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Professional Claims Review

CONFIDENTIAL

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City of El Paso

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CLAIMS REVIEW

Professional Ambulance Claims Review
City of El Paso

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A. Compliance Review Worksheet
B. RAT-STATS printout
C. Curriculum Vitae
D. ABC Signature Form

Purpose

Fitch & Associates, LLC (*FITCH*) was retained by the City of El Paso (*EL PASO*) to conduct a Professional Claims Review of ambulance transports billed to and paid by Federal health care 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 health care providers identified by *EL PASO* as responsible parties for reimbursement of services provided. *FITCH* serves in this capacity as an external auditor of the billing of services by *EL PASO* to Federal providers.

Statistical Sampling Methodology

Sampling Unit

The Sampling Unit contains *Items* reviewed by *FITCH* for this professional review of ambulance claims. For the purpose of this review, an *Item* is defined as an ambulance transport claim filed for payment to a Federal health care program, for medical transports provided by *EL PASO*. Each claim has multiple charges: ambulance base rate and patient loaded mileage for Medicare and Medicaid claims. The sampling unit for the claims billed to a Federal health care program was drawn from a total population of claims billed to and paid by Medicare and Medicaid, which was provided by *EL PASO* for a defined period of time.

Claims Review Population

The Claims Review Population was comprised of claims with dates of service within the period of October 1, 2018 to December 31, 2018 for which *EL PASO* reportedly received reimbursement from the Federal health care programs of Medicare and Medicaid. The information provided indicated a population of 1,840 paid Medicare and Medicaid claims. This information was identified and provided by *EL PASO* and/or their contracted billing agent, *R1 RCM (formerly Intermedix)*.

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 health care program for trips that occurred during the time-period of October 1, 2018 to December 31, 2018. In this case, the Sampling Frame for Medicare and Medicaid represents 1,840 transports.

The Discovery Sample claims were identified by using the Office of the Inspector General's (OIG) RAT – STATs statistical sampling software. Spares were also identified in order 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 not reimbursed by Medicare or Medicaid or had been identified to have a different responsible primary payor other than Medicare or Medicaid 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

A copy of 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 1,840 claims reported to be reimbursed by Medicare and Medicaid. Of the 50 claims, all qualified for inclusion in the Discovery Sample(s), thus no spares were required to be utilized for the completion of this review.

Source of Data

For the purpose of this review, each claim is identified as an *Item* and assigned a corresponding number, independent and unique from the records and account numbers assigned by *EL PASO* and/or *R1 RCM* to the records. *FITCH* requested documentation for each *Item* identified for the Claims Review from *EL PASO.* For secure transfer of these documents in electronic format, a ShareFile folder was created. The request for documents included, but was not limited to:

- Dispatch Documents/Notes
- Electronic Prehospital Care Reports
- Copies of Claims Forms and Invoices (primary and secondary)
- Copies of Proof of Payment (EOBs, RA, R&S, etc.)
- Signature Forms
- Prior Authorization and PCS Forms (as applicable)
- ABN Forms (as applicable)
- Any other relevant documents that are part of the claim file

EL PASO's billing company, *R1 RCM*, provided the documents and uploaded this information for all 50 Discovery Sample Claims into the ShareFile.

Claims Review Objective

FITCH utilizes a review process to analyze each document provided. This process includes inspection of areas of risk identified by the Office of the Inspector General (OIG) in their Compliance Program Guidance for Ambulance Suppliers, as well as the rules and regulations as 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 a variety of other relevant compliance related documents. An extensive array of elements was examined, and relevant areas of risk were included in the process. In this review, particular attention was paid, but not limited to, the following risk 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 objective of the review was to determine whether claims submitted for reimbursement to Federal and State health care programs were appropriate, presented proper documentation, and were accurately billed and paid.

Each claim was independently reviewed, and a worksheet was completed (Attachment A) detailing the information provided. The reviewer examined all submitted documentation for each ambulance transport. The review was constructed 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 codes used to report the patients' signs, symptoms, and condition(s) at the time of transport and are they supported in the Prehospital Care Report?
8. Was the amount reimbursed by the federal health care programs appropriate?

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 number. All the information received for the corresponding claim and the *Item* was entered into a spreadsheet, included with this report as Attachment A and titled Compliance Review Worksheet. An extensive inspection of elements was performed and recorded in the review of the claims in order 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 health care providers:

- Assigned Item Number
- Patient Name
- Account 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 codes on Claims and Determination of Appropriateness
- Accuracy of Total Charges
- Primary Federal 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 Dollar Difference Between the Allowed Amount and the Determined Allowed Amount (overpayment or underpayment) if Applicable

FITCH staff members reviewed 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 reviewer examined the claims in the order of the sequential selection from the RAT-STATs program, to determine if any claims were not paid by that specific Federal health care program. Of the initial 50 claims identified, all 50 items met the criteria for inclusion in the review. No spares were utilized to complete this report.

Each claim was reviewed and compared to the prehospital 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 health care 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 no spares would be required to complete this claims review.

Mileage

Only mileage for which the patient was actually onboard and in transit to the hospital are considered billable miles. Providers must calculate the number of miles traveled by using the ambulance vehicle odometer reading, an acceptable alternate device such as GPS, or an internet mapping tool, and that mileage is to be reported on the claim and must be the actual number of miles traveled.

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 $1/10^{th}$ of a mile for transports up to 100 miles. After review of the documentation, 6 claims reported

fractional mileage on the Prehospital Care Report, those 6 claims billed 1/10th of a mile to Medicare and were appropriately reimbursed.

The Medicaid Ambulance Service Handbook states that mileage reported on the claim to be the actual mileage traveled. After review of the documentation of the 12 claims billed to Medicaid, 10 claims were deemed accurately billed and reimbursed based off what was recorded on the Prehospital Care Report. **Figure 1** specifies the two claims that were determined to have Medicaid mileage discrepancies.

Figure 1: Medicaid Mileage Discrepancies

Item #	Account Number	Payor	Comments
18	50411991	Medicaid	Chart shows mileage to be 12.2, the EOB shows 13 miles billed to Medicaid.
28	50062476	Medicaid	Chart shows mileage to be 0.0, the EOB shows 1 mile billed to Medicaid.

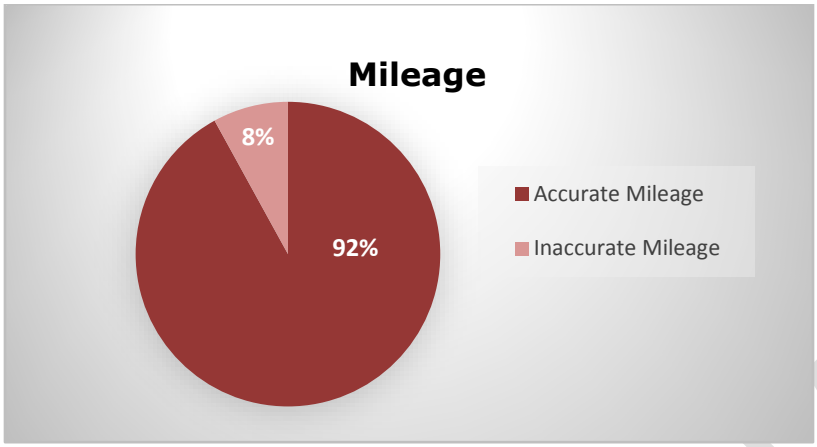
The "Dest. Odom" reported on the Prehospital Care Report were compared to the actual miles submitted on the electronic submission record document and Google maps was utilized to confirm the amount of mileage billed. The reviewer utilized the mapping program to verify the shortest distance between the origin and destination for the claims reviewed. The shortest route between pick up and destination can vary, and such variances may require explanations in the narrative of the Prehospital Care Report, if they are found to be more than what might be reasonably acceptable. After examination of the documentation and review of the mapping program, it was determined that 36 Medicare claims were billed accurately and within an acceptable variance from pick up to drop off locations. **Figure 2** furnishes a list of the shortest distance between origin and destination discrepancies.

Figure 2: Mileage Inaccuracies

Item #	Account Number	Payor	Comments
32	50268902	Medicare	The chart shows 10 miles billed to Medicare, Google maps shows 5.4 & 5.1.
49	50744419	Medicare	The chart shows 6 miles billed to Medicare, Google maps shows 2.6, 2.7 & 3.3

Figure 3 below displays the graphically illustration of the mileage accuracy percentage rate for Figure 1 and Figure 2 above.

Figure 3: Mileage Accuracy Percentage for Figure 1 and Figure 2.



The Prehospital Care Report provided a miles-transported section. A majority of the trips were shown as a whole number, and the likelihood that 42 out of 50 transports would end on a whole mile is statistically a low percentage. When the distance between the origin and destination was verified using the online mapping program of Google Maps, a 1/10th option was provided in the results, confirming that the likelihood that all those trips would end on a whole number was not a reasonable outcome. *FITCH* recommends that *EL PASO* check the mileage configuration on the system to make sure that it is configuring to the 1/10th of a mile and review the process for recording and billing mileage to the nearest 1/10th of a mile. **Figure 4** provides a list of the claims that ended the transport in a whole mile, and gives the distance verified using the mapping system information.

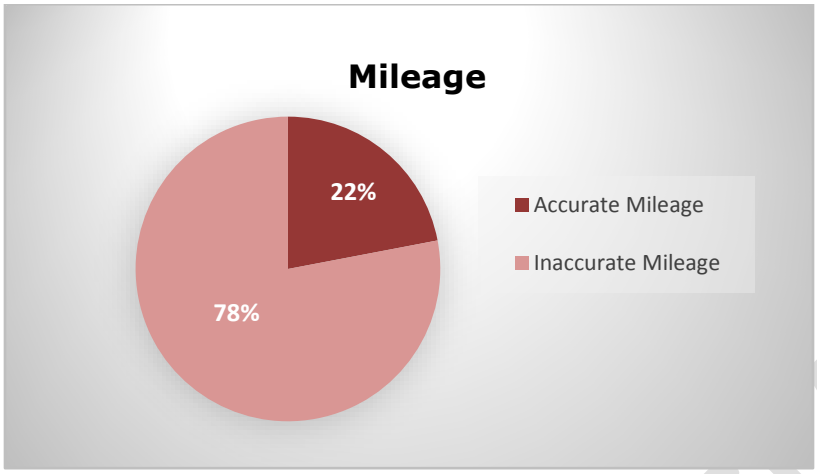
Figure 4: Other possible mileage issues

Item #	Account Number	Payor	Mileage on PCR	Comments
1	50490677	Medicare	3	Google maps shows 2.9, 4.4, & 3.1
2	50744419	Medicare	5	Google maps shows 5.1 & 7.0
3	50457976	Medicaid	5	Google maps shows 5.1 & 4.8
5	49811704	Medicare	8	Google maps shows 8.6, 8.9 & 6.5
6	50009574	Medicare	4	Google maps shows 2.0 & 3.6
7	50295456	Medicare	10	Google maps shows 12.1, 11.4 & 10.9
8	50679614	Medicare	4	Google maps shows 5, 4.3 & 4.7
9	50023308	Medicaid	1	Google maps shows 0.9, 0.8 & 1.1
10	50592635	Medicare	3	Google maps shows 2.1, 2.7 & 3.4
11	49772963	Medicare	2	Google maps shows 2.8, 2.6 & 2.7
12	50850689	Medicare	7	Google maps shows 4.7, 5.5 & 5.6

Item #	Account Number	Payor	Mileage on PCR	Comments
13	50009666	Medicaid	8	Google maps shows 7.7
14	49819105	Medicaid	1	Google maps shows 1.2, 1.4 & 1.1
15	49983483	Medicare	6	Google maps shows 4.9, 7.4 & 5.6
17	50062492	Medicare	12	Google maps shows 10.9
19	50813472	Medicare	4	Google maps shows 5.6, 6.2 & 4.9
20	50651678	Medicaid	5	Google maps shows 2.1, 2.0 & 3.1
21	50553592	Medicaid	7	Google maps shows 7.7 & 6.7
22	50688158	Medicare	4	Google maps shows 4.3, 5.8 & 7.7
23	50379357	Medicare	3	Google maps shows 5.9, 11.6 & 7.9
25	50744390	Medicaid	10	Google maps shows 7.4, 6.7 & 8.0
26	50369380	Medicare	2	Google maps shows 2.8, 2.6 & 2.7
27	50601506	Medicare	4	Google maps shows 4.8, 5.1 & 4.6
29	49983465	Medicare	6	Google maps shows 5.4, 5.1 & 5.2
33	50073941	Medicare	11	Google maps shows 13.1 & 11.7
35	50850675	Medicare	5	Google maps shows 3.4, 4.0 & 3.7
36	49950418	Medicare	7	Google maps shows 9.4, 8.8 & 9.0
37	50243332	Medicare	2	Google maps shows 1.7, 1.8 & 1.9
38	50527731	Medicare	3	Google maps shows 2.8, 4.0 & 3.3
39	50233426	Medicare	4	Google maps shows 2.9 & 4.3
40	50805815	Medicaid	1	Google maps shows 0.3 & 0.4
41	49795604	Medicare	5	Google maps shows 8.3, 7.1 & 7.2
43	50490689	Medicare	8	Google maps shows 11.1
47	50565303	Medicare	5	Google maps shows 3.4 & 3.7
50	50157568	Medicare	2	Google maps shows 0.3, 0.4

Figure 5 provides an overall percentage for Figure 1, Figure 2 and Figure 4 above.

Figure 5: Total Mileage Accuracy Percentage for Figures 1, 2 and 4

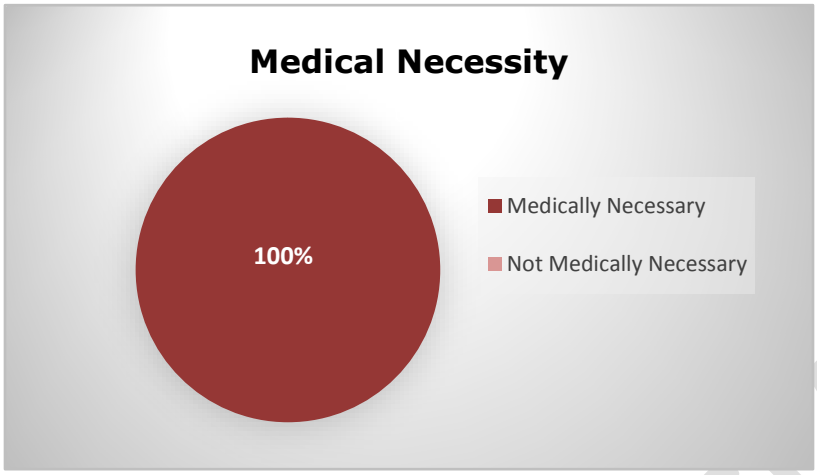


Medical Necessity

The Medicare Benefit Policy Manual, Chapter 10, Section 10.2.1 (Necessity for the Service) details the requirements to be met for medical necessity for ambulance services. According to such, 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. 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. In the review of the 38 Medicare claims for this report, all were deemed to have sufficient information in the Prehospital Care Report to support the medical necessity guidelines provided by Medicare.

Medicaid's Ambulance Service Handbook, Section 2.2 states the condition of the patient must be such that transportation by any other means is medically contraindicated. Of the 12 Medicaid claims reviewed for this report, all were deemed to support medical necessity. **Figure 6** displays the 100% accuracy rate for medical necessity of the claims reviewed.

Figure 6: Medical Necessity Accuracy Percentage



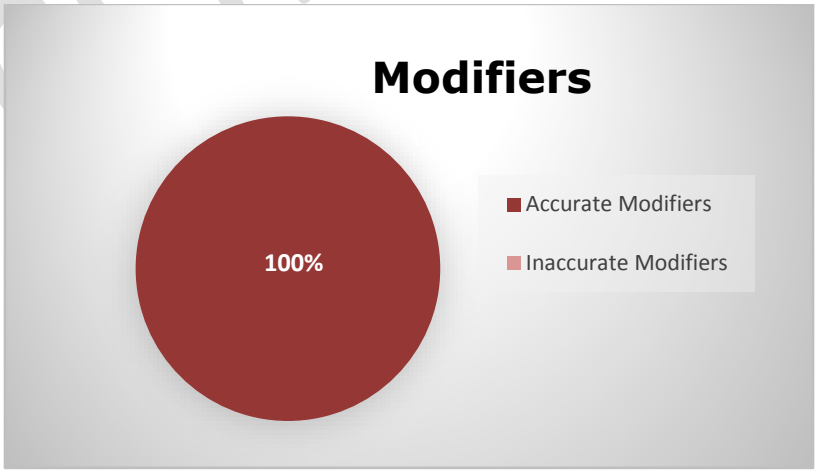
Reason for Transport

Transports from facility to facility are required to provide the reason the patient is being moved, this requires the Prehospital Care Report to clearly indicate the precise treatment, procedure or medical specialist that is available and required at the receiving hospital. There were no hospital to hospital transports included in the Discovery Sample.

Modifiers

Medicare and Medicaid both require origin and destination modifiers for the base rates. Medicaid also requires that providers submit claims for emergency transports with the ET modifier on each procedure code submitted. Any procedure code submitted on the claim from emergency transport without the ET modifier will be subject to prior authorization requirements. All 50 claims reviewed had accurate assignment of modifiers for origin and destination for the claims reviewed. **Figure 7** displays a 100% accuracy rate for the modifiers reviewed in this claims review.

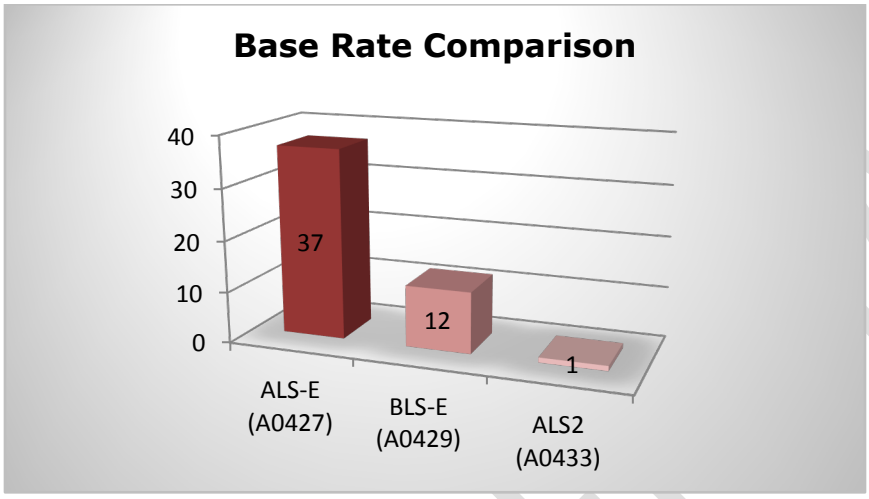
Figure 7: Modifiers Accuracy Percentage



Coding of Charges (Level of Service)

The claims reviewed for this report provided 100 charges associated with 38 Medicare transports and 12 Medicaid transports. The breakdown of the charges were 50 base rates and 50 mileage rates. **Figure 8** below graphically illustrates the base rates billed to the Federal health care provider.

Figure 8: Base Rate Comparison

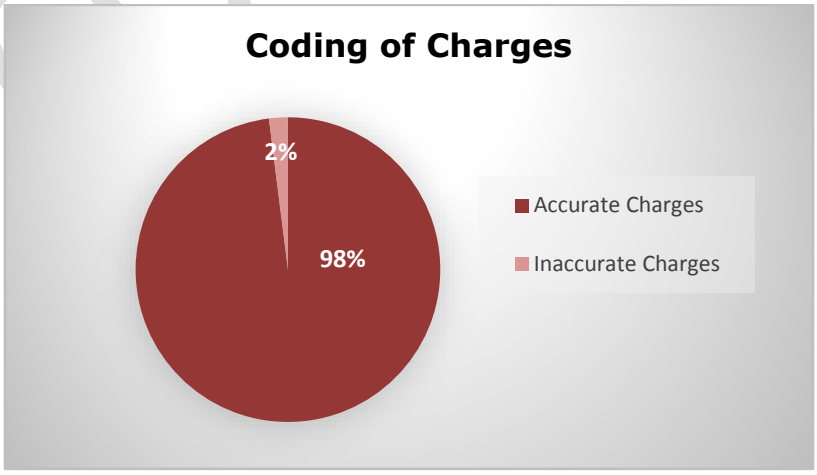


Of the 50 claims reviewed, 49 were deemed accurate for coding of charges. **Figure 9** provides detailed information about the claim deemed inaccurate and **Figure 10** furnishes a graphical representation of the coding of charges percentage accuracy versus error rate.

Figure 9: Coding of Charges

Item #	Account Number	Program	Comments
5	49811704	Medicare	Patient's primary impression is a fever, all vitals were within normal ranges, and this would be a BLS level of service.

Figure 10: Coding of Charges Accuracy Percentage



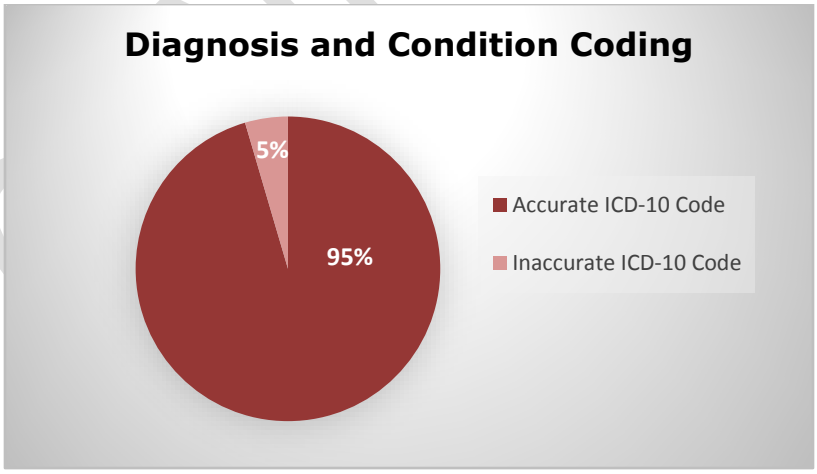
Diagnosis and Condition Coding

Seventy-six (76) Medicare and 24 Medicaid condition/diagnosis codes were utilized in the billing of the 50 claims. The use of acceptable coding is demonstrated in 46 claims reviewed. **Figure 11** breaks down the incorrect ICD codes and **Figure 12**, demonstrates the accuracy rate of 95% for diagnosis and condition coding.

Figure 11: Diagnosis and Condition Coding

Item #	Account Number	Program	Comments
24	50651638	Medicare	R56.9 (Unspecified convulsions) was used as the primary code. The chart notates that convulsions was the dispatch reason, and states that the primary impression is syncope and collapse (R55) which is a more appropriate primary code.
31	50112121	Medicare	I67.89 (Other cerebrovascular disease) was selected as the primary code. Chart specifies the patient has an Altered Mental Status (R41.82) and Hypotension, unspecified (I95.9) either would be more of an appropriate primary code.
38	50527731	Medicare	R69 (Illness, unspecified) was selected for primary, patient was presenting respiratory difficulties, R06.00 (Dyspnea, unspecified) would be a more specific primary code.
45	50176364	Medicare	R69 (Illness, unspecified) was selected for primary, chart stated patient had an Altered Mental Status (R41.82) which would be a more specific primary code.

Figure 12: Diagnosis and Condition Coding Accuracy Percentage



Beneficiary Signatures

Chapter 10, Section 20.1.2 (Beneficiary Signature Requirements) of the Medicare Benefits Policy Manual outlines the specific requirements that must be met for obtaining appropriate patient signatures for

billing ambulance claims to Medicare. The signature of the beneficiary is required for the purposes of submitting claims to Medicare for transport services and for accepting assignment.

If the patient is unable to sign, the reason must be provided in the Prehospital Care Report specifically stating the condition that prevented the patient from signing, and an appropriate alternate signature must be obtained. Ambulance services are often provided to beneficiaries who are mentally or physically incapable of providing their own signatures. When an ambulance provider has a reasonable basis for believing that a beneficiary is physically or mentally incapable of signing the claim at the time of transport, the crew should obtain the signature of an approved authorized representative to include:

- Patient's Legal Guardian
- Patient's Health Care Power of Attorney
- Relative or Other Person Who Received Government Benefits on Behalf of Patient
- Relative or Other Person Who Arranges Treatment of Handles Patient's Affairs
- Representative of an Agency or Institution that Furnished Care, Services or Assistance to Patient

~OR~

- Ambulance Crew and Receiving Facility (when no authorized representative was available and willing to sign.)

A copy of a Signature Form has been included with this report as Attachment D.

Ambulance providers may submit a claim on behalf of a patient despite having been unable to obtain the patient's signature, in reliance on §424.36(b)(1)-(4)(6), under the following conditions: An employee or representative of the institutional provider has signed a form acknowledging: (a) the identity of the patient; (b) the fact that the patient was transported by the specified ambulance provider/supplier to the specified facility on the specified date; and (c) the purpose of the representative's signature is to enable the ambulance provider or supplier to submit a bill for that transport service; and that the beneficiary has received other care, services, or assistance from the institutional provider whose representative signs the form.

Patient signatures were not obtained for three claims where the charts notated that the patient was unable to sign due to being physically or mentally incapable. For these three claims, the crew member signed in the patient representative section of the Prehospital Care Report. The crew member is not classified as a Patient Representative. The crew member can sign Prehospital Care Report if none of the individuals are available or willing to sign on behalf of the beneficiary at the time of transport but this should be completed in a separate section, providing all the conditions listed above are met and other attempts have been exhausted.

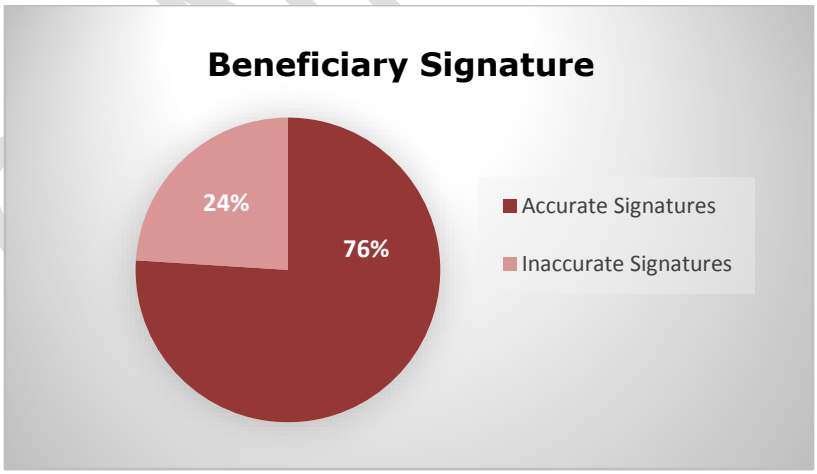
Figure 13 provides a list of nine claims that did not have patient signatures along with the three claims where the crew members signed in the patient representative section of the Prehospital Care Report.

Figure 14 graphically displays a 76% accuracy rate and compliance for beneficiary signature requirements for the claims reviewed.

Figure 13: Beneficiary Signatures

Item #	Account Number	Program	Comments
4	50282724	Medicaid	Patient unable to sign due to mental status. Crew member signed in the Patient Representative section of the Prehospital Care Report.
9	50023308	Medicaid	No patient signature
12	50850689	Medicare	No patient signature
15	49983483	Medicare	Patient unable to sign due to distress level. Crew member signed in the Patient Representative section of the Prehospital Care Report.
16	50661603	Medicare	No patient signature
22	50688158	Medicare	No patient signature
23	50379357	Medicare	No patient signature
26	50369380	Medicare	No patient signature
32	50268902	Medicare	No patient signature
35	50850675	Medicare	Patient unable to sign due to distress level. Crew member signed in the Patient Representative section of the Prehospital Care Report.
45	60176364	Medicare	No patient signature
49	50744419	Medicare	No patient signature

Figure 14: Beneficiary Signature Accuracy Percentage

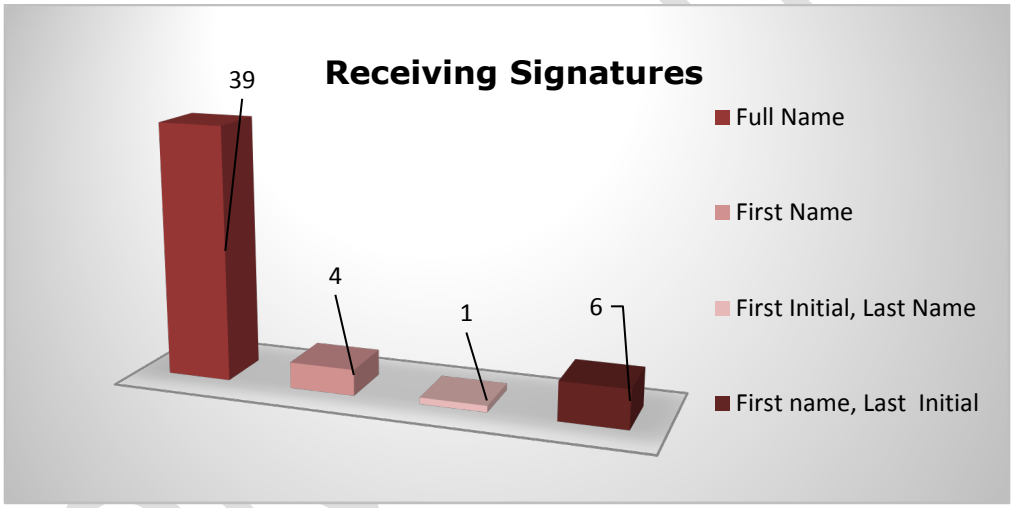


Receiving Facility Signatures

It is best practice to obtain the full name and credentials of the receiving representative. The Prehospital Care Report should provide a signature section for the hospital/receiving agent to verify the transfer of care from the ambulance provider to the facility. The "type of person signing" section of the Prehospital Care Report provided the credential requirements, when "Receiving Nurse" or "ED Tech" were provided. A signature from the receiving facility was obtained on all the claims reviewed, but the accompanied printed version of the signor was not consistent for each claim.

While claims may be supported in other ways, it is best practice to get all appropriate and legible signatures in the chart at the time of transport. **Figure 15** 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 15: Receiving Signature Breakdown



Crew Member Signatures

Medicare requires that services provided be authenticated by the authors. The methods allowed are hand-written or an electronic signature. 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 area of the Prehospital Care Report would determine the identity of the authors of the medical record. Best practice would be to have all crew members that rendered services to the patient sign the Prehospital Care Report.

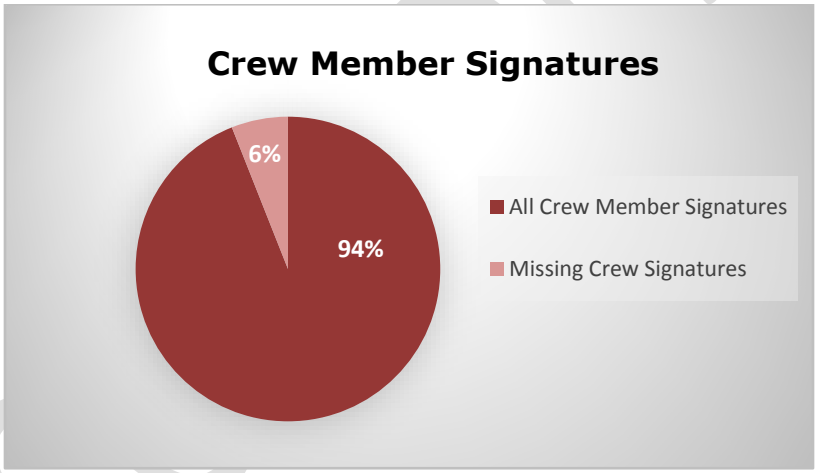
Items 12, 16, 26, and 46 had two crew members listed in the crew member section of the Prehospital Care Report along with two signatures, however, both had the same printed name provided underneath. These 4 claims are not included in the quantified error rates. It is recommended that *EL PASO* take a look at the system to determine what is causing the printed name to appear incorrectly.

Figure 16 presents the claims that did not provide signatures for all crew members on the transport and **Figure 17** reveals the accuracy percentage.

Figure 16: Crew Member Signatures

Item #	Account Number	Comments
6	50009574	Two (2) crew members were listed in the crew member section of the Prehospital Care Report. One signature provided on the Prehospital Care Report. The Conversion Record provided two signatures of the same crew member. The second crew member does not have a signature on either document.
43	50490689	Three (3) crew members were listed in the crew member section of the Prehospital Care Report. Two signatures were provided on the Prehospital Care Report. The Conversion Record only provided two signatures, the same signatures as the Prehospital Care Report.
50	50157568	Three (3) crew members were listed in the crew member section of the Prehospital Care Report. Two signatures were provided on the Prehospital Care Report. The Conversion Record provide three signatures, one out of three provided the printed name of the signor.

Figure 17: Crew Member Signature Accuracy Percentage



Error Quantification

Figure 18 : Error Rate Quantification

Area Reviewed	Error Rate
Mileage	78%
Medical Necessity	0%
Modifiers	0%
Coding of Charges	2%
Diagnoses and Condition Coding	5%
Medicare Beneficiary Signature	24%
Crew Member Signatures	6%

Comparison

Comparing the November 2017 report to this review, the error percentage shows improvement in the areas of Medical Necessity, Modifiers, Coding of Charges, Diagnoses and Condition Coding, and Crew Member Signatures. Mileage and Beneficiary Signatures error rates increased in the 2019 review. It is our intent to identify areas of potential risks for our clients, **Figure 19** provides the comparison table for both of the reviews.

Figure 19 : Error Rate Quantification Comparison

Area Reviewed	November 2017 Error Rate Percentage	May 2019 Error Rate Percentages
Mileage	35%	78%
Medical Necessity	4%	0%
Modifiers	8%	0%
Coding of Charges	4%	2%
Diagnoses and Condition Coding	10.3%	5%
Medicare Beneficiary Signature	8%	24%
Crew Member Signatures	40%	6%

Findings Summary

In the event of an actual audit, the contracted auditor or government agency will make a determination of what they feel is an acceptable range for errors, in part or whole, for those found in a reviewed sample. *FITCH* has seen reported error rates as high as 20% for ambulance services who were reviewed by contracted auditors without the service being placed under a corporate integrity agreement or facing other severe punishment from the Federal authorities. These ambulance services organizations *were* required to refund claims found in error, and in some cases, were also required to pay an additional fine. Additionally, in some of these instances, the ambulance service was placed on pre-payment review of all Medicare or Medicaid claims for a period of time until the auditing agency was able to determine that the errors had be sufficiently addressed and processes created or improved to prevent such in the future.

In instances where an ambulance service has been placed under corporate integrity agreements, the regulating agencies require that claims meet a much more stringent 95% accuracy rate. These services must maintain error rates of less than 5% in sample audits or be subjected to a full sample review. *FITCH* subscribes to the theory that striving to achieve a minimal error rate is the best practice. In doing so, our recommendations for areas of improvement are based upon more strict guidelines found in corporate integrity agreements, or more specifically those with a 5% or greater error rate.

This report acknowledged that Medical Necessity, Modifiers, Coding of Charges, and Diagnoses and Condition Coding had a 5% or less error rate. The areas of Mileage, Beneficiary Signature, and Crew Member Signature, however, had error rates higher than this benchmark and inasmuch could indicate the possibility of more serious issues which might require an increased evaluation of the population of claims. Mileage and Beneficiary Signatures are two areas that are consistently focused upon in Federal and State health care program audits.

- **Mileage:** Medicare requires that patient loaded mileage be reported in fractional miles and billed to the nearest 10^{th} of a mile. After review of the documentation, 6 claims reported fractional mileage on the Prehospital Care Report, those 6 claims billed $1/10^{th}$ of a mile to Medicare. The Prehospital Care Report provided a miles transported section, a majority of the trips were shown as a whole number, and the statistical likelihood that 42 out of 50 transports would end on a whole mile is a low percentage. When the distance between the origin and destination was verified using the online mapping program of Google Maps, a $1/10^{th}$ option was provided in the results, confirming that the likelihood that all those trips would not end on a whole number. It would appear that patient loaded mileage is being rounded to the nearest whole number by crew members completing the chart. Additionally, there is no indication that this is being questioned or verified prior to the submission of the bill. In some instances, for the claims reviewed, the actual patient loaded miles traveled were more than what was billed (due to rounding down), and in other instances the billed amount was for more (rounding up) than what would be considered and accurate reporting. The latter of these is a concern and puts *EL PASO* at risk for overbilling mileage and committing a violation that could result in the need for

refund(s) of charges, and in the event of an audit, could put the organization at risk for fines and/or other penalties. It is our recommendation that *EL PASO* check the mileage configuration on the system to make sure that it is configuring to the 1/10th of a mile as well as review the policies and procedures for reporting actual mileage, and for verifying and billing mileage on Medicare and Medicaid claims.

It is recommended that *EL PASO* review and make immediate improvement in the following areas in order to mitigate risks associated with the reported error rates:

- **Beneficiary Signature:** Medicare requires the signature of the beneficiary for the purpose of accepting assignment and for submitting claims for the transports. 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 Prehospital Care Report. Appropriate signatures must be obtained prior to submitting claims for reimbursement to Medicare. The error rate of 24% shows an area requiring additional focus by the service. Signatures should be obtained for all transports; not just Medicare. Signatures represent authorization to bill, accept assignment and should indicate an acknowledgement that the notice of 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.

- **Crew Member Signature:** Medicare requires that all medical records be authenticated by the author. This requirement is fully met by having all crew members that rendered services to the patient sign the Prehospital Care Report. Each crew member participating in a patient transport has responsibilities including attesting to the duties they performed and the facts reported in the Prehospital Care Report. Failure on behalf of all crew members to review the Prehospital Care Report for accuracy and signing as to their role and responsibility could put the service or crew member(s) at risk for a variety issues including, but not limited to, non-compliance with Federal health care provider rules and regulations. *FITCH* recommends that the processes and software be reviewed to ensure that *EL PASO* is accurately recording the signatures of all caregivers participating in each transport.

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 billing of any claim(s) could be called into question.

EL PASO should remain vigilant in its efforts for providing accurate, objective and thorough reporting of each claim in the Prehospital Care Report. The organization should continue to focus ongoing efforts on maintaining the lowest level of errors through regular quality assurance reviews and ongoing education. Failure to do so could lead to complacency in documentation and billing practices and would be detrimental to the organization in a variety of ways that could be harmful to the service and the community.

Credentials

Anthony Minge, EdD, Fitch & Associates Senior Partner, designed the original plan for the full sampling and reviewed the findings. The curriculum vitae for Anthony 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 #	Account Number	Program Billed	D.O.S.	Mileage	Mileage Correct per Docs?	Reason for Transport Doc'd?	Filed HCPCS Codes	Description	IRO HCPCS If Differs	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	Diagnosis Supported by	ICD-10 Code
1	50490677	CARE	12/02/2018	3.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R53.1
							A0425	Ground Mileage										$45.00	$22.11	$22.11	Y	Z74.3
2	50399474	CARE	11/25/2018	5.0	W	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R07.9
							A0425	Ground Mileage										$75.00	$36.85	$36.85	Y	Z74.3
3	50457976	CAID	11/29/2018	5.0	W	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y	NA	Y	Y	Y	$855.00	$271.02	$271.02	Y	R07.0
							A0425	Ground Mileage										$75.00	$22.37	$22.37	Y	Z99.89
4	50282724	CAID	11/14/2018	2.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y	NA	Y	Y	U	$855.00	$271.02	$271.02	Y	R68.89
							A0425	Ground Mileage										$30.00	$8.95	$8.95		
5	49811704	CARE	10/06/2018	8.0	W	NA	A0427	ALS 1 Emerg	A0429	N	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R53.1
							A0425	Ground Mileage										$120.00	$58.96	$58.96	Y	Z99.89
6	50009574	CARE	10/22/2018	4.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Error	U	$855.00	$416.64	$416.64	Y	R40.1
							A0425	Ground Mileage										$60.00	$29.48	$29.48	Y	Z74.3
7	50295456	CARE	11/16/2018	10.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R11.10
							A0425	Ground Mileage										$150.00	$73.70	$73.70	Y	Z99.89
8	50679614	CARE	12/17/2018	4.0	W	NA	A0429	BLS Emerg		Y	Y	RH	Y	NA	Y	Y	U	$855.00	$350.86	$350.86	Y	L98.429
							A0425	Ground Mileage										$60.00	$29.48	$29.48	Y	Z74.3
9	50023308	CAID	10/25/2018	1.0	W	NA	A0427	ALS 1 Emerg		Y	Y	ETEH	Y	NA	Y	Y	N	$855.00	$271.02	$271.02	Y	R55
							A0425	Ground Mileage										$15.00	$4.47	$4.47		
10	50592635	CARE	12/10/2018	3.0	W	NA	A0427	ALS 1 Emerg		Y	Y	PH	Y	NA	Y	Y	N	$855.00	$416.64	$416.64	Y	F29
							A0425	Ground Mileage										$45.00	$22.11	$22.11	Y	Z99.89

11	49772963	CARE	10/05/2018	2.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R53.1
							A0425	Ground Mileage										$30.00	$14.74	$14.74	Y	Z74.3
12	50850689	CARE	12/31/2018	7.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Error	N	$855.00	$416.64	$416.64	Y	R06.00
							A0425	Ground Mileage										$105.00	$51.59	$51.59	Y	Z74.3
13	50009666	CAID	10/24/2018	8.0	W	NA	A0427	ALS 1 Emerg		Y	Y	ETSH	Y	NA	Y	Y	U	$855.00	$271.02	$271.02	Y	R56.9
							A0425	Ground Mileage										$120.00	$35.80	$35.80	Y	Z74.43
14	49819105	CAID	10/09/2018	1.0	W	NA	A0429	BLS Emerg		Y	Y	ETSH	Y	NA	Y	Y	Y	$855.00	$228.22	$228.22	Y	T14.8XXA
							A0425	Ground Mileage										$15.00	$4.47	$4.47		
15	49983483	CARE	10/22/2018	6.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	U	$855.00	$416.64	$416.64	Y	R06.00
							A0425	Ground Mileage										$90.00	$44.22	$44.22	Y	Z74.3
16	50661603	CARE	12/16/2018	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Error	N	$855.00	$416.64	$416.64	Y	R60.0
							A0425	Ground Mileage										$75.00	$36.85	$36.85		Z99.89
17	50062492	CARE	10/29/2018	12.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R06.00
							A0425	Ground Mileage										$180.00	$88.44	$88.44	Y	Z74.3
18	50411991	CAID	11/26/2018	13.0	N	NA	A0429	BLS Emerg		Y	Y	ETSH	Y	NA	Y	Y	Y	$855.00	$228.22	$228.22	Y	T14.8XXA
							A0425	Ground Mileage										$105.00	$58.17	$58.17		
19	50813472	CARE	12/28/2018	4.0	W	NA	A0429	BLS Emerg		Y	Y	SH	Y	NA	Y	Y	Y	$855.00	$350.86	$350.86	Y	S89.92XA
							A0425	Ground Mileage										$60.00	$29.48	$29.48		
20	50651678	CAID	12/15/2018	5.0	W	NA	A0429	BLS Emerg		Y	Y	ETRH	Y	NA	Y	Y	Y	$855.00	$240.23	$240.23	Y	R07.9
							A0425	Ground Mileage										$75.00	$23.55	$23.55		
21	50553592	CAID	12/07/2018	7.0	W	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y	NA	Y	Y	Y	$855.00	$271.02	$271.02	Y	R10.9
							A0425	Ground Mileage										$105.00	$31.32	$31.32		
22	50688158	CARE	12/18/2018	4.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	N	$855.00	$416.64	$416.64	Y	R41.82

							A0425	Ground Mileage											$60.00	$29.48	$29.48	Y	Z74.3
23	50379357	CARE	11/23/2018	3.0	W	NA	A0433	ALS 2		Y	Y	RH	Y	NA	Y	Y	N		$855.00	$603.04	$603.04	Y	I46.9
							A0425	Ground Mileage											$45.00	$22.11	$22.11	Y	Z99.89
24	50651638	CARE	12/14/2018	4.6	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y		$855.00	$416.64	$416.64	N	R56.9
							A0425	Ground Mileage											$75.00	$33.90	$33.90	Y	Z74.3
25	50744390	CAID	12/22/2018	10.0	W	NA	A0427	ALS 1 Emerg		Y	Y	ETRh	Y	NA	Y	Y	Y		$855.00	$271.02	$271.02	Y	R06.00
							A0425	Ground Mileage											$150.00	$44.75	$44.75		
26	50369380	CARE	11/22/2018	2.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Error	N		$855.00	$416.64	$416.64	Y	K92.0
							A0425	Ground Mileage											$30.00	$14.74	$14.74	Y	Z74.3
27	50601506	CARE	12/11/2018	4.0	W	NA	A0429	BLS Emerg		Y	Y	SH	Y	NA	Y	Y	Y		$855.00	$350.86	$350.86	Y	R42
							A0425	Ground Mileage											$60.00	$29.48	$29.48	Y	Z74.3
28	50062476	CAID	10/29/2018	0.0	N	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y	NA	Y	Y	Y		$855.00	$271.02	$271.02	Y	R56.9
							A0425	Ground Mileage											$15.00	$4.47	$4.47		
29	49983465	CARE	10/21/2018	6.0	W	NA	A0429	BLS Emerg		Y	Y	RH	Y	NA	Y	Y	Y		$855.00	$350.86	$350.86	Y	R51
							A0425	Ground Mileage											$90.00	$44.22	$44.22	Y	Z74.3
30	49721320	CARE	10/02/2018	2.8	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y		$820.00	$416.64	$416.64	Y	R07.9
							A0425	Ground Mileage											$45.00	$20.64	$20.64	Y	Z74.3
31	50112121	CARE	11/01/2018	11.1	Y	NA	A0427	ALS 1 Emerg		Y	Y	SH	Y	NA	Y	Y	U		$855.00	$416.64	$416.64	N	I67.89
							A0425	Ground Mileage											$180.00	$81.81	$81.81	Y	Z74.3
32	50268902	CARE	11/14/2018	10.0	N	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y	NA	Y	Y	N		$855.00	$416.64	$416.64	Y	R06.89
							A0425	Ground Mileage											$150.00	$73.70	$73.70	Y	Z99.89
33	50073941	CARE	10/29/2018	11.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y		$855.00	$416.64	$416.64	Y	R07.9
							A0425	Ground Mileage											$165.00	$81.07	$81.07	Y	Z74.3

34	50735758	CARE	12/20/2018	0.5	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R03.0
							A0425	Ground Mileage										$15.00	$3.69	$3.69	Y	Z99.89
35	50850675	CARE	12/31/2018	5.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	U	$855.00	$416.64	$416.64	Y	R41.82
							A0425	Ground Mileage										$60.00	$29.48	$29.48	Y	Z74.3
36	49950418	CARE	10/19/2018	7.0	W	NA	A0427	ALS 1 Emerg		Y	Y	SH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R73.09
							A0425	Ground Mileage										$105.00	$51.59	$51.59	Y	Z74.3
37	50243332	CARE	11/12/2018	2.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	U	$855.00	$416.64	$416.64	Y	R69
							A0425	Ground Mileage										$30.00	$14.74	$14.74	Y	Z74.3
38	50527731	CARE	12/04/2018	3.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	U	$855.00	$416.64	$416.64	N	R69
							A0425	Ground Mileage										$45.00	$22.11	$22.11	Y	Z74.3
39	50233426	CARE	11/11/2018	4.0	W	NA	A0429	BLS Emerg		Y	Y	RH	Y	NA	Y	Y	U	$855.00	$350.86	$350.86	Y	R10.9
							A0425	Ground Mileage										$60.00	$29.48	$29.48	Y	Z99.89
40	50805815	CAID	12/27/2018	1.0	W	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y	NA	Y	Y	Y	$855.00	$285.28	$285.28	Y	T14.8XXA
							A0425	Ground Mileage										$15.00	$4.71	$4.71		
41	49795604	CARE	10/06/2018	5.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R11.0
							A0425	Ground Mileage										$75.00	$36.85	$36.85	Y	Z74.3
42	50009633	CARE	10/24/2018	3.0	Y	NA	A0429	BLS Emerg		Y	Y	SH	Y	NA	Y	Y	Y	$855.00	$350.86	$350.86	Y	S49.91XA
							A0425	Ground Mileage										$45.00	$22.11	$22.11	Y	Z74.3
43	50490689	CARE	12/02/2018	8.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Error	U	$855.00	$416.64	$416.64	Y	R55
							A0425	Ground Mileage										$120.00	$58.96	$58.96	Y	Z74.3
44	50145682	CAID	11/03/2018	2.0	Y	NA	A0429	BLS Emerg		Y	Y	ETEH	Y	NA	Y	Y	Y	$855.00	$228.22	$228.22	Y	R50.9
							A0425	Ground Mileage										$30.00	$8.95	$8.95		
45	50176364	CARE	11/06/2018	2.2	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	N	$855.00	$416.64	$416.64	N	R69

							A0425	Ground Mileage										$45.00	$16.21	$16.21	Y	Z74.3
46	50019271	CARE	10/25/2018	3.5	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y	NA	Y	Error	Y	$855.00	$350.86	$350.86	Y	R53.1
							A0425	Ground Mileage										$60.00	$25.80	$25.80	Y	Z74.3
47	50565303	CARE	12/08/2018	5.0	W	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R07.9
							A0425	Ground Mileage										$75.00	$36.85	$36.85	Y	Z74.3
48	50673043	CARE	12/17/2018	2.5	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y	NA	Y	Y	Y	$855.00	$416.64	$416.64	Y	R07.9
							A0425	Ground Mileage										$45.00	$18.43	$18.43	Y	Z74.3
49	50744419	CARE	12/21/2018	6.0	N	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y	NA	Y	Y	N	$855.00	$416.64	$416.64	Y	S09.90XA
							A0425	Ground Mileage										$90.00	$44.22	$44.22	Y	Z99.89
50	50157568	CARE	11/05/2018	2.0	W	NA	A0429	BLS Emerg		Y	Y	SH	Y	NA	Y	Error	Y	$855.00	$350.86	$350.86	Y	S01.91XA
							A0425	Ground Mileage										$30.00	$14.74	$14.74	Y	Z74.3

Attachment B

RAT STATS Printout

FITCH
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Windows RAT-STATS
Statistical Software
Random Number Generator

Date:	3/10/2019	**Time:**	14:47	**Seed Number**	**Frame Size**
Audit:	El Paso Oct-Dec 2018 Claims Sample			53222.96	1,840

Order	**Value**	**Account Number**	**Incident Number**	**Date of Service**
25	36	50744390	18-0082685	12/22/2018
13	46	50009666	18-0069350	10/24/2018
21	65	50553592	18-0079199	12/07/2018
3	99	50457976	18-0077546	11/29/2018
40	122	50805815	18-0083891	12/27/2018
18	152	50411991	18-0076751	11/26/2018
4	195	50282724	18-0074251	11/14/2018
9	227	50023308	18-0069736	10/25/2018
28	231	50062476	18-0070556	10/29/2018
20	283	50651678	18-0081145	12/15/2018
44	392	50145682	18-0071779	11/03/2018
14	407	49819105	18-0066024	10/09/2018
23	459	50379357	18-0076124	11/23/2018
2	485	50399474	18-0076567	11/25/2018
38	493	50527731	18-0078687	12/04/2018
17	528	50062492	18-0070483	10/29/2018
33	544	50073941	18-0070505	10/29/2018
32	567	50268902	18-0074045	11/14/2018
7	570	50295456	18-0074526	11/16/2018
5	608	49811704	18-0065452	10/06/2018
43	620	50490689	18-0078206	12/02/2018
36	635	49950418	18-0068230	10/19/2018
49	710	50744419	18-0082534	12/21/2018
27	715	50601506	18-0080226	12/11/2018
41	737	49795604	18-0065370	10/06/2018
16	804	50661603	18-0081271	12/16/2018
24	822	50651638	18-0080973	12/14/2018
6	847	50009574	18-0068862	10/22/2018
1	982	50490677	18-0078175	12/02/2018
10	993	50592635	18-0080089	12/10/2018
30	1010	49721320	18-0064328	10/02/2018
45	1023	50176364	18-0072347	11/06/2018
11	1035	49772963	18-0065088	10/05/2018
37	1057	50243332	18-0073612	11/12/2018
26	1064	50369380	18-0075985	11/22/2018
34	1193	50735758	18-0082348	12/20/2018
31	1278	50112121	18-0071286	11/01/2018
29	1287	49983465	18-0068779	10/21/2018
39	1391	50233426	18-0073477	11/11/2018
8	1401	50679614	18-0081597	12/17/2018

19	1407	50813472	18-0084113	12/28/2018
12	1450	50850689	18-0084865	12/31/2018
15	1493	49983483	18-0068832	10/22/2018
50	1526	50157568	18-0072079	11/05/2018
47	1557	50565303	18-0079465	12/08/2018
35	1564	50850675	18-0084769	12/31/2018
22	1621	50688158	18-0081754	12/18/2018
48	1677	50673043	18-0081498	12/17/2018
46	1789	50019271	18-0069535	10/25/2018
42	1796	50009633	18-0069316	10/24/2018

Order	Value	Spares		
		Account Number	Incident Number	Date of Service
51	300	49785015	18-0065244	10/05/2018
52	225	49935015	18-0067927	10/18/2018
53	1082	50666019	18-0081419	12/16/2018
54	771	50307455	18-0069729	10/25/2018
55	679	50176331	18-0072392	11/06/2018
56	1545	49789536	18-0065445	10/06/2018
57	1768	50527704	18-0078777	12/05/2018
58	563	50047620	18-0070249	10/28/2018
59	1285	49935046	18-0067955	10/18/2018
60	474	50282732	18-0074147	11/14/2018

Attachment C

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

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

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

- Provides 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
- Develops 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

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
- "Fiscal Things That Can Go Bump in the Night", The Leadership Edge – EMS!.com, March 21, 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

Attachment D

Signature Form

Ambulance Signature Form

Patient Name: _____ Transport Date: _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf **[ABC]** for any services provided to me by **[ABC]** now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by **[ABC]**, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to **[ABC]** any payments that I receive directly from the insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **[ABC]**. I authorize **[ABC]** to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to **[ABC]** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **[ABC]**, now, in the past, or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received **[ABC]** Notice of Privacy Practices.

SIGNATURE SECTION:

ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X_____ _____
Patient Signature or Mark Date

If the patient signs with an ''X" or other mark, someone should sign below as a witness. This can be an ambulance crew member.

X_____ _____
Witness Signature Date

_____
Witness Printed Name

NOTE: If the patient is a minor, the parent or legal guardian should sign in this section.

SECTION II–AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

- ☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
- ☐ Relative or other person who received government benefits on behalf of patient
- ☐ Relative or other person who arranges treatment or handles the patient's affairs
- ☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered to the patient.

X_____ _____ _____
Representative Signature Date Printed Name of Representative

_____
Representative Address

SECTION III – AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and** (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

1. Reason patient is incapable of signing:_____
2. Name and Location of Receiving Facility:_____ Time at Receiving Facility:_____

X_____ _____ _____
Signature of Crewmember Date Printed Name of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility on the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

X_____ _____ _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Rep

C. If personnel is unable or unwilling to sign obtain hospital face sheet or Physician/RN can sign the run report.


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& ASSOCIATES