Internal Audit Office

DATE: September 19, 2022

TO: Jonathan Killings, Interim Fire Chief

FROM: Edmundo S. Calderon, CIA, CGAP, CRMA, Chief Internal Auditor

SUBJECT: Fitch & Associates, LLC Professional Claims Review– Revised Final Report

Attached is a copy of the revised Professional Claims Review Report, dated May 2022.

The City of El Paso contracted Fitch & Associates, LLC to conduct a Professional Claims Review of ambulance transports billed to and paid by Federal and/or State Healthcare Providers. Fitch & Associates concluded their review of 50 transport claims with dates of service within the period of October 1, 2021 to December 31, 2021 (3 months). The review of the 50 claims identified an increase in error rates from the previous review conducted in May 2021 for documenting the medical necessity of the transport, coding diagnoses and conditions, and obtaining Medicare Beneficiary Signatures.

Digitech Computer LLC reviewed the results and provided responses to Fitch & Associates. Fitch & Associates updated their report to reflect that Beneficiary Signatures were only "crew compliance" issues and not billing issues.

If you have any questions, please feel free to contact me at extension 21365.

cc: Financial Oversight and Audit Committee
Tomas Gonzalez, City Manager
Mario D'Agostino – Deputy City Manager for Public Safety & Support Services

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May 2022

Professional Claims Review

CONFIDENTIAL

Final

City of El Paso

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El Paso, TX 79901

FITCH & ASSOCIATES, LLC

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CLAIMS REVIEW

Professional Ambulance Claims Review
City of El Paso

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Attachments

A. Compliance Review Worksheet
B. RAT-STATS printout
C. Completion of the Centers for Medicare & Medicaid Services, CMS-1500 Claim Form
D. Ground Ambulance Transport Services and Deceased Beneficiaries
E. Curriculum Vitae

Purpose

Fitch & Associates, LLC (*FITCH*) was appointed by the City of El Paso (*EL PASO*) to conduct a Professional Claims Review of ambulance transports billed to and paid by Federal and/or State healthcare providers. *FITCH* is an emergency services consulting firm, not a legal entity and this report is not provided as legal counsel, rather it is a clarification of the applicable rules, regulations and laws governing the billing of medical transport services to Federal and/or State healthcare providers identified by *EL PASO* as responsible parties for reimbursement of services provided. *FITCH* serves in this role as an external auditor of the billing of services by *EL PASO and/or their contracted revenue cycle management agent, Digitech Computer LLC (DIGITECH)* to Federal and State providers.

Statistical Sampling Methodology

Sampling Unit

The Sampling Unit contains *Items* examined by *FITCH* for this professional review of ambulance claims. An *Item,* for this review, is identified as an ambulance transport claim filed for payment to a Federal or State healthcare program, for medical transports provided by *EL PASO*. The sampling unit for the claims billed to a Federal or State health care program was pulled from a total population of claims billed to and paid by Medicare and/or Medicaid, which was provided by *EL PASO* for a defined period of time.

Claims Review Population

The Claims Review Population consist of claims with dates of service within the timeframe of October 1, 2021 through December 31, 2021 for which *EL PASO* stated to have received reimbursement from a Federal or State healthcare program of Medicare or Medicaid. A population of 1,274 paid Medicare and Medicaid claims was provided. This information was identified and delivered by *EL PASO* and/or their contracted billing agent, *DIGITECH.*

Sampling Frame

The Sampling Frame for Medicare and Medicaid claims selected is identical to the Claims Review Population and represents all items for which *EL PASO* reportedly received reimbursement from a Federal or State health care program for transports that occurred during the time-period of October 1, 2021 through December 31, 2021. For this review, the Sampling Frame for Medicare and Medicaid represents 1,274 transports.

The Office of the Inspector General's (OIG) RAT –STATs statistical sampling software was utilized in identifying the Discovery Sample. Spares were also identified to allow for claims that may have been inappropriately included in the Claims Review Population and selected for the Discovery Sample. These would be claims that were identified to have a different responsible primary payor other than Medicare or Medicaid or had not been reimbursed by the Federal or State health care provider but had been inappropriately included for the drawing of the Discovery Sample. This will be discussed further in the *Spares* section of this report.

Statistical Sampling Documentation

The RAT-STATs printout of randomly selected items comprising the Discovery Sample is included with this report as Attachment B. The sample contained 50 randomly selected items from a list of 1,274 claims reported to be reimbursed by Medicare or Medicaid. Of the 50 claims, 49 qualified for inclusion in the Discovery Sample, with one spare being required for the completion of this review.

Source of Data

Each claim is acknowledged as an *Item* and assigned a corresponding number, independent and unique from the records and account numbers assigned by *EL PASO* and/or *DIGITECH* to the records. *FITCH* ask for documentation for each *Item* identified for the Claims Review from *EL PASO.* Access to a ShareFile folder was established for secure transfer of these documents in electronic format. The request for documents included, but was not limited to:

- Dispatch Notes
- ePCR
- Face Sheets
- Beneficiary Signature Forms
- Proof of Crew Signature
- Primary Claim (HCFA 1500)
- Remittance Reports/Proof of Payment
- Secondary Claim/Invoice for Medicare Coinsurance
- Proof of Coinsurance payment (if received)
- Any other information relevant to billing

DIGITECH., *EL PASO's* contracted billing agent, provided the documents and uploaded this information for all 50 Discovery Sample Claims and requested Spares into the ShareFile.

Claims Review Objective

FITCH applies a robust review process to analyze each document provided. This process includes inspection of areas of risk acknowledged by the OIG in their Compliance Program Guidance for Ambulance Suppliers, as well as the rules and regulations outlined in the Medicare Claims Processing Manual, the Texas Medicaid Provider Procedures Manual Ambulance Services Handbook, in publications from the Centers for Medicare and Medicaid Services (CMS), and significant other relevant compliance related documents. An extensive assortment of elements was analyzed, and relevant areas of risk were included in the process. In this review, attention was paid, but not limited to, the following areas:

- Accuracy of Reported and Billed Mileage
- Accuracy of Service Level Billed
- Documentation of Medical Necessity
- Appropriateness of Modifiers
- Appropriateness of Patient/Beneficiary Signature
- Appropriateness of Coding of Signs and Symptoms
- Any Deviation from or Alteration of Documentation for Billing

The specific intent of the review was to establish whether claims presented for reimbursement to Federal and State healthcare programs were appropriate, presented proper documentation, and were correctly billed and paid.

Each claim was independently reviewed, and a spreadsheet was completed (Attachment A) specifying the information provided. The reviewer examined all submitted documentation for each ambulance transport. The review was developed to answer the following questions:

1. Is the mileage properly documented?
2. Is the reason for ground ambulance transport documented?
3. Does the claim meet medical necessity criteria for ambulance transport?
4. Are the appropriate HCPCS codes used for charges and are those charges supported by documentation?
5. Are appropriate modifiers used to identify origins and destinations?
6. Are beneficiary or appropriate alternate signatures obtained to meet Medicare's beneficiary signature requirements?
7. Were the appropriate ICD-10 and LCD codes used to report the patients' signs, symptoms, and condition(s) at the time of transport and are they supported in the Hospital Care Report?
8. Was the amount reimbursed by the Federal or State health care programs appropriate?
9. Was the Medicare coinsurance appropriately billed to the patient or secondary insurance?
10. Was the coinsurance invoice paid?

Review Protocol

Claims in the Random Sample identified using the RAT-STATs program were assigned an *Item* number which corresponds to *EL PASO's* account numbers. All the information received for the corresponding claim and the *Item* was entered into a spreadsheet, titled Compliance Review Worksheet, and included with this report as Attachment A. An inspection of elements was performed and recorded during this review of claims to determine the appropriateness of each. The list below catalogs the key aspects of the data components examined for each claim to determine accuracy and appropriateness of the charges assigned and the payments from the Federal and State healthcare providers:

- Assigned Item Number
- Patient Name
- Account Number
- Run Number
- Program Billed
- Date of Service
- Origin and Destination
- Loaded Miles Billed for Reimbursement
- Determination of Mileage Supported by Documents and Verified by Mapping Software
- Procedure Codes Submitted (HCPCS) and Reimbursed

- Determination of Appropriate HCPCS if Different from Claim
- Determination of Whether Charges are Supported by Documentation
- Determination of Whether Documents Support Medical Necessity for Medicare/Medicaid
- Determination of Appropriateness of Modifiers
- Patient Signature Requirements Fulfilled
- ICD-10 and LCD codes on Claims and Determination of Appropriateness
- Accuracy of Total Charges
- Primary Federal or State Health Program that Reimbursed the Claims
- Primary Payments
- Allowed Amount for each Procedure Code
- Determination of Correct Allowed Amount and Comparison to Amount Paid
- Reimbursed Procedure Code if Different than Code Filed

The *FITCH* team assessed the information, including the procedure codes, modifiers, and units submitted from the claims and billing files, and compared them to the same information on the electronic submission record.

The claims were examined in the order of the sequential selection from the RAT-STATs program, to determine if any claims were not paid by that specific Federal or State healthcare program. Of the initial 50 claims identified, 49 items met the criteria for inclusion in the review and one spare was utilized to complete this review.

Each claim was reviewed and compared to the Hospital Care Report (*EL PASO's* version of the electronic patient care report) and other supporting and relevant documentation provided, to determine if all information billed for was accurate and appropriately supported. The following sections provide the detailed findings of this review.

Claims Review Findings

Spares

The appropriate deployment of an *Item* from the Spares list would be for a claim that was billed but had received no payment from the appropriate Federal or State healthcare provider or was determined to have primary insurance coverage from another source (than a Federal or State program). After review of the Discovery Sample, it was determined that one (1) spare would be required to complete this claims review.

Figure 1: Spare List

Item #	Original Account Number	Spare	Comments
47	32908	31385	No payment from the Federal or State healthcare provider billed.

Mileage

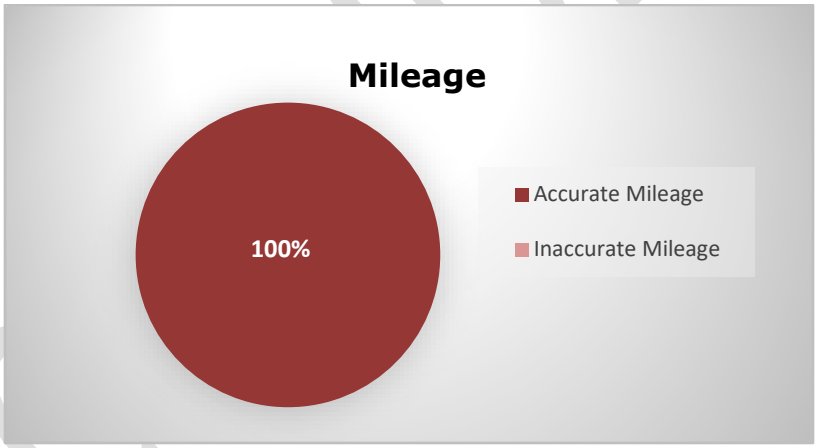
The Medicare Claims Processing Manual, Chapter 15, Section 30.1.2 and 30.2.1 states that ambulance providers and suppliers must submit mileage to Medicare in fractional units and bill to the nearest 1/10th of a mile for transports up to 100 miles. All 45 Medicare claims had mileage billed to the 1/10th of a mile.

The Texas Medicaid Provider Procedures Manual, Section 2.2 says that mileage reported on the claim form must be the actual number of miles traveled. The 5 Medicaid claims were examined and verified to be accurately billed to the actual number of miles traveled.

A mapping program was utilized to verify the shortest distance between the origin and destination for the claims reviewed. Routes between pick up and destination can vary, and such variances may require explanations in the narrative of the Hospital Care Report, if they are found to be more than what might be reasonably acceptable. By utilizing the mapping program, it also allows the reviewer to confirm if mileage billed for the transport was within reason. It was determined that all claims were billed correctly and within acceptable variance from the origin to the destination.

Figure 2 below displays the graphically illustration of the mileage accuracy percentage rate for Medicare and Medicaid.

Figure 2: Mileage Accuracy Percentage for Medicare and Medicaid



Medical Necessity

According to Chapter 10, Section 10.2.1 (Necessity for the Service) of the Medicare Benefit Policy Manual, medical necessity is defined to *only be when the patient's condition is such that use of any other method of transportation is contraindicated, whether or not such means is available*. Texas Medicaid's Ambulance Service Handbook, Section 2.2 also states *the condition of the patient must be such that transportation by any other means is medically contraindicated.* In any case in which some means of transportation other than an ambulance could be used without posing a danger to the patient's health,

then no reimbursement will be made for the ambulance services. Medical necessity is not met simply because no other means of transport are currently available.

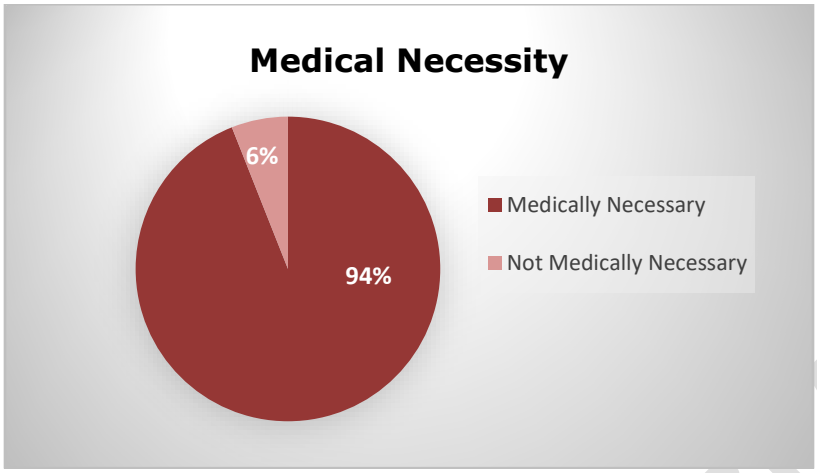
Documentation to establish the medical necessity of an ambulance transport needs to present a complete description of the patient's condition at the time of transport, along with descriptions of interventions and the patient response to those interventions. Any additional documentation to support medical necessity and to validate that the patient could only be safely transported by ground ambulance would be suitable to add to in the Hospital Care Report and is recommenced as best practice to ensure accuracy and mitigate risk.

Of the 45 Medicare and 5 Medicaid claims reviewed for this report, three (3) claims were questioned by our reviewers as to the medical necessity of the transport. **Figure 3** provides the claims deemed to not clearly provided the medical necessity of the transport and **Figure 4** displays a 94% accuracy rate for medical necessity of the claims reviewed.

Figure 3: Medical Necessity

Item #	Account Number	Payor	Comments
21	35441	Medicare	Pt. had fallen 2 days prior was seen at the hospital and returned home. The narrative states that daughter called EMS because pt. was not responding correctly and wanted him reevaluated. Chart stated patients' mental status was his normal baseline. Chart states primary impression is injury – face, and primary symptom as skin – swelling – localized. Chart does not paint a clear picture as to why the ambulance was needed nor the medical need for the ambulance.
36	29789	Medicaid	Pt. had been seen at a clinic where a sonagram had been completed which showed a possible blood clot in lower leg. Clinic released pt. and advised pt.to seek further medical evaluation at a hospital. Narrative says pt. stated she did not have a ride and an ambulance was called for transport. Medical necessity is not met simply because no other means of transportation is currently available.
43	33407	Medicare	Call was made for lift assist for a person that had slipped out of bed. Crew picked pt. up and placed back into bed. Pt. immediately began trying to get out of bed again. The daughter requested transport because she "didn't know how to handle her". The chart states there were no life threats or injuries. Medical Necessity is not established.

Figure 4: Medical Necessity Accuracy Percentage



Reason for Transport

Transports from one facility to another requires documentation of the reason the patient must be moved from one hospital to another. This requires that the Hospital Care Report be detailed enough to clearly indicate the precise treatment, procedure, or if relevant, medical specialist that is available and required at the receiving facility (and not at the transferring hospital). There were no hospital-to-hospital transports included in this review.

Modifiers

Medicare and Medicaid require that specific modifiers be utilized to identify both the point of origin and the destination of the ambulance transport. It is a requirement of both Medicare and Medicaid that transports be from and to a covered destination in order to be eligible for reimbursement.

In Texas, Medicaid claims must be recorded with an ET modifier, preceding the origin and destination modifier, for each procedure code submitted for emergency transports. Any emergency transport procedure code without the ET modifier will be subject to prior authorization requirements. All Texas Medicaid claims reviewed accurately provided the ET modifier. Modifiers may not directly influence payment of a claim; however, they should be used to accurately support the origin and destination documented in the Hospital Care Report.

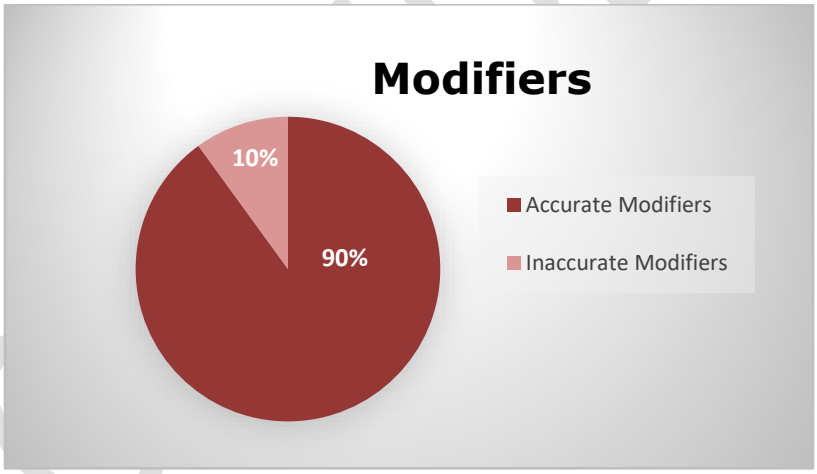
Figure 5 provides a list of the 5 claims that had incorrect modifiers. Inaccuracy in the use of modifiers can be an identifier of other documentation problems or errors that could cause billing errors and/or put the service at risk.

Figure 5: Inaccurate Modifiers

Item #	Account Number	Payor	Comments
13	35518	Medicare	The modifier billed was RH (Residence to Hospital). The patient was picked up address does not match the patient's information. If the patient is picked up a residence that is not the patient's home, the modifiers should be SH (Scene to Hospital).
21	35441	Medicare	The modifier billed as SH (Scene to Hospital). The pickup address matches the patients address. The modifiers should be RH (Residence to Hospital).
23	33320	Medicare	The modifier billed as SH (Scene to Hospital). The pickup address matches the patients address. The modifiers should be RH (Residence to Hospital).
25	28329	Medicare	The modifier billed as RH (Residence to Hospital). The address is associated with a state support living center. The modifiers should be EH (Residential, domiciliary, or custodial facility to Hospital).
33	31042	Medicare	The modifier billed as PH (Physician's Office to Hospital). The pickup location is a dialysis clinic. The modifiers should be JH (Non-Hospital based dialysis facility to Hospital).

Figure 6 provides a graphic of the error rate for the modifiers reviewed.

Figure 6: Modifiers Accuracy Percentage



Coding of Charges (Level of Service)

The claims reviewed for this report provided 100 charges associated with the 45 Medicare and 5 Medicaid transports. The breakdown of the charges were 50 base rates and 50 miles rates. **Figure 7** below graphically illustrates the base rates billed to the Federal health care provider and **Figure 8** details the State health care provider breakdown.

Figure 7: Medicare Base Rate Comparison

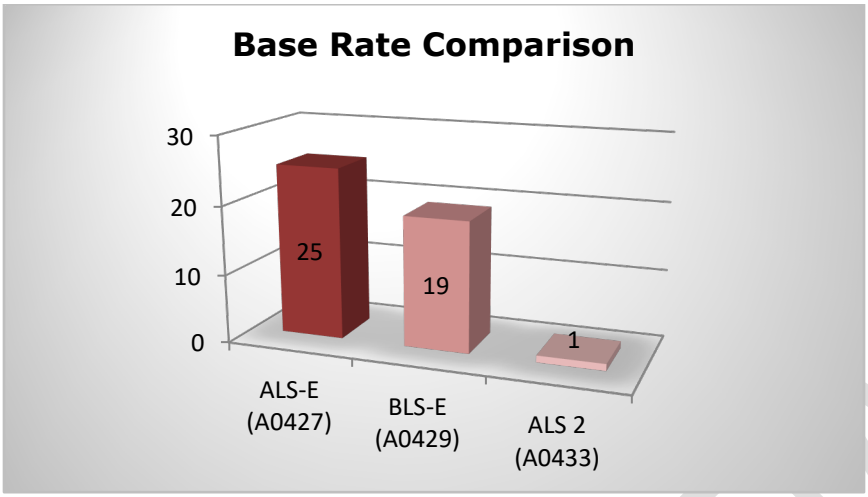
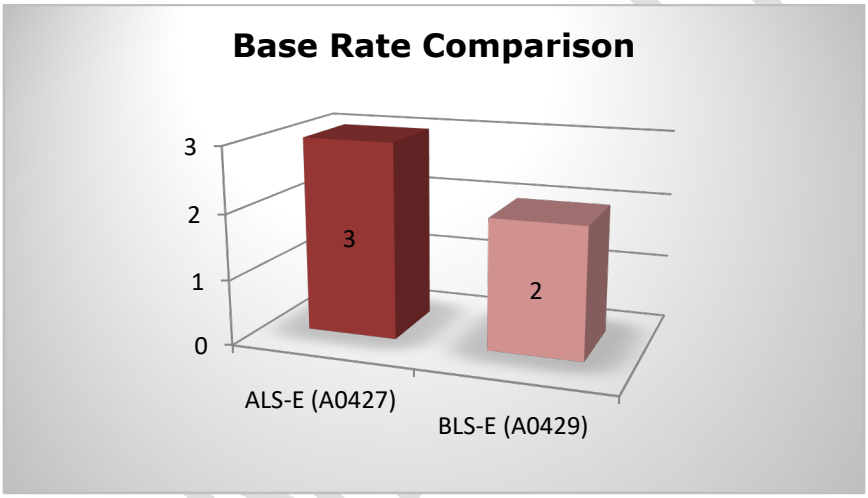


Figure 8: Medicaid Base Rate Comparison



The Texas Medicaid manual, Section 2.4.2.1 (Ambulance Disposable Supplies) states that reimbursement for BLS and ALS disposable supplies (procedure codes A0382 and A0398 respectively) is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport. Out of the 5 Medicaid claims reviewed none of the claims showed charges for supplies. *EL PASO* should take the time to review the Texas Medicaid Provider Procedure Manual with its billing company to ensure that documentation provides adequate guidance to ensure the proper charges are being applied for the claims billed to Medicaid in order to capture all allowable revenue.

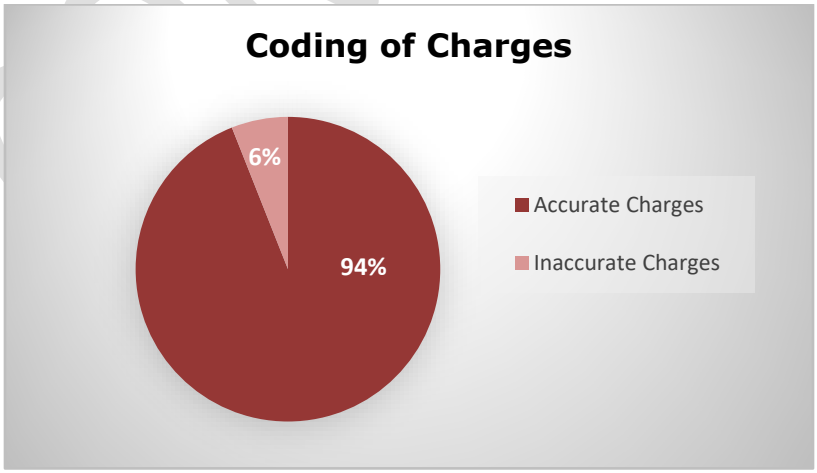
Of the Medicare and Medicaid claims reviewed, three (3) were deemed inaccurate for coding of charges. **Figure 9** provides details for those three (3) claims deemed inaccurate for coding of charges.

Figure 9: Coding of Charges

Item #	Account Number	Program	Original HCPSP Code	Correct HCPCS Code	Comments
17	36845	Medicare	A0429	A0427	The call type was breathing problems, primary symptom was notated as shortness of breath. Narrative states SpO2 is 88% on room air. Oxygen placed on patient, increased SpO2 to 95%. Difficulty breathing is an ALS level of service.
19	26998	Medicaid	A0427	A0429	The call type was sick person, the primary symptom was suicidal ideations. The pt. took pills in an attempt to take own life> the pt. was ambulatory and walked outside and got onto the stretcher. Suspected drug overdose and/or threat to self (suicidal) are both BLS level of services.
33	31042	Medicare	A0427	A0429	The call type was allergic reaction/stings. Primary symptom was general fatigue. The pt. had just received a dialysis treatment. Narrative states pt. was complaining of shortness of breath onset was 2 weeks. Narrative is only one sentence and does not paint a picture of the pts. need for the ambulance. No oxygen was provided to the pt.

Figure 10 displays the accuracy percentage of 94% for coding of charges. While there are 3 claims with errors, which would indicate an error rate of 6%. There was 1 claim that would cost the service money in lost revenue due to billing at a lower level than allowable that would not be looked upon unfavorably in a Federal or State payor audit. While this may be an instance where the billing agent erred on the side of caution, this could indicate a need for additional training of the person(s) responsible for this aspect of coding and charge assignments along with training to the crew members to enhance the supporting documentation in the chart.

Figure 10: Coding of Charges Accuracy Percentage



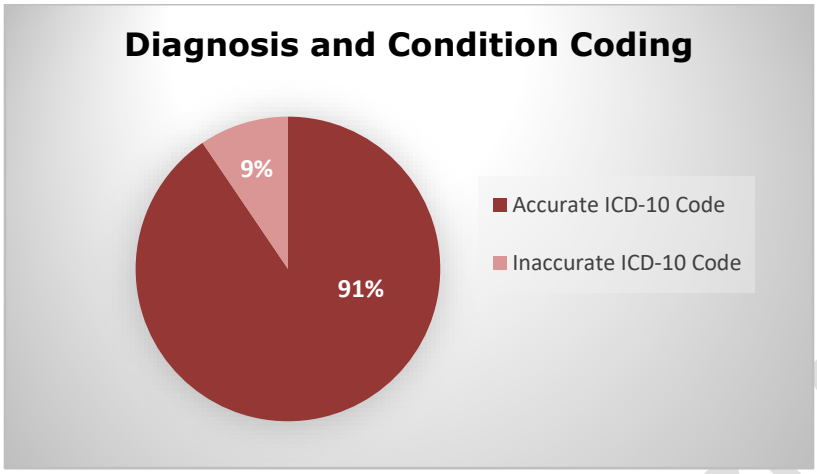
Diagnosis and Condition Coding

Ninety-five (95) condition/diagnosis codes were utilized in the billing of the 50 claims. The use of acceptable coding is demonstrated in 41 claims reviewed. **Figure 11** breaks down the ICD-10 codes that were deemed inaccurate or could have had a more definitive code assigned for the condition(s) charted. **Figure 12** demonstrates the accuracy rate of 91% for diagnosis and condition coding.

Figure 11: Diagnosis and Condition Coding

Item #	Account Number	Program	Comments
3	31943	Medicare	R68.89 – Other general symptoms and signs was provided as primary. A more specific code was notated in the chart. R53.1 – Weakness.
19	26998	Medicaid	R68.89 – Other general symptoms and signs was provided as primary and is included on the Medicaid LCD list, but a more specific code is available. T14.91XA – Suicide attempt.
24	38965	Medicare	A41.9 – Sepsis, unspecified organism was provided as the primary code, which is a diagnosis. The signs and symptoms of sepsis provided in the chart should be assigned for the primary code. R53.1 – Weakness, R50.9 Fever, I95.9 - Hypertensive, or R73 -Elevated blood glucose level.
27	37558	Medicare	R68.89 – Other general symptoms and signs was provided as primary. A more specific code was notated in the chart. R53.1 – Weakness or R42 – Dizziness and giddiness.
28	38889	Medicare	T14-90XA – Injury, unspecified was selected for primary. A slightly more specific code was described in the chart. S09.90XA – Unspecified injury to head, initial encounter.
36	29789	Medicaid	I82.409 – Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity was selected for the primary code but is not on the Medicaid emergency medical condition list that is required for all emergency ambulance claims. R09.89 (Other specified symptoms and signs involving the circulatory and respiratory systems) is on the Medicaid emergency medical condition list.
40	38802	Medicare	A general code of R68.89 – Other general symptoms and signs was provided as primary. The chart notated weakness, R53.1.
41	33644	Medicare	B96.89 – Other specified bacterial agents as the cause of diseases classified elsewhere was select for the primary code. A more appropriate primary code would have been R41.82 – Altered mental status.
44	38697	Medicare	T14-90XA – Injury, unspecified was selected for primary. A more specific code was described in the chart. S49.92XA – Unspecified injury of left shoulder and upper arm, initial encounter.

Figure 12: Diagnosis and Condition Coding Accuracy Percentage



Certification Statements

The Center for Medicare and Medicaid Services (CMS) requires that ambulance services have a certification statement verifying that non-emergent ambulance transports are necessary when the patient is under the direct care of a physician. There were no non-emergent transports in this review.

Beneficiary Signatures

Title 42 – Public Health, Chapter IV, Part 424, Section 424.36 – Signature Requirements states that *if the patient is incapable of signing the chart, the chart may be signed on his/her behalf.* Medicare provides 6 alternate signature options. One of those options being the ambulance provider but only if the other 5 options are not available. The ambulance supplier must provide a statement at the time of transport that the patient was physically and mentally incapable of signing the chart and that none of the 5 options were available or willing to sign the chart on the patient's behalf. Section 424.37 (Evidence of authority to sign on behalf of the beneficiary) states that if the patient is incapable of signing then the party that signed *must also provide a brief statement that explains the conditions that make it impractical for the patient to sign the chart*.

The document on Completion of the **Centers for Medicare & Medicaid Services, CMS-1500 Claim Form, item 12** entitled "Patient or authorized person's signature" states that "*if the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by: "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign the form.*" This indicates that even though a lifetime signature may be on file, a reason for the patient not being able to sign must still be documented at time of service on the Hospital Care Report. The claims listed in **Figure 13** did not provide that statement from the crew and/or conditions that made it impractical for the patient to sign.

Figure 13: Beneficiary Unable to Sign Reason

Item #	Account Number	Program	Comments
8	28916	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart does not state that the patient is mentally or physically unable to sign nor does it provide the reason the patient did not sign the chart.
11	30017	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart did have a receiving facility signature notating the transfer of service. There was not representative signature section in the chart. The narrative did states Pt physically unable to sign PCR.
13	35518	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart does not state that the patient is mentally or physically unable to sign nor does it provide the reason the patient did not sign the chart.
26	29664	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart does not state that the patient is mentally or physically unable to sign nor does it provide the reason the patient did not sign the chart.
29	31132	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart does not state that the patient is mentally or physically unable to sign nor does it provide the reason the patient did not sign the chart.
33	31042	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart does not state that the patient is mentally or physically unable to sign nor does it provide the reason the patient did not sign the chart
48	32944	Medicare	The chart answers the questions; "Is the patient able to sign?" - No and "Is an authorized representative available?" - No. The chart does not state that the patient is mentally or physically unable to sign nor does it provide the reason the patient did not sign the chart.

Figure 14 graphically displays an 86% accuracy rate and compliance for providing the reason the patient was unable to sign the Hospital Care Report at the time of transport.

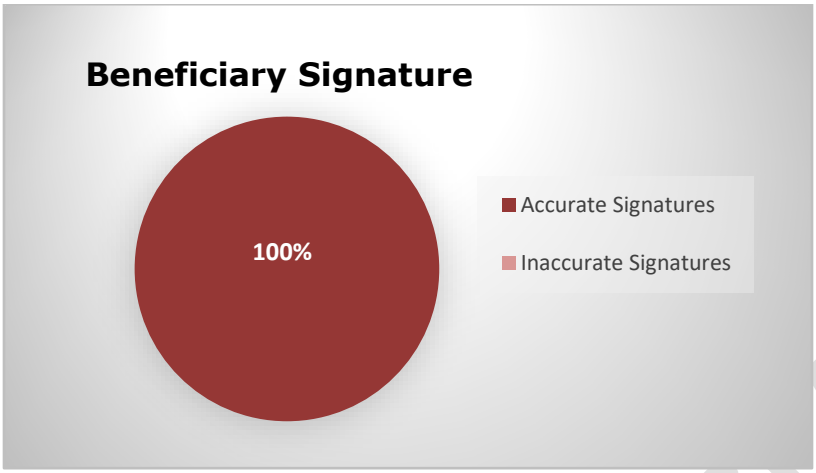
Figure 14: Beneficiary Unable to Sign Reason Accuracy Percentage

Medicare requires a signature of the patient, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. The Medicare Benefits Policy Manual, Chapter 10, Section 20.1.2 outlines the specific requirements that must be met for obtaining appropriate patient signatures for billing ambulance claims.

Although not all Medicare Administrative Contractors accept lifetime signatures, Novitas presently does for the purpose of billing. It is reasonable to anticipate that Novitas will follow suit at some point in the future with the other Medicare Administrative Contractors. It is highly unlikely that the transporting crew members know that there is a lifetime signature on file. Obtaining the patient signature at the time of transport would speed up the billing process by eliminating the billing team from reaching out to the patient for signature if the patient did not have a signature on file from a previous transport. Furthermore, crew members most likely would not know if there is a lifetime signature on file and are probably not even taking such into consideration, nor should they. Their goal, and a best practice recommendation, should be to properly obtain the signature of the beneficiary or document the reason they cannot sign and obtain one of the suitable alternates, for every transport.

The lack of signatures in the Hospital Care Report did not impact the validity of the claim to Medicare since a signature from the patient was available from a previous transport. **Figure 15** provides a 100% accuracy rate for patient signatures.

Figure 15: Beneficiary Signature Accuracy Percentage

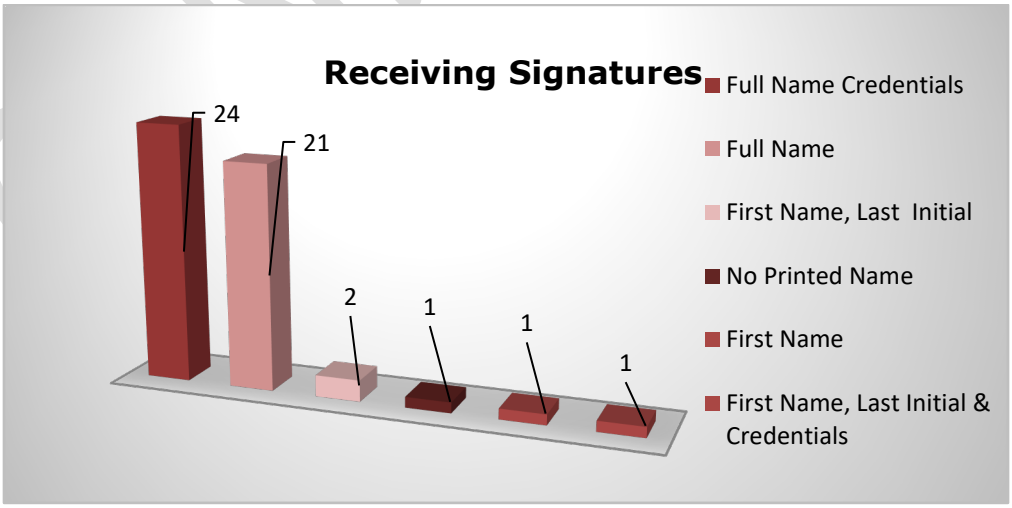


Receiving Facility Signatures

The Hospital Care Report should provide a signature section for the receiving facility representative to verify the transfer of care from the ambulance provider to the facility. It is best practice to obtain the signature, full printed name, and credentials of the receiving representative. While claims may be supported in other ways, it is considered best practice to get all appropriate and legible signatures including credentials in the chart at the time of transport. A signature from the receiving facility was obtained on all 50 claims reviewed.

Figure 16 represents the different types of printed signatures obtained from the receiving facility. This section is not included in the quantified error rates for the claims reviewed, as it is recommended for best practice and could, if necessary, be accounted for in other ways.

Figure 16: Receiving Signature Breakdown



Crew Member Signatures

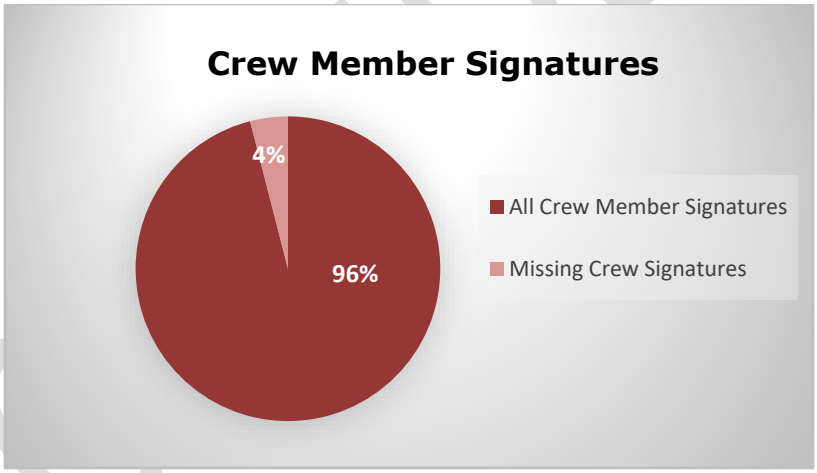
All Hospital Care Reports should be signed by all members of the ambulance crew who are present during the patient transport, including the driver, and others who participated and provided care. Medicare Program Integrity manual, Section 3.3.2.4 – Signature Requirements states that services provided be authenticated by the persons responsible for the care of the patient. All signatures must be legible, if not, a typed or printed signature or signature log must be available. In this case the printed name in the crew member section of the Hospital Care Report would determine the identity of the authors of the medical record.

Figure 17 shows the claims that did not provide signatures for all crew members on the transport and **Figure 18** displays the crew member signature accuracy percentage.

Figure 17: Crew Member Signatures

Item #	Account Number	Comments
1	36048	Three (3) crew members were listed in the crew member section of the Hospital Care Report. Two signatures were provided.
41	33644	Two (2) crew members were listed in the crew member section of the Hospital Care Report. One signature was provided.

Figure 18: Crew Member Signature Accuracy Percentage



Error Quantification

Figure 19: Error Rate Quantification

Area Reviewed	Error Rate
Mileage	0%
Medical Necessity	6%
Reason for Transport	NA
Modifiers	10%
Coding of Charges	6%
Diagnoses and Condition Coding	9%
Certification Statement	NA
Crew Documenting Unavailable Medicare Beneficiary Signature & Obtaining Alternate	14%
Crew Member Signatures	4%

Findings Summary

For this report, Mileage and Crew Member signatures had an error rate of less than 5%. The areas of Medical Necessity, Modifiers, Coding of Charges, Diagnoses and Condition Coding, and Beneficiary Signature had error rates higher than 5% and inasmuch could imply the possibility of more serious issues which might require an increased evaluation of the population of claims.

- **Modifiers:** It is important to accurately identify the origin and destination locations in order to appropriately assign the correct modifiers. There are specific modifiers for scene, hospitals, nursing homes and other locations. Currently modifiers do not have a negative impact on reimbursement, but this could change at some point in the future. Addressing these issues now can have a positive effect in the future. Seeking 100% accuracy in all areas, not just those directly impacting reimbursement, is considered best practice.

- **Coding of Charges:** CMS and the Office of the Inspector General (OIG) have placed special attention on claims that are billed for reimbursement at levels of service higher than that required by the patient at the time of transport and/or are contradictory to the information provided in the chart and the supporting documentation. One (1) of the claims found to be billed at a lower level of service than what was indicated in the Hospital Care Report. This could have been the biller erring on the side of caution. This information should be reviewed with the individuals responsible for assigning the codes and charges to ensure all parties are clear as to the responsibility to accurately report the level of service.

As for the supply charge, *EL PASO* should take the time to review the Texas Medicaid Provider Procedure Manual with its billing company to ensure that documentation provides adequate guidance to ensure the proper charges are being applied for the claims billed to Medicaid to receive all allowable revenue.

- **Diagnoses and Condition Coding:** While the diagnosis and condition codes selected did not affect reimbursement of the claims, inaccurate and unsupported use of codes should be noted as a concern. Specificity and detail were greatly expanded with the implementation of ICD-10 diagnosis coding. Crew member's documentation may need to be more precise in order to allow the billing representative the best ability to most appropriately code the condition of the patient that required the need for transport by ambulance. The documentation should be thorough, accurate and honest in reporting the patient's condition at the time of transport. This information is vital for the coders and billing agents to be able to accurately identify the need for transport, assign accurate service levels and provides support for the medical necessity of the transport. It is also important that if the specific information (left leg, right arm etc.) is provided in the chart that the billing agent using the specific ICD-10 designating which side the injury is on.

  Texas Medicaid provides a specific list of emergency medical condition codes that are required on all Medicaid emergency ambulance claims. This specific list of codes can be found in the Medicaid Ambulance Service Handbook, Section 2.4.6.

- **Beneficiary Signature:** Medicare requires the signature of the beneficiary for the purpose of accepting assignment and for submitting claims. When the patient is unable to sign, an appropriate alternate signature is required, along with the specific mental or physical reason that the patient cannot sign themselves. This reason should be supported in the Hospital Care Report with detailed documentation. Appropriate signatures must be obtained prior to submitting claims for reimbursement to Medicare. Obtaining signatures for all transports is vital to all billing dynamics, not just Medicare. Signatures represent authorization to bill, shows acceptance of assignment and should indicate an acknowledgement that the notice as they relate to privacy practices has been provided (unless that is provided to the patient in another format at another time). Training of field personnel and billing representatives as to the rules and requirements for obtaining appropriate signatures and recording is recommended.

Comparison

Comparing to the four previous audits, Mileage stayed constant with the 2021 audit with a 0% error rate. Medical Necessity and Diagnoses and Condition Codes increased compared to 2019, 2020 and 2021 reviews. Modifiers decreased back to the level identified in the 2020 review (which was a 10% error rate). This is an 11% improvement from the 2021 review; however, it is 10% higher that the lowest

reported in the 2019 review. Crew Members Signatures in the 2022 review showed improvement with the best error rate across all the reviews.

Figure 24 provides the comparison table for all five (5) of the reviews.

Figure 20: Error Rate Quantification Comparison

Area Reviewed	November 2017 Error Rate Percentage	May 2019 Error Rate Percentages	July 2020 Error Rate Percentage	May 2021 Error Rate Percentage	May 2022 Error Rate Percentage
Mileage	35%	78%	40%	0%	0%
Medical Necessity	4%	0%	0%	2%	6%
Reason for Transport	2%	NA	NA	2%	NA
Modifiers	8%	0%	10%	22%	10%
Coding of Charges	4%	2%	8%	26%	6%
Diagnoses and Condition Coding	10.3%	5%	7%	8%	9%
Certification Statements	NA	NA	NA	100%	NA
Crew Documenting Unavailable Medicare Beneficiary Signature & Obtaining Alternate	8%	24%	20%	6%	14%
Crew Member Signatures	40%	6%	8%	24%	4%

Conclusion

A conservative approach has been taken when reviewing these claims. This means that our claims reviewers are stringent and err on the side of caution when examining the claims and supporting information provided. Our recommendations are based on experience and interpretation of documents such at the OIG Work Plan, the Center for Medicare and Medicaid Services guidelines, Medicare and Medicaid billing manuals, and a variety of other resource documents utilized in the application of the rules and regulations governing medical transport billing. While the case may be made to refute our findings in some instances, it is our intent to identify all areas where a service's documentation and billing of any claim(s) could be called into question and assist in process improvement.

Credentials

Anthony Minge, EdD, Fitch & Associates Senior Partner, designed the original plan for the full sampling and reviewed the findings. The curriculum vitae for Dr. Minge is included in Attachment C. A certified ambulance coder, Melissa Coons, reviewed the claims including codes used for diagnosis and compared them with the documentation. Mrs. Coon's curriculum vitae is also included in attachment C.

Attachment A

Compliance Review Worksheet

FITCH
A ASSOCIATES

Item #	AC ID	ePCR	Program Billed	D.O.S.	Mileage	Mileage Correct per Docs?	Reason for Transport Doc'd?	Filed HCPCS Codes	Description	Charges supported by docs?	Meets Medicare Med Necessity?	Modifiers	Modifiers Correct?	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by	ICD-10 Code
1	36048	21-00842	Medicare	12/2/2021	6.4	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Error	Y	$855.00	$436.28	$436.28	$349.02	CARE	$97.03	INS	$0.00	Y	R06.89
								A0425	Ground Mileage									$96.00	$48.83	$48.83	$39.06					Y	Z74.3
2	38470	21-00882	Medicare	12/16/2021	4.6	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$436.28	$436.28	$349.02	CARE	$94.28	INS	$0.00	Y	R41.82
								A0425	Ground Mileage									$69.00	$35.10	$35.10	$28.08					Y	Z74.3
3	31943	21-00767	Medicare	11/4/2021	9.8	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$186.62	CARE	$264.61	CAID	$0.00	N	R68.89
								A0425	Ground Mileage									$147.00	$74.77	$74.77	$59.82					Y	Z74.3
4	32205	21-00776	Medicare	11/7/2021	5.1	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$81.26	Self	$0.00	Y	L98.499
								A0425	Ground Mileage									$76.50	$38.91	$38.91	$31.13					Y	Z74.3
5	40822	21-00910	Medicare	12/27/2021	5.5	Y	NA	A0429	BLS Emerg	Y	Y	NH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$81.87	CAID	$0.00	Y	R19.7
								A0425	Ground Mileage									$82.50	$41.97	$41.97	$33.53					Y	Z74.3
6	38891	21-00853	Medicare	12/6/2021	2.0	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$436.28	$436.28	$349.02	CARE	$90.31	INS	$0.00	Y	R41.82
								A0425	Ground Mileage									$30.00	$15.26	$15.26	$12.21					Y	Z74.3
7	38331	21-00872	Medicare	12/13/2021	10.1	Y	NA	A0427	ALS 1 Emerg	Y	Y	NH	Y	NA	Y	Y	U	$855.00	$436.28	$436.28	$349.02	CARE	$102.67	INS	$0.00	Y	R41.82
								A0425	Ground Mileage									$151.50	$77.06	$77.06	$61.65					Y	Z74.3
8	28916	21-00723	Medicare	10/18/2021	1.1	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	N	$855.00	$436.28	$436.28	$349.02	CARE	$88.94	Self	$0.00	Y	J44.1
								A0425	Ground Mileage									$16.50	$8.39	$8.39	$6.74					Y	Z74.3
9	35746	21-00836	Medicaid	11/30/2021	1.6	Y	NA	A0427	ALS 1 Emerg	Y	Y	ETSH	Y	NA	Y	Y	Y	$855.00	$285.28	$285.28	$285.28	CAID	$0.00	NA	$0.00	Y	O26.90
								A0425	Ground Mileage									$24.00	$7.54	$7.54	$7.54						
10	29757	21-00733	Medicare	10/22/2021	7.6	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$98.86	CAID	$0.00	Y	I10
								A0425	Ground Mileage									$114.00	$57.99	$57.99	$46.39					Y	Z74.3
11	30017	21-00737	Medicare	10/23/2021	1.3	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$75.46	INS	$0.00	Y	R10.9
								A0425	Ground Mileage									$19.50	$9.92	$9.92	$1.98					Y	Z74.3

Item #	AC ID	ePCR	Program Billed	D.O.S.	Mileage	Mileage Correct per Docs?	Reason for Transport Doc'd?	Filed HCPCS Codes	Description	Charges supported by docs?	Meets Medicare Med Necessity?	Modifiers	Modifiers Correct?	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by	ICD-10 Code
12	27895	21-00700	Medicare	10/8/2021	8.4	Y	NA	A0429	BLS Emerg	Y	Y	RHGW	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$86.30	CAID	$0.00	Y	R58
								A0425	Ground Mileage									$126.00	$64.09	$64.09	$51.27					Y	Z74.3
13	35518	21-00817	Medicare	11/22/2021	2.4	Y	NA	A0429	BLS Emerg	Y	Y	RH	N	NA	Y	Y	N	$855.00	$367.39	$367.39	$293.91	CARE	$77.14	CAID	$0.00	Y	R41.82
								A0425	Ground Mileage									$36.00	$18.31	$18.31	$14.65					Y	Z74.3
14	27865	21-00699	Medicare	10/8/2021	8.1	Y	NA	A0427	ALS 1 Emerg	Y	Y	JH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$99.62	INS	$0.00	Y	R55
								A0425	Ground Mileage									$121.50	$61.80	$61.80	$49.44					Y	Z74.3
15	33846	21-00806	Medicare	11/18/2021	0.6	Y	NA	A0427	ALS 1 Emerg	Y	Y	PH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$88.18	CAID	$0.00	Y	R06.02
								A0425	Ground Mileage									$9.00	$4.58	$4.58	$0.92					Y	Z74.3
16	39949	21-00909	Medicare	12/27/2021	11.8	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$105.27	INS	$0.00	Y	K92.0
								A0425	Ground Mileage									$177.00	$90.03	$90.03	$72.02					Y	Z74.3
17	36845	21-00857	Medicare	12/7/2021	2.1	Y	NA	A0429	BLS Emerg	N	Y	NH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$76.68	CAID	$0.00	Y	R06.89
								A0425	Ground Mileage									$31.50	$16.02	$16.02	$12.82					Y	Z74.3
18	40654	21-00919	Medicare	12/31/2021	2.4	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$77.14	INS	$0.00	Y	T14.90XA
								A0425	Ground Mileage									$36.00	$18.31	$18.31	$3.66					Y	Z74.3
19	26998	21-00685	Medicaid	10/2/2021	3.6	Y	NA	A0427	ALS 1 Emerg	N	Y	ETRH	Y	NA	Y	Y	U	$855.00	$285.28	$285.28	$285.28	CAID	$0.00	NA	$0.00	N	R68.89
								A0425	Ground Mileage									$54.00	$16.96	$16.96	$16.96						
20	39839	21-00906	Medicaid	12/25/2021	1.8	Y	NA	A0427	ALS 1 Emerg	Y	Y	ETSH	Y	NA	Y	Y	Y	$855.00	$285.28	$285.28	$285.28	CAID	$0.00	NA	$0.00	Y	O26.90
								A0425	Ground Mileage									$27.00	$8.48	$8.48	$8.48						
21	35441	21-00835	Medicare	11/29/2021	3.1	Y	NA	A0429	BLS Emerg	Y	N	SH	N	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$78.21	INS	$0.00	Y	T14.90XA
								A0425	Ground Mileage									$46.50	$23.65	$23.65	$4.73					Y	Z74.3
22	35373	21-00822	Medicare	11/24/2021	1.7	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$76.07	CAID	$0.00	Y	R10.9
								A0425	Ground Mileage									$25.50	$12.97	$12.97	$10.38					Y	Z74.3

Item #	AC ID	ePCR	Program Billed	D.O.S.	Mileage	Mileage Correct per Docs?	Reason for Transport Doc'd?	Filed HCPCS Codes	Description	Charges supported by docs?	Meets Medicare Med Necessity?	Modifiers	Modifiers Correct?	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by	ICD-10 Code
23	33320	21-00797	Medicare	11/15/2021	5.8	Y	NA	A0427	ALS 1 Emerg	Y	Y	SH	N	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$96.11	INS	$0.00	Y	R73.09
								A0425	Ground Mileage									$87.00	$44.25	$44.25	$35.40					Y	Z74.3
24	38965	21-00893	Medicare	12/20/2021	4.3	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$93.82	CAID	$0.00	N	A41.9
								A0425	Ground Mileage									$64.50	$32.81	$32.81	$26.25					Y	Z74.3
25	28329	21-00707	Medicare	10/11/2021	2.7	Y	NA	A0429	BLS Emerg	Y	Y	RH	N	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$77.60	CAID	$0.00	Y	R06.02
								A0425	Ground Mileage									$40.50	$20.60	$20.60	$16.48					Y	Z74.3
26	29664	21-00731	Medicare	10/21/2021	4.9	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	N	$855.00	$436.28	$436.28	$349.02	CARE	$94.74	CAID	$0.00	Y	R07.9
								A0425	Ground Mileage									$73.50	$37.39	$37.39	$7.48					Y	Z74.3
27	37558	21-00866	Medicare	12/11/2021	11.7	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$186.62	CARE	$64.51	INS	$0.00	N	R68.89
								A0425	Ground Mileage									$175.50	$89.27	$89.27	$17.85					Y	Z74.3
28	38889	21-00888	Medicare	12/19/2021	0.5	Y	NA	A0429	BLS Emerg	Y	Y	\HGW	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$74.24	INS	$0.00	N	T14.90XA
								A0425	Ground Mileage									$7.50	$3.82	$3.82	$3.06					Y	Z74.3
29	31132	21-00758	Medicare	10/31/2021	3.2	Y	NA	A0427	ALS 1 Emerg	Y	Y	NH	Y	NA	Y	Y	N	$855.00	$436.28	$436.28	$349.02	CARE	$92.14	CAID	$0.00	Y	R55
								A0425	Ground Mileage									$48.00	$24.42	$24.42	$19.54					Y	Z74.3
30	39212	21-00894	Medicare	12/21/2021	1.0	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$75.01	CAID	$0.00	Y	M54.9
								A0425	Ground Mileage									$15.00	$7.63	$7.63	$6.10					Y	Z74.3
31	35896	21-00836	Medicare	11/30/2021	1.9	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$90.16	CAID	$0.00	Y	U07.1
								A0425	Ground Mileage									$28.50	$14.50	$14.50	$11.60					Y	Z74.3
32	30577	21-00748	Medicare	10/27/2021	1.7	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$436.28	$436.28	$349.02	CARE	$89.85	CAID	$0.00	Y	S79.919A
								A0425	Ground Mileage									$25.50	$12.97	$12.97	$2.59					Y	Z74.3
33	31042	21-00754	Medicare	10/30/2021	0.7	Y	NA	A0427	ALS 1 Emerg	N	Y	PH	N	NA	Error	Y	N	$855.00	$436.28	$436.28	$349.02	CARE	$88.33	INS	$0.00	Y	R06.02
								A0425	Ground Mileage									$10.50	$5.34	$5.34	$4.27					Y	Z74.3

Item #	AC ID	ePCR	Program Billed	D.O.S.	Mileage	Mileage Correct per Docs?	Reason for Transport Doc'd?	Filed HCPCS Codes	Description	Charges supported by docs?	Meets Medicare Med Necessity?	Modifiers	Modifiers Correct?	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by	ICD-10 Code
34	29287	21-00727	Medicare	10/19/2021	2.3	Y	NA	A0433	ALS 2	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$631.46	$631.46	$505.17	CARE	$129.80	INS	$0.00	Y	I46.9
								A0425	Ground Mileage									$34.50	$17.55	$17.55	$14.04					Y	Z74.3
35	34866	21-00825	Medicare	11/25/2021	1.3	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$202.75	CARE	$166.62	CAID	$0.00	Y	R09.02
								A0425	Ground Mileage									$19.50	$9.92	$9.92	$7.97					Y	Z74.3
36	29789	21-00732	Medicaid	10/21/2021	1.7	Y	NA	A0429	BLS Emerg	Y	N	ETPH	Y	NA	Y	Y	Y	$855.00	$240.23	$240.23	$240.23	CAID	$0.00	NA	$0.00	N	I82.409
								A0425	Ground Mileage									$25.50	$8.01	$8.01	$8.01						
37	36712	21-00853	Medicare	12/6/2021	1.6	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$89.70	INS	$0.00	Y	I95.9
								A0425	Ground Mileage									$24.00	$12.21	$12.21	$9.77					Y	Z74.3
38	34995	21-00805	Medicaid	11/18/2021	2.6	Y	NA	A0429	BLS Emerg	Y	Y	ETRH	Y	NA	Y	Y	Y	$855.00	$240.23	$240.23	$240.23	CAID	$0.00	NA	$0.00	Y	M54.9
								A0425	Ground Mileage									$39.00	$12.25	$12.25	$12.25						
39	37553	21-00866	Medicare	12/10/2021	6.8	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$83.86	CAID	$0.00	Y	R10.9
								A0425	Ground Mileage									$102.00	$51.88	$51.88	$41.50					Y	Z74.3
40	38802	21-00889	Medicare	12/19/2021	6.7	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$97.48	INS	$0.00	N	R68.89
								A0425	Ground Mileage									$100.50	$51.12	$51.12	$40.90					Y	Z74.3
41	33644	21-00804	Medicare	11/17/2021	6.0	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Error	U	$855.00	$436.28	$436.28	$349.02	CARE	$96.42	CAID	$0.00	N	B96.89
								A0425	Ground Mileage									$90.00	$45.78	$45.78	$36.62					Y	Z74.3
42	35828	21-00840	Medicare	12/1/2021	3.1	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$436.28	$436.28	$349.02	CARE	$91.99	INS	$0.00	Y	I10
								A0425	Ground Mileage									$46.50	$23.65	$23.65	$18.92					Y	Z74.3
43	33407	21-00797	Medicare	11/15/2021	1.4	Y	NA	A0429	BLS Emerg	Y	N	RH	Y	NA	Y	Y	U	$855.00	$367.39	$367.39	$293.91	CARE	$75.62	INS	$0.00	Y	I95.9
								A0425	Ground Mileage									$21.00	$10.68	$10.68	$8.54					Y	Z74.3
44	38697	21-00885	Medicare	12/18/2021	4.1	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$79.74	INS	$0.00	N	T14.90XA
								A0425	Ground Mileage									$61.50	$31.28	$31.28	$25.02					Y	Z74.3

Item #	AC ID	ePCR	Program Billed	D.O.S.	Mileage	Mileage Correct per Docs?	Reason for Transport Doc'd?	Filed HCPCS Codes	Description	Charges supported by docs?	Meets Medicare Med Necessity?	Modifiers	Modifiers Correct?	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by	ICD-10 Code
45	32404	21-00782	Medicare	11/9/2021	2.3	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$293.91	CARE	$76.99	INS	$0.00	Y	R09.02
								A0425	Ground Mileage									$34.50	$17.55	$17.55	$3.51					Y	Z74.3
46	34607	21-00820	Medicare	11/23/2021	1.3	Y	NA	A0429	BLS Emerg	Y	Y	NH	Y	NA	Y	Y	Y	$855.00	$367.39	$367.39	$246.57	CARE	$63.62	INS	$0.00	Y	S39.82XA
								A0425	Ground Mileage									$19.50	$9.92	$9.92	$7.94					Y	Z74.3
47	31385	21-00750	Medicare	10/28/2021	11.0	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	U	$855.00	$436.28	$436.28	$349.02	CARE	$104.05	INS	$0.00	Y	R68.89
								A0425	Ground Mileage									$165.00	$83.93	$83.93	$67.14					Y	Z74.3
	32902																										
48	32944	21-00789	Medicare	11/12/2021	2.6	Y	NA	A0429	BLS Emerg	Y	Y	RH	Y	NA	Y	Y	N	$855.00	$367.39	$367.39	$293.91	CARE	$77.45	INS	$0.00	Y	S09.90XA
								A0425	Ground Mileage									$39.00	$19.84	$19.84	$15.87					Y	Z74.3
49	36723	21-00852	Medicare	12/6/2021	2.3	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$90.77	Self	$0.00	Y	R07.9
								A0425	Ground Mileage									$34.50	$17.55	$17.55	$14.04					Y	Z74.3
50	26784	21-00683	Medicare	10/1/2021	1.1	Y	NA	A0427	ALS 1 Emerg	Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$436.28	$436.28	$349.02	CARE	$88.94	INS	$0.00	Y	I95.9
								A0425	Ground Mileage									$16.50	$8.39	$8.39	$6.71					Y	Z74.3

Attachment B

RAT STATS Printout

FITCH
& ASSOCIATES

Windows RAT-STATS
Statistical Software
Random Number Generator

Date: 3/9/2022 **Time:** 9:43

Audit: El Paso Claims review

10/1/2021 to 12/31/2021 **Seed Number** 34984.99 **Frame Size** 1,274

Order	Value	Date of Service	AC ID	ePCR ID	Payor
50	17	10/1/2021	26784	21-0068343	Medicare
19	31	10/2/2021	26998	21-0068555	Medicaid
14	105	10/8/2021	27865	21-0069912	Medicare
12	109	10/8/2021	27895	21-0070009	Medicare
25	146	10/11/2021	28329	21-0070754	Medicare
8	227	10/18/2021	28916	21-0072317	Medicare
34	247	10/19/2021	29287	21-0072711	Medicare
26	270	10/21/2021	29664	21-0073121	Medicare
36	289	10/21/2021	29789	21-0073222	Medicaid
10	292	10/22/2021	29757	21-0073385	Medicare
11	312	10/23/2021	30017	21-0073701	Medicare
32	373	10/27/2021	30577	21-0074875	Medicare
33	409	10/30/2021	31042	21-0075485	Medicare
29	424	10/31/2021	31132	21-0075812	Medicare
3	469	11/4/2021	31943	21-0076783	Medicare
4	508	11/7/2021	32205	21-0077617	Medicare
45	542	11/9/2021	32404	21-0078235	Medicare
48	586	11/12/2021	32944	21-0078923	Medicare
47	588	11/12/2021	32902	21-0078997	Medicare
43	621	11/15/2021	33407	21-0079746	Medicare
23	626	11/15/2021	33320	21-0079796	Medicare
41	671	11/17/2021	33644	21-0080453	Medicare
15	682	11/18/2021	33846	21-0080631	Medicare
38	692	11/18/2021	34995	21-0080550	Medicaid
13	740	11/22/2021	35518	21-0081767	Medicare
46	757	11/23/2021	34607	21-0082090	Medicare
22	765	11/24/2021	35373	21-0082225	Medicare
35	780	11/25/2021	34866	21-0082566	Medicare
21	829	11/29/2021	35441	21-0083596	Medicare
31	832	11/30/2021	35896	21-0083632	Medicare
9	845	11/30/2021	35746	21-0083699	Medicaid
42	853	12/1/2021	35828	21-0084079	Medicare
1	859	12/2/2021	36048	21-0084220	Medicare
49	907	12/6/2021	36723	21-0085279	Medicare
6	911	12/6/2021	38891	21-0085330	Medicare
37	912	12/6/2021	36712	21-0085335	Medicare
17	934	12/7/2021	36845	21-0085733	Medicare
39	981	12/10/2021	37553	21-0086637	Medicare
27	983	12/11/2021	37558	21-0086691	Medicare

7	1021	12/13/2021	38331	21-0087284	Medicare
2	1068	12/16/2021	38470	21-0088256	Medicare
44	1082	12/18/2021	38697	21-0088587	Medicare
28	1096	12/19/2021	38889	21-0088880	Medicare
40	1100	12/19/2021	38802	21-0088939	Medicare
24	1124	12/20/2021	38965	21-0089355	Medicare
30	1128	12/21/2021	39212	21-0089428	Medicare
20	1192	12/25/2021	39839	21-0090665	Medicaid
16	1210	12/27/2021	39949	21-0090952	Medicare
5	1211	12/27/2021	40822	21-0091019	Medicare
18	1268	12/31/2021	40654	21-0091967	Medicare

Attachment C

Completion of the Centers for Medicare & Medicaid Services, CMS-1500 Claim Form

FITCH
& ASSOCIATES

Completion of the Centers for Medicare & Medicaid Services, CMS-1500 Claim Form

All paper claims you submit must be on the appropriate Centers for Medicare & Medicaid (CMS) claim form.

The CMS claim form is available in red ink. This is the only format that is accepted. Photocopies are unprocessable.

Ordering CMS Claim Forms

The CMS-1500 (*02-12*) claim form specifications require red drop out ink in order to facilitate the use of image processing technology such as Optical Character Recognition (OCR), facsimile transmission and image storage. It is available in various formats (e.g., single copy, duplicate, etc.).

The CMS claim form may be purchased from local printers or through the following organizations:

U. S. Government Printing Office
Superintendent of Documents
Washington, DC 20402
PH: (202) 512-1800 (Pricing Desk)
FAX: (202) 512-2250

or

Order Department
AMA
P.O. Box 109050
Chicago, IL 60610-9050

To place an order with your American Express, Visa or Master Card, call 1-800-621-8335.

Mailing Instructions for Paper Claims

- Paper claims mailing address for Jurisdiction H customers
- Paper claims mailing address for Jurisdiction L customers

Medicare Secondary Payer Claims

For information on submitting claims when Medicare is Secondary, please refer to the CMS-1500 (02-12) Claim Form Instructions when Medicare is Secondary.

Paper to Electronic Claim Crosswalk (5010)

A crosswalk for each block on the 1500 paper claim form and the equivalent electronic data in the ANSI ASC X12N format, version 5010 is available Paper to Electronic Claims Crosswalk (5010).

Part B Direct Data Entry (DDE)

Part B Providers may use the Novitasphere Portal DDE option to submit claims electronically to Novitas. Novitasphere is our free, secure internet portal (JH) (JL). DDE allows users to enter claims one at a time to be processed as an electronic claim submission – which means faster claims processing for you. More information on using this feature is available in the Novitasphere Part B User Manual Supplement: Direct Data Entry.

Completion of the CMS-1500 (02-12) Claim Form

To view a copy of the CMS-1500 claim form (02-12) refer to the 1500 Claim Form (02-12).

Do not use the upper right margin of the claim form; the contractor uses it. Any obstructions in this area will hinder timely and accurate processing of claims.

The top right margin of the claim form should **not** contain:

- any type of adhesive-backed label
- printing or headings (including the Medicare contractor address)
- ink, markers, whiteout, etc.

Please print legibly or type all information. Claims may also be computer-prepared.

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. Items 12 and 31 are exempt from this requirement.

- MM = Month (e.g., December = 12)
- DD = Day (e.g., Dec 15 = 15)
- YY = 2 position Year (e.g., 2015 = 15)
- CCYY = 4 position Year (e.g., 2015 = 2015)
- (MM | DD | YY) or (MM | DD | CCYY) A space must be reported between month, day, and year (e.g., 12 | 15 | 15 or 12 | 15 | 2015). This space is delineated by a dotted vertical line on the Form CMS-1500
- (MMDDYY) or (MMDDCCYY) No space between month, day, and year (e.g., 121515 or 12152015). The date must be one continuous number.

1500 (02-12) Claim Data Elements

ITEM 1

To show the type of health insurance coverage applicable to this claim, check the appropriate box, e.g., if a Medicare claim is filed check the Medicare box.

ITEM 1a INSURED'S I.D. NUMBER (associated with Block 1)

Enter the patient's Medicare Beneficiary ID Number whether Medicare is the primary or secondary payer.

Completion of this item is required for all claims.

ITEM 2 PATIENT'S NAME

Enter the patient's last name, first name, and middle initial, if any, exactly as shown on the patient's Medicare card.

Completion of this item is required for all claims.

ITEM 3 PATIENT'S BIRTH DATE AND SEX

Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Completion of this item is required for all claims.

ITEM 4 INSURED'S NAME

If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word "SAME". If there is no insurance primary to Medicare, leave blank.

Completion of this item is conditional for insurance information.

ITEM 5 PATIENT'S ADDRESS

Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and telephone number. If the patient has an unlisted telephone number or does not have a telephone number, enter 000-000-0000. Reminder, please report the address where the home visit occurred rather than the beneficiary's address if they are out of the area.

Completion of this item is required for all claims; address and telephone must be indicated.

ITEM 6 PATIENT RELATIONSHIP TO INSURED

Check the appropriate box for patient's relationship to the insured when item 4 is completed.

Completion of this item is conditional for insurance information when item 4 is completed.

ITEM 7 INSURED'S ADDRESS

Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.

Completion of this item is conditional for insurance information when items 4, 6 and 11 are completed.

ITEM 8 PATIENT STATUS

Leave blank.

ITEM 9 OTHER INSURED'S NAME

Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word "SAME". If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

Note: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his / her benefits under a Medigap policy to the participating physician or supplier.

Participating physicians / suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his / her benefits under a Medigap policy to a participating physician / supplier is called a mandated Medigap transfer.

A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in 1882(g) (1) of Title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation, which is incorporated by reference in the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the application of deductibles, coinsurance amounts or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the A / B Medicare Administrative Contractor (MAC) (B) or Durable Medical Equipment (DME) MAC to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his / her own supplemental claim.

ITEM 9a OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the policy and / or group number of the Medigap insured preceded by MEDIGAP, MG or MGAP.

Note: Complete Item 9d even when the provider enters a policy and / or group number in item 9a.

ITEM 9b OTHER INSURED'S DATE OF BIRTH

Leave blank.

ITEM 9c EMPLOYER'S NAME

Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter state postal code, and ZIP code copied from the Medigap insured's Medigap identification card.

For example:

1257 Anywhere Street
Baltimore, MD 21204

Is shown as "1257 Anywhere St MD 21204"

ITEM 9d INSURANCE PLAN NAME OR PROGRAM NAME

Enter the Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID). Refer to the CMS Claims Processing Manual Pub 100-04, Chapter 28, §70.6.4 for more information concerning the COBA Medigap claim based crossover process.

ITEM 10a THROUGH 10c IS PATIENT'S CONDITION RELATED TO

Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24.

Enter the state postal code.

Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Completion of items 10a-c is required for all claims; "Yes" or "No" must be indicated.

ITEM 10d RESERVED FOR LOCAL USE

Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by "MCD".

ITEM 11 INSURED'S POLICY, GROUP OR FECA NUMBER

When submitting paper or electronic claims, item 11 must be completed. By completing this information, the physician / supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer. **Claims without this information will be rejected.**

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a-11c. Items 4, 6, and 7 must also be completed.

Circumstances under which Medicare may be secondary to another insurer, includes:

- Group Health Plan Coverage
- Working Aged;
- Disability (Large Group Health Plan); and
- End Stage Renal Disease
- No Fault and / or other Liability
- Work-Related Illness / Injury
- Workers' Compensation
- Black Lung
- Veterans Benefits

If there is no insurance primary to Medicare, enter the word "NONE" in item 11 and leave items 11A-C, 4, 6 and 7 blank. Then proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab previously collected and retained Medicare Secondary Payer (MSP) information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, enter the word "None" in item 11 of the CMS-1500, when submitting a claim for payment of a reference lab service.

> Where there has been no face-to-face encounter with the beneficiary, the claim will follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Note: For paper claims, to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's Explanation of Benefits (EOB) notice must be forwarded along with the claim form. (See CMS' Medicare Secondary Payer Manual, Pub. 100-05, Chapter 3)

ITEM 11a INSURED'S DATE OF BIRTH

If there is insurance primary to Medicare, enter the insured's 8-digit birth date (MM | DD | CCYY) and sex, if different from item 3. Otherwise, leave blank.

ITEM 11b EMPLOYER'S NAME or SCHOOL NAME:

If there is insurance primary to Medicare, provide this information to the right of the vertical dotted line. Otherwise, leave blank.

Enter the employer’s name, if applicable. If there is a change in the insured’s insurance status, e.g., retired, enter the word "Retired" followed by the six-digit or eight-digit retirement date (MM/DD/CCYY).

ITEM 11c INSURANCE PLAN NAME OR PROGRAM NAME

If there is insurance primary to Medicare, enter the complete insurance plan or program name, e.g., Blue Shield of (State). Otherwise, leave blank

If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.

ITEM 11d IS THERE ANOTHER HEALTH BENEFIT PLAN

Leave blank. Not required by Medicare.

ITEM 12 PATIENT OR AUTHORIZED PERSON'S SIGNATURE

The patient or authorized representative must sign and enter either a 6-digit date
(MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date
(e.g., January 1, 2015) unless the signature is on file.

The patient or an authorized representative must sign and enter the six-digit date (MMDDYY) for this item unless the patient is deceased, you do not have direct contact with the patient (laboratory), or the signature is on file.

Please use **Signature Exception** below for situations where the patient is deceased or you do not have direct contact with the patient (laboratory) or signature on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file. If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by: "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign the form. The signature on file authorization is effective indefinitely unless the patient or the patient's representative revokes the arrangement.

The patient's signature authorizes the release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service and (or) supplier, when the provider of service and (or) supplier accepts assignment on the claim.

All claims must have item 12 completed. Failure to include an appropriate signature and six-digit, eight-digit date or a "signature on file" statement will result in a claim rejection. A Medigap authorization signature in item 13 does not satisfy the Block 12 signature requirement.

Signature By Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must sign his / her name and address next to the mark.

Signature on File

Providers of service and (or) suppliers are permitted to obtain and retain on file a lifetime authorization from the beneficiary. This authorization allows the provider of service and (or) supplier to submit assigned and non-assigned claims on the beneficiary's behalf.

To utilize this procedure, the patient must sign and date a brief statement as follows:

> **(Name of Beneficiary) (Medicare Beneficiary ID Number)**
> **"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier.**
> **I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."**
> **(Beneficiary Signature) (Date)**

Once the provider of service and (or) supplier has obtained the patient's one-time authorization, any later Medicare claims may be submitted by the provider of service and (or) supplier without obtaining any additional signature and date from the patient. When submitting claims, the statement "Signature on file" must be reflected in the patient's signature space (item 12) of the Health Insurance Claim Form.

When using this procedure, the provider of service and / or supplier must:

Complete and submit the appropriate Medicare billing form for all services covered by the request for payment, even when the provider of service and (or) supplier has not accepted assignment.

Incorporate, by stamp or otherwise, on any bill sent to the beneficiary, information to the effect "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare for you."

Cancel the authorization at the request of the patient.

Make the patient signature files available for contractor inspection upon request. Novitas Solutions will conduct periodic audits of signature files on a random basis. Completion of this item is required for all claims.

ITEM 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier.

The patient or his / her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and / or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating provider of service and (or) supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his / her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating physician / supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

Completion of this item is conditional for Medigap.

Note: If you wish to report "Signature on File" in item 13 in lieu of the patient's actual signature, the following statement must be signed and dated by the patient and maintained in your records.

> **(Name of Beneficiary) (Medicare Beneficiary ID Number) (Medigap Policy Number)**
> **"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier.**
> **I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) any information needed to determine these benefits payable for related services."**
> **(Beneficiary Signature) (Date)**

ITEM 14 DATE OF CURRENT ILLNESS

Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy.

For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD |YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM| DD | YY) date in item 19.

Do not enter a qualifier in item 14.

Reminder: For date fields other than date of birth, report either 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date. Intermixing the two formats on the claim is not allowed.

Completion of this item is required for all chiropractic services; conditional for other services.

ITEM 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

Leave blank. Not required by Medicare.

ITEM 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

Enter the 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date the patient is unable to work in current employed occupation.

An entry in this item may indicate employment related insurance coverage.

Completion of this item is conditional for disability information.

ITEM 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17. When multiple referring, ordering or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

Enter one of the following qualifiers as appropriate to identify the role this physician (or non-physician practitioner) is performing:

Qualifier Provider Role

DN Referring Provider

DK Ordering Provider

DQ Supervising Provider

Enter the qualifier to the left of the dotted vertical line on item 17.

Note: Under certain circumstances, Medicare permits a non-physician practitioner to perform these roles. Refer to the CMS Benefit Policy Manual, Pub 100-02, Chapter 15, for non-physician practitioner rules. Enter non-physician practitioner information according to the rules for physicians.

Referring Physician - A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician - A physician, or when appropriate, a non-physician practitioner who orders nonphysician services for the patient. Refer to the CMS Benefit Policy Manual, Pub 100-02, Chapter 15, for non-physician

practitioner rules.

Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment and services incident to that physician's or non-physician practitioner's service.

All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering / referring physician's name and National Provider Identifier (NPI).

The following situations / services require the submission of the referring / ordering provider information:

- Parenteral and enteral nutrition;
- Medicare covered services and items that are the result of a physician’s order or referral;
- Immunosuppressive drugs claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests).
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17.
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner.
- All claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

ITEM 17a – Leave Blank

ITEM 17b – Enter the NPI of the referring, ordering or supervising physician or non-physician practitioners listed in item 17. All physicians and non-physician practitioners who order services or refer Medicare beneficiaries must report this data.

ITEM 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Completion of this item is conditional for medical services related to hospitalization.

ITEM 19 ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)

Enter the six - digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date the patient was last seen and the NPI of his / her attending physician when a physician providing routine foot care submits claims.

Chiropractic

A physical examination may be used to document subluxation if an x-ray is not used. Report all that apply by using the letters P, A, R and / or T (P - pain / tenderness; A - asymmetry / misalignment; R - range of motion; T - tissue); or enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services.

By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that the relevant information requirements (including level of subluxation) are on file, along with the appropriate x-ray and are available for review.

Unlisted Drug Codes

Enter the drug name and dosage when submitting a claim for a Not Otherwise Classified (NOC) drug.

Unlisted procedure code or NOC codes

Enter a concise description of an unlisted procedure code or a "not otherwise classified" code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Multiple Modifiers (-99)

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Homebound

When an independent lab renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient, enter the statement "Homebound".

For the definition of "homebound" and a complete definition of a medically necessary laboratory service to a homebound or an institutional patient, please review Covered Medical and Other Health Services , Laboratory Services From Independent Labs, Physicians, and Providers and Definitions .

Assigned Benefits

When the beneficiary absolutely refuses to assign benefits to a participating provider, enter the statement, "Patient refuses to assign benefits".

In this case, no payment may be made on the claim.

Hearing Aid

When billing services involving the testing of a hearing aid is used to obtain intentional denials when other payers are involved, enter the statement, "testing for hearing aid".

Dental

When dental exams are billed; enter the specific surgery for which the exam is being performed.

Post-Operative Care

When providers share postoperative care, enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and / or relinquished date for a global surgery claim.

Demonstration ID Number

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter demonstration ID number “56” for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

Clinical Trial Registry Number

Enter the numeric, 8-digit clinical trial registry number (when present on the claim) preceded by the 2 alpha characters "CT" when placed in item 19 of the paper CMS-1500 (02-12), i.e., CT12345678.

Note: The "CT" prefix is only used on paper claims to distinguish the 8-digit number from any other information that may be placed in Item 19.

Anti-Markup Payment Limitation

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test subject to the anti-markup payment limitation.

For additional information, please refer to the CMS Claims Processing Manual, Pub 100-04, Chapter 1, §30.2.9 .

Method II Suppliers

Method II suppliers shall enter the most current Hematocrit (HCT) value for the injection of Aranesp for End Stage Renal Disease (ESRD) beneficiaries on dialysis.

Individuals and entities who bill administrations of Erythropoiesis Stimulating Agents (ESAs) or anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer, must enter the most current hemoglobin or hematocrit test results.

The test results shall be entered as:

- TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and
- Most current numeric test result figure up to 3 numerics and a decimal point [xx.x]
    - Examples:
        - Hemoglobin tests TR / R1 / 9.0
        - Hematocrit tests TR / R2 / 27.0

Completion of this item is conditional as described above.

ITEM 20 OUTSIDE LAB

Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation.

Enter the acquisition price under charges if the "yes" block is checked. "Yes" indicates that an entity other than the entity billing for the service performed the diagnostic test. "No" indicates, "no anti-markup tests are included on the claim."

When "yes" is annotated, item 32 shall be completed.

When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form CMS-1500 (02-12).

Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.

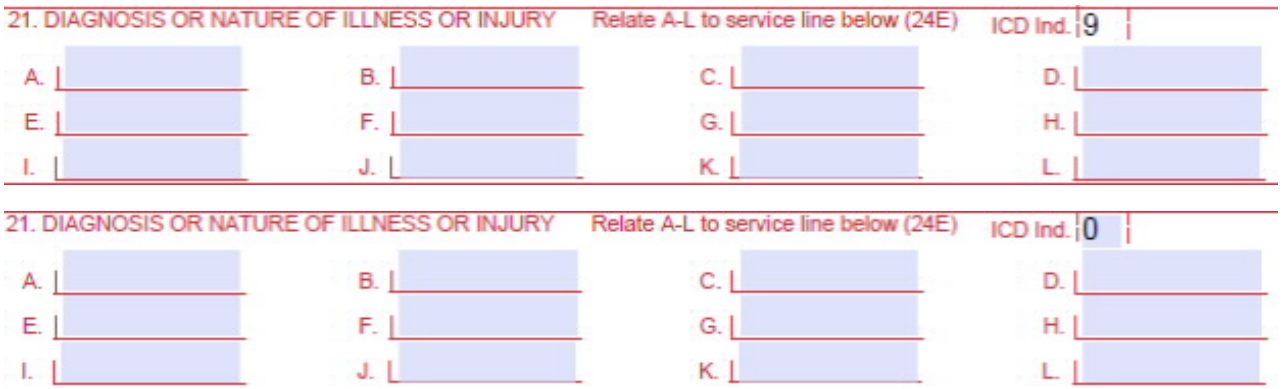
Note: This item is a required when billing for diagnostic tests subject to the anti-markup payment limitation.

ITEM 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Enter the patient's diagnosis / condition.

With the exception of claims submitted by ambulance suppliers (*specialty type 59*), all physician and nonphysician specialties (*i.e., PA, NP, CNS, CRNA*) use diagnosis codes to the highest level of specificity for the date of service.

Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.



The "**ICD Indicator**" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:

Indicator Code Set

- 0 ICD-10-CM diagnosis

Enter the indicator as a single digit between the vertical, dotted lines.

Enter up to 12 diagnosis codes. Note that this information appears opposite lines with letters A-L.

Correlate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Do not insert a period in the ICD-10-CM code.

Completion of this item is required for all claims, other than those submitted by ambulance suppliers.

ITEM 22 MEDICAID RESUBMISSION

Leave blank. Not required by Medicare.

ITEM 23 PRIOR AUTHORIZATION NUMBER

Enter the Investigational Device Exemption (IDE) when an investigational device is used in an FDA-approved clinical trial. The IDE number should be reported in Block 23 and the Clinical Trial Number in Block 19.

Refer to Block 19 instructions for submitting the Clinical Trail Number in addition to the IDE number that is required in Block 23.

Post Market Approval (PMA) numbers should also be placed here when applicable.

Repetitive Non-Emergent Ambulance Transport or Hyperbaric Oxygen (NJ only)

The Unique Tracking Number (UTN) must populate the first 14 positions. All other data submitted in item 23 must begin in position 15.

ITEM 24

The six service lines in item 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service.

The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

NDC (National Drug Code) Red Shaded Portion

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through 13 of Item 24.

The NDC is preceded with the qualifier N4 and followed immediately by the 11-digit NDC code (e.g., N499999999999).

Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is preceded by the appropriate qualifier:

- Units (UN),
- International units (F2),
- Gram (GR), or
- Milliliter (ML)

There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

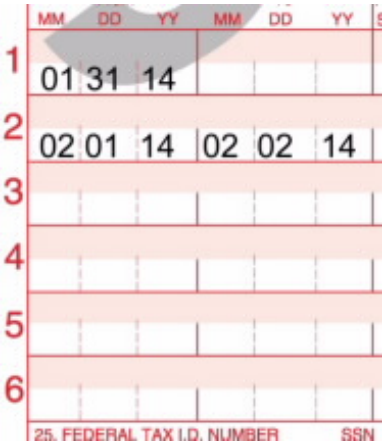
ITEM 24A DATES OF SERVICE

Enter the six or eight - digit date (MMDDYY) (MMDDCCYY) for each procedure, service, or supply.

When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G.

Only report a range by month, do not combine months in a range date.

Completion of this item is required for all claims; all lines of service.



ITEM 24B PLACE OF SERVICE

Enter the appropriate Place of Service (POS) code from the list provided below. Identify the location where the item is used or the service is performed.

When a service is rendered to a patient who is a registered inpatient or an outpatient (off campus or on campus) of a hospital, use the inpatient hospital POS code 21, Off Campus-Outpatient Hospital POS code 19, or On Campus-Outpatient Hospital POS code 22, respectively.

Completion of this item is required for all claims; all lines of service.

POS Code / Name Description

01 / Pharmacy - A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.

03 / School – A facility whose primary purpose is education.

04 / Homeless Shelter - A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

05 / Indian Health Service Free-standing Facility - A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. Not applicable for adjudication of Medicare claims.

06 / Indian Health Service Provider-based Facility - A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. Not applicable for adjudication of Medicare claims.

07 / Tribal 638 Free-Standing Facility - A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization. Not applicable for adjudication of Medicare claims.

08 / Tribal 638 Provider-Based Facility - A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. Not applicable for adjudication of Medicare claims.

09 / Prison / Correctional Facility - A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.

11 / Office - Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 / Home - Location, other than hospital or facility, where the patient receives care (private residence).

13 / Assisted Living Facility - Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.

14 / Group Home - A residence with shared living areas, where clients receive supervision and other services, such as social and / or behavioral services, custodial services, and minimal services (e.g. medical administration).

15 / Mobile Unit - A facility / unit that moves from place-to-place, and is equipped to provide preventive, screening, diagnostic, and / or treatment services.

16 / Temporary Lodging - A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

17 / Walk-in Retail Health Clinic - A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services not applicable for adjudication of Medicare claims

18 / Place of Employment / Worksite - A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. Not applicable for adjudication of Medicare claims

19 / Off Campus-Outpatient Hospital - A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization (Effective 1/1/2016).

20 / Urgent Care Facility - Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 / Inpatient Hospital - A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 / On Campus-Outpatient Hospital - A portion of a hospital's main campus, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective 1/1/2016)

23 / Emergency Room / Hospital - A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 / Ambulatory Surgical Center - A freestanding facility (other than a physician's office) where surgical and diagnostic services are provided on an ambulatory basis.

25 / Birthing Center - A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.

26 / Military Treatment Facility - A medical facility operated by one or more of the Uniformed Services Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31 / Skilled Nursing Facility - A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 / Nursing Facility - A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 / Custodial Care Facility - A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 / Hospice - A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

41 / Ambulance—Land - A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 / Ambulance—Air or Water - An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

49 / Independent Clinic - A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

50 / Federally Qualified Health Center - A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 / Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 / Psychiatric Facility-Partial Hospitalization - A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 / CMHC (Community Mental Health Center) - A facility that provides outpatient services, (including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility); 24 hours a day emergency care services; day treatment, other partial hospitalization services or psychosocial rehabilitation services; screening for admission to state mental health facilities; consultation and education services.

54 / Intermediate Care Facility / Mentally Retarded - A facility that primarily provides health-related care services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.

55 / Residential Substance Abuse Treatment Facility - A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 / Psychiatric Residential Treatment Center - A facility or distinct part of a facility that provides 24-hour therapeutically, planned and professionally staffed group living and learning environment.

57 / Non-residential Substance Abuse Treatment Facility - A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

60 / Mass Immunization Center - A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61 / Comprehensive Inpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 / Comprehensive Outpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65 / End-Stage Renal Disease Treatment Facility - A facility other than a hospital, that provides dialysis treatment, maintenance, and / or training to patients or caregivers on an ambulatory or home-care basis.

71 / State or Local Public Health Clinic - A facility maintained by either State or local health department that provides ambulatory primary medical care under the general direction of a physician.

72 / Rural Health Clinic - A certified facility, located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.

81 / Independent Laboratory - A laboratory certified to perform diagnostic and / or clinical tests independent of an institution or a physician's office.

99 / Other Place of Service - Other place of service not identified above.

ITEM 24C TYPE OF SERVICE

Not required by Medicare. Leave blank.

ITEM 24D PROCEDURES, SERVICES, OR SUPPLIES

Enter the procedures, services or supplies using the (Healthcare Common Procedure Coding System (HCPCS). When applicable, show the correct HCPCS modifiers with the HCPCS code. The CMS-1500 (02-12) claim form has the capacity to capture up to four modifiers.

Enter the acquisition cost for pharmaceutical or radiopharmaceutical diagnostic imaging agents or for therapeutic radionuclides. This is required in order to receive reimbursement. Please specify that the dollar amount listed is the acquisition cost.

PROCEDURES, SERVICES, OR SUPPLIES

(Explain Unusual Circumstances)

CPT / HCPCS | MODIFIER

Example:

A9500 | Acquisition Cost = $120.00

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or an not otherwise classified (NOC) code, include a narrative description in item 19, if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Claim(s) will be returned as unprocessable if an "unlisted procedure code" or an NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

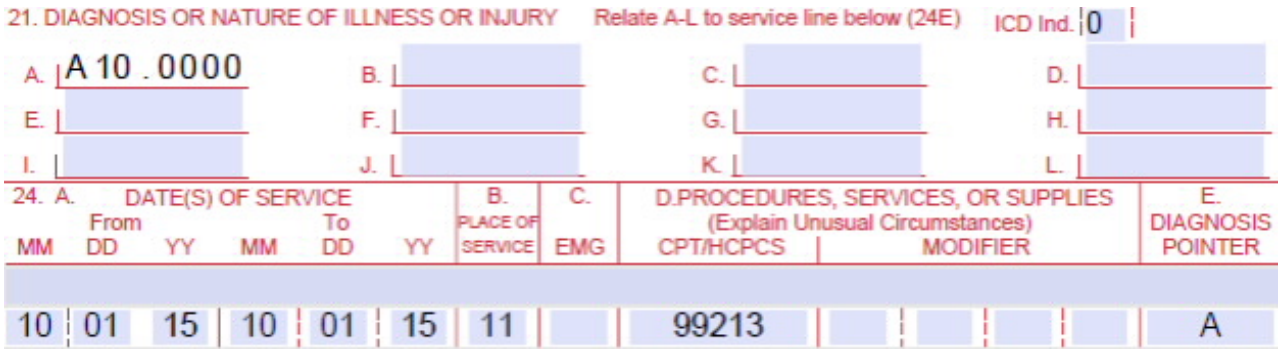
ITEM 24E DIAGNOSIS CODE

Enter the diagnosis code as shown in item 21 to relate the date of service and the procedures performed for the primary diagnosis. Enter only one reference per line item. When multiple services are performed, enter the primary reference for each service.

The reference to supply in 24E will be a letter from A-L.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

ICD10:



Completion of this item is required for all claims, other than those submitted by ambulance suppliers.

ITEM 24F ($) CHARGES

Enter the charge for each listed service.

Completion of this item is required for all claims (all lines of service).

ITEM 24G DAYS OR UNITS

Enter the number of days or units.

This item is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. If only one service is performed, the number 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24G. Convert hours into minutes and enter the total minutes required for the procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems.

Rounding of oxygen contents is as follows:

- For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in item 24G, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24G.
- For stationary liquid systems, units of contents shall be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24G.
- For units of portable contents only (i.e., no stationary gas or liquid system used) round to the nearest five feet or one liquid pound, respectively.

For ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a "0" before the decimal (e.g. 0.9). For more information on loaded miles and fractional mileage, please visit the CMS Claims Processing Manual, Pub 100-04, Chapter 15, §§20.2 and 30.1.2 .

Note: This field should contain an appropriate numerical value. The A / B MAC (B) will automatically default to "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, the system will automatically default to "0.1" unit when total mileage units are missing in this field.

Completion of this item is required for all claims, all lines of service.

ITEM 24H EPSDT FAMILY PLANNING

Leave blank. Not required by Medicare.

ITEM 24I

Leave Blank. Not required by Medicare.

ITEM 24J

Enter the rendering provider's NPI number in the lower un-shaded portion.

In the case of an 'incident to' service of a physician or non-physician practitioner, enter the NPI of the supervisor (when the person who ordered the service is not supervising), in the lower un-shaded portion.

Do not report information in the shaded portion of 24J.

ITEM 25

Enter the provider or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate box.

Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the Coordination of Benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement.

Reimbursement may be delayed for claims submitted without tax identification information.

ITEM 26 PATIENT'S ACCOUNT NUMBER

Enter the patient's account number assigned by the provider of service and / or supplier's accounting system.

This is an optional item to enhance patient information.

ITEM 27 ACCEPT ASSIGNMENT

Check the appropriate item to indicate whether the provider of service and / or supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in item 9 and MEDIGAP payment authorization is given in item 13, the provider of service and / or supplier must also be a Medicare participating provider of service and / or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.

The following provider and / or supplier claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating provider of service and (or) supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers;
- Ambulatory surgical center (ASC) services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance Services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine

ITEM 28 TOTAL CHARGE

Enter the total charge in item 28 for all services reported in item 24F.

All CMS 1500 (02-12) claim forms will be treated individually; therefore, when documentation is required it must be submitted for each claim form. Claims not submitted in this manner will be returned to the provider.

Multiple 1500 claim forms requiring the same attachment require photocopies for each individual claim form (i.e. (explanation of benefits (EOB); operative reports; medical records).

Completion of this item is required for all claims.

ITEM 29 AMOUNT PAID

Enter the total amount the patient paid on covered services.

The total amount should not exceed the total charges.

Completion of this item is required for all claims.

ITEM 30 BALANCE DUE

Leave blank. Not required by Medicare.

ITEM 31 SIGNATURE OF THE PROVIDER OF SERVICE AND (OR) SUPPLIER INCLUDING DEGREE OR CREDENTIALS

Enter the signature of the provider and / or supplier, or his / her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 2015) the form was signed.

When the ordering physician or non-physician practitioner is directly supervising the 'incident to' service, enter the signature of the ordering physician or non-physician practitioner in item 31.

When the ordering physician or non-physician practitioner is not supervising the 'incident to' service, enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

Completion of this item is required for all claims.

Note: This is a required field; however, the claim can be processed if a physician, supplier, or authorized person's signature is missing, but an authorization is attached to the claim; or if the signature field has a computer generated signature' or if "signature on file" is indicated. A computer generated "signature" that does not name an individual person is not acceptable.

For example, "ABC Anesthesia Group" would not be considered an acceptable computer generated signature.

ITEM 32 NAME, ADDRESS AND ZIP CODE OF THE SERVICE LOCATION

The name, address, and zip code of the service location is required for all services, including place of service home – 12.

Only one name, address and zip code may be entered in this item. If additional entries are needed, submit separate claim forms.

When billing for purchased diagnostic tests, providers (namely physicians) shall identify the supplier's name, address, and ZIP code. When more than one supplier is used, submit a separate claim form for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted CMS-1490S claim form, it should be determined if it is a foreign claim. If it is a foreign claim before it is entered in the system.

The A / B MAC (B) processing the foreign claim will verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMEMAC only). This field is required.

When more than one supplier is used, submit a separate claim form for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), enter the physical location where the service was rendered if other than home.

If the supplier is a certified mammography-screening center, enter the 6-digit Federal Drug Administration (FDA) approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

ITEM32a

If required by Medicare claims processing policy, enter the NPI of the service facility.

Beginning April 1, 2015, billing physician and supplier must report the NPI of the performing physician or supplier in Item 32a on all anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different jurisdiction.

ITEM 32b

Not reported.

ITEM 33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER

Enter the physician's individual / group or supplier's billing name, address (physical location, no PO Boxes), ZIP code, and telephone number.

This is a required field.

ITEM 33a

Enter the NPI of the billing provider or group. This is a required field.

ITEM 33b

Not generally reported. However, some Medicare policies may instruct to use this item.

Billed In Error

Claim submissions that were billed in error (needs a line item removed) cannot be completed in the IVR or Novitasphere Portal, the Return of Monies to Medicare Form or Part B Redetermination and Clerical Error Reopening Request Form must be used in these situations.

Note: The claim must be fully processed before completing one of the forms listed above.

Incomplete or Invalid Information on Claim Submissions (Return as Unprocessable)

CMS is continuing efforts to reduce costs and administrative waste. For some time, the denial of claims with incomplete or invalid information has resulted in claims surfacing inappropriately into the appeals process. This practice has not only been costly, it has resulted in an inappropriate use of the appeals system.

Paper or electronic claims are returned to you as unprocessable if the claim contains certain incomplete or invalid information. No appeal rights will be afforded to these claims, or portion of these claims, because no "initial determination" can be made rendering the claim unprocessable.

This editing process not only saves Medicare Trust Funds, there is little change and no additional administrative burden for you. You will be able to correct an unprocessable claim under this editing system.

You may continue to submit corrections via the telephone, on a development letter, as a new claim, or in any format. However, you will not be granted a review because "returned" claims have no appeal rights.

One caution: Please correct "returned" claims promptly because only when that is done will you have met your legal obligation for submitting a Medicare claim. If you are a non-participating provider and currently bill beneficiaries prior to submitting a claim, you may continue to do so.

What does "Return as Unprocessable" mean?

Returning a claim as unprocessable does not mean your Medicare contractor will physically return every claim you submit with incomplete or invalid information. The term "return as unprocessable" is used to refer to the many processes utilized by your Medicare contractor for notifying you that your claim cannot be processed, and that it must be corrected or resubmitted.

Some (not all) of the various techniques for returning claims as unprocessable include:

- Incomplete or invalid information is detected at the front-end of your Medicare contractor's claims processing system. The claim is returned to you, either electronically or in a hardcopy / checklist type form, with an explanation of the error, and how to correct it.
- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed by your Medicare contractor. If corrections are submitted within a 45-day period, the claim is processed. Otherwise, the suspended portion is "returned as unprocessable" and you are notified by means of the remittance notice.
- Incomplete or invalid information is detected within the claims processing system and is returned for Incomplete Claim Reject (ICR) references through the remittance process by your Medicare Contractor. You are notified of any error(s) through the remittance notice, along with how to correct it.

Note: An incomplete claim is a claim with missing, required information (e.g., no NPI). An invalid claim is a claim that contains complete and necessary information; however, the information is illogical or incorrect (e.g., incorrect NPI).

What information will be provided to assist you in correcting a claim?

To assist you in furnishing the appropriate corrections, the following information will be supplied (as long as it is on the received claim):

- Beneficiary's name;
- Medicare Beneficiary ID Number;
- Dates of service;
- Patient account or control number

An explanation of the errors will also be provided. This explanation will either be in the form of a description or a code.

Which Incomplete or Invalid Information will be 'Returned as Unprocessable'?

The following information will be returned as unprocessable if it is not completed and / or entered accurately on the claim. Please note that a required data element must always be present on a claim (Refer to Exhibit I).

To assist you in completing your claim:

Refer to Exhibit I, for details on items or conditional information that will cause a claim to be returned for ICR references. Please verify that your printing specifications are correct on a claim.

Claims will be returned as unprocessable if the required information is submitted incorrectly.

Special Note: If you do not submit information for a required or conditional item(s) because the information is normally kept on file with your Medicare contractor, and can be supplied by your Medicare contractor, then the claim will not be returned as unprocessable.

Exhibit I

Your claim will be returned for the following ICR references:

1. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified below) and his / her name is not present in item 17 or if the NPI is not entered in item 17b.

2. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and / or NPI required of the supervising physician is not entered in items 17 or if the NPI is not entered in item 17b.

3. For diagnostic tests subject to anti-markup

- If a "YES" or "NO" is not indicated in item 20.
- If the "YES" box is checked in item 20 and the purchase price is not entered under the word "$CHARGES".
- If the "YES" box is checked and the purchase price is entered under $CHARGES, but item 32a is blank (*no name or provider number is provided*).
- If the "YES" box is checked, and more than one test is billed on the claim;
- If both the Technical Component (TC) and Professional Component (PC) are billed on the same claim and the dates of service and places of service do not match;
- If the "YES" box is checked, both the TC and PC are submitted and the date of service and place of service codes do not match.
- If there is an indication on the claim that a test is subject to the anti-markup payment limitation, more than one test is billed on the claim, and line level information for each total acquisition amount is not submitted for each test.
- If the service is billed using a global code rather than having each component billed as a separate line item.
- If the NPI of the performing entity belongs to the billing provider OR the performing entity is not a valid, Medicare enrolled entity.

4. If a diagnosis code listed in item 21 is missing, invalid or truncated or if the narrative diagnosis is not listed on an attachment.

5. If an ICD-10-CM diagnosis code within the code range of V00 through Y99 is reported in the first field of Item 21 for dates of service on or after 10/01/2015 or for dates of service prior to 10/01/2015, an ICD-9-CM "E" code (external causes of injury and poisoning) is reported in the first field of Item 21

6. If a performing physician / supplier or other practitioner is a member of a group practice and does not enter the National Provider Identifier (NPI) in item 24J and the group number in item 33.

7. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete.

8. If there is insurance primary to Medicare indicated in item 11 by either an insured / group policy number, but the insurance / program name in item 11c is incomplete.

9. For chiropractor claims:

- If the x-ray date(*s*) is not entered in item 19.
- If the initial date "actual" treatment began is not entered in item

10. For Certified Registered Nurse Anesthetist (CRNA) and Anesthesia Assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and they do not enter the group's name or billing number in item 33 and their personal NPI number in item 24J.

11. For durable medical, orthotic, and prosthetic claims, if the name or NPI of the location where the order was accepted is not entered in item 32.

12. For physicians who maintain dialysis patients and receive a monthly capitation payment:

- If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's NPI is not entered in item 24J.
- If the name or NPI of the facility involved with the patient's maintenance of care and training is not entered in item 32.

13. For foot care claims, if the date the patient was last seen and the attending physician's NPI are not present in item 19.

14. For immunosuppressive drug claims, if a referring / ordering physician was used and their name and / or NPI are not present in items 17 or 17a.

15. For all laboratory services, if the services of a referring / ordering physician are used and his or her name and / or NPI are not present in items 17 or 17a.

16. For laboratory services performed by participating hospital-leased laboratory or an independent laboratory (including services to a patient at home or in an institution), if the name or NPI of the laboratory where services were performed is not in item 32.

17. For independent laboratory services involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if a prescribing physician does not validate any laboratory service(s) performed at home or in an institution by entering the appropriate annotation in item 19 (i.e. "Homebound").

18. For mammography "screening" and "diagnostic" claims, if a qualified screening center does not accurately enter their six-digit, FDA-approved facility identification number in item 32 when billing the technical or global component.

19. For physician assistant, nurse practitioner, and clinical nurse specialist claims, if services are performed in a hospital setting but neither the hospital's name or NPI is entered accurately in item 32.

20. For parenteral and enteral nutrition claims, if the services of an ordering / referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 or if the NPI is not entered in item 17b.

21. For portable X-Ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and / or NPI is not entered in items 17 or if the NPI is not entered in item 17b.

22. For radiology and pathology claims for hospital inpatients, if the referring / ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist's name, if appropriate, is not entered in item 17 or if the NPI is not entered in item 17b.

23. For outpatient services provided by a qualified, independent physical or occupational therapist:

- If the NPI of the attending physician is not present in item 19.
- If the date the patient was last seen by the attending physician is not present in item 19.

24. If a HCPCS modifier must be associated with a HCPCS procedure code or if the HCPCS modifier is invalid.

If my claim is returned as unprocessable through the remittance notice, how will I be notified of the error(s)?

Medicare Inpatient Adjudication (MIA) / Medicare Outpatient Adjudication (MOA) / Reference Remark Codes will be used if your claim is returned as unprocessable through the remittance process.

Please note that MIA / MOA Code MA130 will be present on the remittance notice for any claim returned for incomplete or invalid information.

Note: For free listing of Claim Adjustment Reason Codes and Remittance Remark Codes, please visit Washington Publishing Company . If you do not have Internet access, you may contact them at (301) 949-9740 to obtain copies; however, fees may apply.

Glossary of Terms

Incomplete Claim: A claim submitted with missing required information (i.e., no provider number, no patient telephone number or at least 000-000-0000 for an unlisted telephone number).

Invalid Claim: A claim that contains complete and necessary information; however, the information is illogical or incorrect.

The following are a few examples of either invalid or incomplete data element returns for ICR references:

- A claim billed for a referred service is missing the referring physician information (blocks 17),
- Incomplete or invalid use of modifiers is reported in block 24D,
- A member of a group practice does not submit the rendering NPI in block 24J,
- Incomplete or invalid diagnosis codes are used on physician claims (block 21),
- Patient's relationship to insured is not completed (block 6),
- The insurance that is primary to Medicare is indicated, but the insurance plan / program name is incomplete (block 11c), or
- An anesthesiology claim is submitted and the elapsed time from patient prep to personal attendance is not included; (block 24G), or there is no indication if the service was medically directed, personally performed or medically supervised (block 24D).

Appeal Rights

The law prohibits Medicare contractors to extend appeal rights for claims that contain incomplete or invalid information. No notice of appeal rights will be furnished in connection with the returned claim for OCR references

because no "initial determination" on the claim was made. No beneficiary Explanation of Medicare Benefits (EOMB) will be issued for a returned claim.

You cannot bill the beneficiary for the services; the claim must be corrected and resubmitted through the normal claim filing procedures.

Optical Character Recognition (OCR) 1500 Claim Form Submission

Instructions / Helpful Hints

Instructions on the preferred method of submitting the CMS 1500 (02-12) claim form.

Returned Claims

If a claim returns for OCR references, you will receive notification on your normal provider voucher or reconciliation file with the appropriate returned information. It is your responsibility to verify that all information is complete before resubmitting the claim.

Note: For EMC billers, all existing batch and claim level returns for OCR references will be retained. Use the PCLR 5001-5004 reports for these returns.

Mandatory Claims Submission

Timely Filing Requirements

Attachment D

Ground Ambulance Transport Services and Deceased Beneficiaries

FITCH
& ASSOCIATES

Ground Ambulance Transport Services and Deceased Beneficiaries

Novitas Solutions, in collaboration with *the Centers for Medicare & Medicaid Services (CMS*), continues to focus on lowering the *Comprehensive Error Rate Testing* (*CERT*) claims paid error rate. Currently, one area of concern identified in the CERT data is the denial of ground ambulance transport in regards to a deceased beneficiary

Ambulance Benefit

"The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport."

Ground BLS (Basic Life Support) Ambulance Service

" *Basic life support* (*BLS*) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an EMT-Basic *(emergency medical technician-basic)*. These laws may vary from State to State or within a State. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral IV *(intravenous)* line."

Ground ALS1 (Advanced Life Support, Level 1)

"ALS1 is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention."

"An *advanced life support* (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service."

"An ALS intervention is a procedure that is in accordance with State and local laws, required to be done by an EMT-Intermediate *(emergency medical technician-intermediate)* or EMT-Paramedic."

ALS1 - Emergency

"When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call."

Ground ALS2 (Advanced Life Support, Level 2)

"An ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus

or by continuous infusion *(excluding crystalloid fluids)* or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below":

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway or
- Intraosseous line

Documentation

"Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services. In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made."

"In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service."

Air Ambulance Services

"Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, contractors 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."

"There are two categories of air ambulance services: fixed wing *(airplane)* and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded *(patient onboard)* miles flown and is expressed in statute miles *(not nautical miles)*.

FW (Fixed Wing) Air Ambulance

Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

RW (Rotary Wing) Air Ambulance

Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle."

Beneficiary Signature Requirements

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- Beneficiary's legal guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the beneficiary
- Relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs
- Representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary
- Representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36*(b) (1 – 4)*
- Representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service. A provider/supplier *(or his/her employee)* cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purposes of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment. *(***Note***: there is a 12-month period for filing a Medicare claim, depending upon the date of service.)*

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary *(or his or her estate)* for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

Beneficiary deceased upon arrival

"Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements."

Payment is dependent upon the timing of the beneficiary's death and when the ambulance was dispatched.

- If the beneficiary is pronounced dead prior to the ambulance dispatch, there is no payment by Medicare.
- If the beneficiary is pronounced dead after the ambulance is dispatched, but prior to the beneficiary being loaded on the ambulance, then the provider's Basic Life Support rate, no rural or mileage adjustment, is paid and the ambulance provider is to use the QL modifier on the claim.
- If the beneficiary is pronounced dead after the ambulance pick up and prior to the arrival at the receiving facility, then the ambulance services are paid at the medically necessary level of care furnished and supported in the documentation.

CERT Review Findings

Documentation supports that the beneficiary was already deceased at the time the ambulance was called.

Example 1:

The documentation noted that the beneficiary was pronounced dead two hours prior to the ambulance being dispatched. The ambulance crew returned to their station and did not transport the beneficiary.

In this case, the ambulance provider cannot bill Medicare per the above stated guidelines.

Example 2:

The ambulance provider was called and dispatched for a beneficiary who was unresponsive and having shallow breathing. Upon arrival, the ambulance crew finds that the beneficiary has a do not resuscitate order and that the attending physician was in agreement with the do not resuscitate orders and instructed that CPR not be performed. The ambulance crew returned to their station and did not transport the beneficiary.

In this case, the ambulance provider can bill their Basic Life Support rate only and should append the QL modifier to the claim line.

In the situation of a deceased beneficiary, timing of the pronouncement of death is key to proper billing. Documentation must also support whether or not the pronouncement of death occurred:

- Prior to the ambulance being dispatched,
- After the ambulance was dispatched, but prior to the beneficiary being loaded into the ambulance for transport, or
- After the beneficiary is loaded on the ambulance for transport, but prior to the arrival at the receiving facility

It is our goal at Novitas Solutions to have claims paid correctly and to lower the CERT error rate.

Prior Authorization of Repetitive Non-Emergent Ambulance Transport – JL Only

The Centers for Medicare & Medicaid Services (CMS) implemented a prior authorization model for repetitive scheduled non-emergent ambulance transports. CMS is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

Prior authorization does not create new clinical documentation requirements. Instead, it requires the same information necessary to support Medicare payment, just earlier in the process.

Prior authorization allows providers and suppliers to address issues with claims prior to rendering services and to avoid an appeal process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

Phase I

Ambulance suppliers or beneficiaries began submitting prior authorization requests in New Jersey and Pennsylvania on December 1, 2014 for transports occurring on or after December 15, 2014. All repetitive scheduled non-emergent ambulance transports with a date of service on or after December 15, 2014 must have completed the prior authorization process or claims will be subject to prepayment review.

Phase II

Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (*MACRA*) expands the prior authorization model for repetitive scheduled non-emergent ambulance transports to Maryland, Delaware, and the District of Columbia no later than January 1, 2016.

For more information, please visit the CMS Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport page or the Prior Authorization Initiatives page of our website.

References:

- CMS' Benefit Policy Manual, Publication 100-02, Chapter 10 - Ambulance Services
- CMS' Claims Processing Manual, Publication 100-04, Chapter 15 – Ambulance
- Medicare Ambulance Transports
- LCDs *(Local Coverage Determinations)*:
  - Effective for services performed ***prior*** to October 1, 2015
    - JL Ambulance (Ground) Services, L32252
    - JH Ambulance Services (Ground Ambulance), L32606
  - Effective for services performed ***on or after*** October 1, 2015
    - JL Ambulance (Ground) Services, L35162
    - JH Ambulance Services (Ground Ambulance), L35162

Attachment E

Curriculum Vitae

FITCH
& ASSOCIATES

Anthony W. Minge, EdD **2901Williamsburg Terr., Ste G**
Partner, Fitch & Associates **Platte City, Missouri 64079**

SUMMARY

Dr. Minge is a proven managerial executive with extensive experience in financial, operational and personnel management, and compliance, as well as planning, leadership and business development. He is the firm's compliance and revenue cycle management subject matter expert, oversees and orchestrates all educational programs, and is the program co-chair for the highly successful Pinnacle EMS Leadership Conference. His dynamic management and leadership characteristics combined with strong teaching, training, outreach, management, and marketing skills provide for market growth and development of sustainable action plans for clients.

CAREER

2012 - Present ***Senior Partner***
Fitch & Associates **Platte City, Mo.**

2007 -2012 ***Senior Associate / Director of Patient Accounts***
Fitch & Associates / MedServ International **Platte City, Mo.**

- Provided business and financial management of patient accounts department responsible for processing more than 60,000 ground and air medical transport claims per year.
- Corporate Compliance Officer
- Developed accounts receivable management, policy and procedure, and protocol design for multiple ground and air services
- Developed electronic "dashboard" style reporting product.

2006 – 2007 ***Manager of Business Services***
Northwest Medstar **Spokane, Wash.**

- Provided business and financial leadership and management of the air-medical transport system of Inland Northwest Health Services
- Established and managed annual company strategic, operational and financial goals and objectives. Carried out operation/strategic objectives
- Responsible for expense management and cash flow including oversight of MedStar's patient accounts and multiple business service projects
- Established budgetary controls and implemented new business objectives that were instrumental in turning organization into a profit center within less than one year

2001-2005 ***Business Manager Transport Services***
Children's Medical Center of Dallas **Dallas, Texas**

- Assisted in program development, clinical, competitive and fiscal performance of the department
- Provided leadership to ensure success in analyzing and monitoring the internal and external environment effecting the department
- Designed and managed inter-department billing and collections team for all transports, significantly increasing department contributions to the hospital.

- Redesigned departmental operations creating a profit center from a cost center becoming second largest revenue generating center in the hospital
- Oversaw installation of new healthcare information management and billing system

1999-2001 **Supervisor, Patient Financial Services**
Children's Medical Center of Dallas **Dallas, Texas**

- Supervised Medicaid/Medicare collections team for hospital patient financial services unit.
- Developed strategic alliances with outpatient clinics and operations to educate each resulting in better billing and collection outcomes
- Developed working relationship between hospital and State/Government provider relations resulting in enhancement of billing operations and greater collections

1995-1999 ***Supervisor/Interim Manager***
Olsten Health Services **Irving, Texas**

- Designed and supervised first Medicaid and Medicare billing and collections team for Texas
- Developed training programs for infusion billing and collections
- Supervised and managed multi-state home health and infusion services 100+ person billing, collections and audit team
- Increased revenue and collections for home nursing and home infusion service divisions through education of staff, realignment of duties and process improvements

EDUCATION

Argosy University; Dallas, Texas 2016
Doctorate of Education
Organizational Leadership

Amberton University; Garland, Texas 2002
Master of Business Administration
Strategic Leadership

Midwestern State University; Wichita Falls, Texas 1994
Bachelor of Business Administration
Marketing

CURRENT MEMBERSHIPS

- Association of Critical Care Transport
- American Ambulance Association
- Association of Air Medical Services
- National EMS Management Association
- National Association of Emergency Medical Technicians

PUBLICATIONS

- Co-authored, with Dr. Thomas Abramo, "2005 International Transport" Chapter for American Academy of Pediatrics
- "How Can I Increase Our Billing Receipts and Decrease Our Collection Time?", Best Practices in Emergency Services, August 2010 Vol. 13 No. 8, p. 9
- "Healthcare Reform: "Is Your Agency the Coyote or the Road Runner?" EMS Insider January 2013
- "EMS leaders must treat employees equitably, not equally", The Leadership Edge – EMS1.com August 2015
- "3 Critical Financial Indicators to Watch", The Leadership Edge – EMS1.com July 20, 2016
- "Scrutiny of ambulance operations highlights need for compliance", Compliance Today, September 2016 (co-authored with Matthew Streger)
- "Give EMS Compliance Training the Respect It Deserves", The Leadership Edge – EMS1.com July 9, 2017
- "Getting the Most Out of Your EMS Billing: An Interview with Anthony Minge, EdD", Journal of Emergency Medical Services Magazine, January 17, 2018
- "10 Tips for Managing EMS Billing Compliance Issues in the Fire Service", Chief Concerns-FireRescue1 January 2019
- "Fiscal things that can go bump in the night", The Leadership Edge – EMS1.com July 2019
- "7 ways to prepare your fire department for the next recession", Chief Concerns – FireRescue1 August 2019

CURRENT FACULTY

- Beyond The Street – EMS Supervisor Training
- Ambulance Service Manager Program
- Communications Center Manager Program
- Pinnacle EMS Leadership Conference

Melissa Dawn Coons
Fitch & Associates

2901 Williamsburg Terr., Ste G
Platte City, Missouri 64079

SUMMARY

Mrs. Coons has excellent organizational, project management and analytical skills. These skills facilitate strong team work and customer service. Her administrative skills have facilitated success while leading internal teams as well as assisting external customers manage their high level workloads while meeting strict deadlines. These skills and her attention to detail along with her past experience in high volume medical billing make her proficient in the medical claims review processes.

CAREER

Present
Fitch & Associates

Claims Review Specialist
Platte City, Mo.

2013 – 2015
Fitch & Associates / MedServ International

Assistant Director Patient Accounts
Platte City, Mo.

- Primary responsibility to oversee billing for more than 60,000 ground and air medical transport claims per year.
- Provided leadership to ensure success in day to day operations.
- Developed training documentation to educate billing and collection teams to advance processes.

EDUCATION

National Academy of Ambulance Compliance
Certified Ambulance Coder

Northwest Missouri State University, Maryville Missouri
Bachelor of Science
Management and Marketing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