Medicare intermediary may face crippling long-term payment suspensions, as well as significant civil (and possible criminal) exposure. Any ambulance service provider with concerns regarding pending, threatened or potential exposure should immediately contact experienced counsel.

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