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Professional Claims Review

CONFIDENTIAL

City of El Paso

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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. Curriculum Vitae

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 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, 2019 to December 31, 2019 for which *EL PASO* reportedly received reimbursement from the Federal health care programs of Medicare and Medicaid. The information provided indicated a population of 2,146 paid Medicare and Medicaid claims. This information was identified and provided by *EL PASO* and/or their contracted billing agent, *R1 RCM*.

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 trips that occurred during the time-period of October 1, 2019 to December 31, 2019. In this case, the Sampling Frame for Medicare and Medicaid represents 2,146 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 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 2,146 claims reported to be reimbursed by Medicare and Medicaid. Of the 50 claims, 49 qualified for inclusion in the Discovery Sample(s), thus one spare was required to be utilized for the completion of this review.

Source of Data

For this review, 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 *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 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

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 acknowledged 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, 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 establish whether claims submitted for reimbursement to Federal and State health care programs were appropriate, presented proper documentation, and were correctly billed and paid.

Each claim was independently reviewed, and a worksheet 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 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 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 and incident 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 extensive inspection of elements was performed and recorded in the review of the 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 health care providers:

- Assigned Item Number
- Patient Name
- Account Number
- Incident 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

FITCH staff members examined 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 audited 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 or State health care program. Of the initial 50 claims identified, all 49 items met the criteria for inclusion in the review. One (1) spare was utilized to complete this report.

Each claim was reviewed and compared to the Hospital 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 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 one spare would be required to complete this claims review.

Figure 1: Spares

Item #	Original Account Number	Utilized Account Number	Comments
15	54828856	55177644	No payment received from Federal or State health care provider.

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 41 Medicare claims had mileage billed to the 1/10th of a mile.

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. Only mileage for which the patient was onboard and in transit to the hospital are considered billable miles.

The "Dest. Odom" reported on the Hospital 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. There were inconsistencies in how the miles were provided on the Hospital Care Report. Some charts had to be calculated manually, taking the scene odometer reading minus the destination odometer reading to calculate the actual miles traveled with the patient on board. Other charts had the scene odometer set to zero, with the total miles provided in the destination odometer section of the chart. To avoid confusion and improve accuracy in billing, consistency in supplied mileage is recommended.

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 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. **Figure 2** furnishes the shortest distance between origin and destination discrepancies as well as under billing of mileage.

Figure 2: Mileage Distance Inaccuracies

Item #	Account Number	Payor	Comments
29	54539137	Medicare	The chart shows 10 miles billed to Medicare; Google maps shows 4.8, 4.6, and 4.7.
33	54470738	Medicaid	The chart shows 4 miles billed to Medicaid, Google maps shows 8.2, 9.2, and 13.2

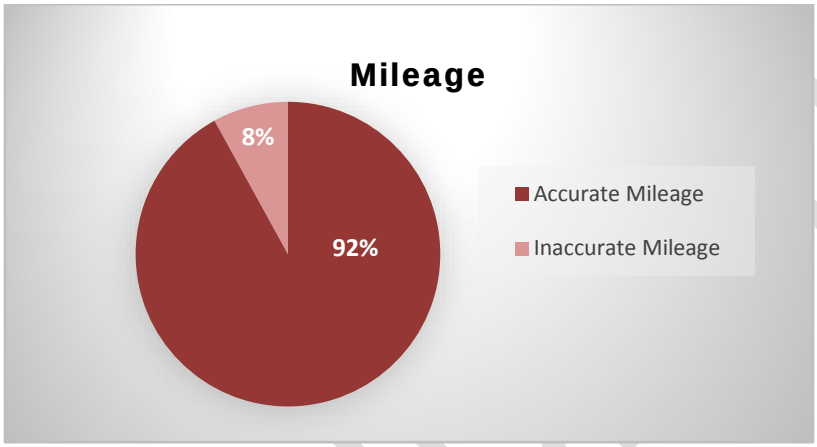
The Medicaid Ambulance Service Handbook states that mileage reported on the claim to be the actual mileage traveled. After review of the documentation of the 9 claims billed to Medicaid, 2 claims were deemed inaccurate, **Figure 3** provides the details of those two claims.

Figure 3: Medicaid Mileage Discrepancies

Item #	Account Number	Payor	Comments
19	55277240	Medicaid	Chart shows mileage to be 2.9, the EOB shows 3 miles billed to Medicaid.
50	54586355	Medicaid	Chart shows mileage to be 0.6, the EOB shows 1 mile billed to Medicaid.

Figure 4 below displays the graphically illustration of the mileage accuracy percentage rate for Figure 2 and Figure 3 above.

Figure 4: Mileage Accuracy Percentage for Figure 2 and Figure 3.



After examination of the documentation and review of the mapping program, it was found that the mileage on the Hospital Care Report did not match the mileage that was submitted to the Federal and State health care programs on 17 claims. The mileage stated on the Hospital Care Report was incorrect, it was confirmed that the mileage submitted to the Federal or State health care provider was accurate, when compared to the mapping program. Although the billing company appears to be making the appropriate verification of mileage, it causes an inconsistency in the records and could create a problem if the biller did not consistently check for accurate mileage. This is a training issue that should be addressed immediately.

Sixteen (16) of the 50 transports record mileage as a whole number. 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. This is a decrease of whole number transports compared to the claims review completed in May 2019, but *FITCH* still identifies this as a potentially severe compliance issue and 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. *EL PASO* should also review the process for recording and billing mileage to the nearest 1/10th of a mile and determine why the Hospital Care Report mileage is inaccurate. This will help determine how to correct the issue to document the patient loaded mileage accurately.

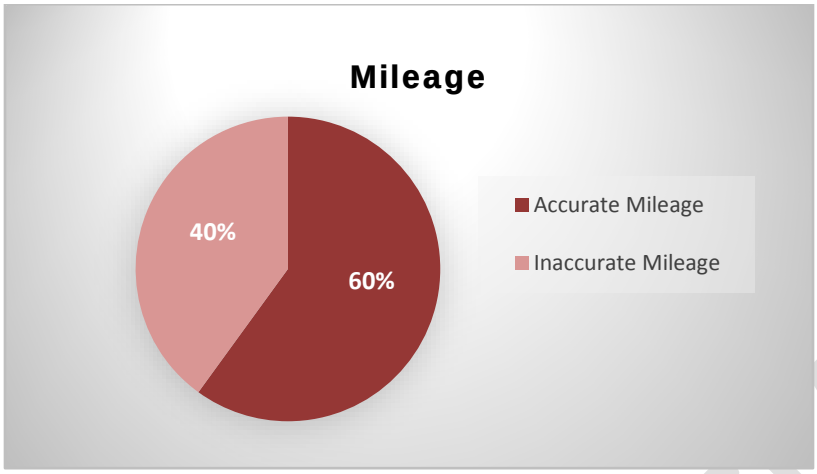
Figure 5 provides a list of the claims that ended the transport in a whole mile, and gives the distance verified using the mapping system information.

Figure 5: Other possible mileage issues

Item #	Account Number	Payor	Mileage Billed	Comments
1	54773451	Medicaid	11	Google maps shows 6.9 & 7.9
5	54491821	Medicare	2	Google maps shows 1.1
10	55078923	Medicare	10	Google maps shows 10.5, 9.4 & 12.3
14	54815742	Medicare	5	Google maps shows 3.7, 4.7 & 4.2
15	55177644	Medicare	5	Google maps shows 6.6, 4.8 & 8.1
19	55277240	Medicaid	3	Google maps shows 2.8, 3.2, & 2.9
22	54984172	Medicare	3	Google maps shows 3.7, 3.9 & 4.2
21	54722254	Medicare	8	Google maps shows 6.3. 6.0 & 6.2
25	55361855	Medicare	9	Google maps shows 8.8, 9.8 & 10.8
28	54722289	Medicaid	1	Google maps shows 0.9
32	55202885	Medicare	4	Google maps shows 5.1, 6.4, & 10.9
34	55164330	Medicare	11	Google maps shows 11.9, 11.5
40	54431925	Medicare	9	Google maps shows 9.3
42	55190326	Medicare	3	Google maps shows 2.4, 2.3 & 2.6
44	55450216	Medicare	2	Google maps shows 1.3
47	54599143	Medicare	4	Google maps shows 5.5, 4.5 & 5.3

Figure 6 provides an overall percentage for Figure 2, Figure 3, and Figure 5 above.

Figure 6: Total Mileage Accuracy Percentage for Figures 2, 3 and 5

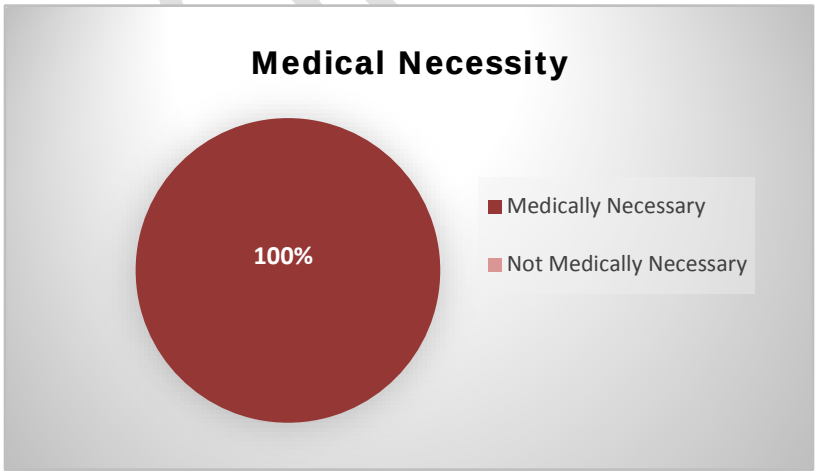


Medical Necessity

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.

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 50 Medicare and Medicaid claims reviewed for this report, all were deemed to support medical necessity. **Figure 7** displays the 100% accuracy rate for medical necessity of the claims reviewed.

Figure 7: Medical Necessity Accuracy Percentage



Reason for Transport

There was no hospital to hospital transports included in the Discovery Sample. Transports from facility to facility are required to provide the reason the patient is being moved. This requires the Hospital Care Report to clearly indicate the precise treatment, procedure or medical specialist that is available and required at the receiving hospital. No trips in this review required that level of detail. It is important to remember that all trips, however, should appropriately record the signs and symptoms for which the patient is being treated and transported. This is addressed later in this report.

Modifiers

Modifiers identifying the place of origin and destination of the ambulance trip must be submitted on all ambulance claims. Non-covered service modifiers are used in the third and fourth modifier position on a claim. The non-covered service modifiers are GA, GY, GZ and GX. These modifiers are used when the services provided are not covered by Medicare and are often referred to as "billing for denial".

Medicaid requires that providers present 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.

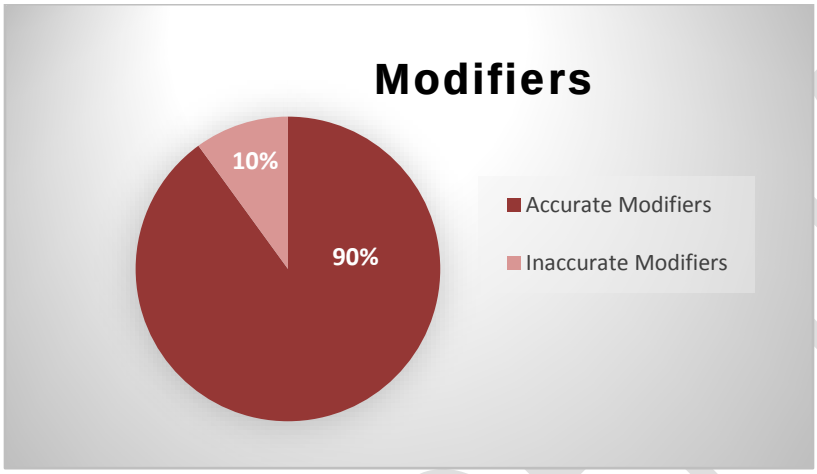
Five (5) of the 50 Medicare and Medicaid claims reviewed had an inaccurate modifier assignment for the place of origin. **Figure 8** explains the reason behind the modifier inaccuracies and **Figure 9** displays a 90% accuracy rate for the modifiers reviewed in this claims review.

Figure 8: Inaccurate Modifiers

Item #	Account Number	Payor	Comments
16	55348323	Medicare	The modifiers billed were EH (Residential, domiciliary, or custodial facility to Hospital). The patient was picked up at from a Rehabilitation Center. Rehabilitation services for the rehabilitation of injured, disable or sick persons, is classified under Skilled Nursing Facility (NH).
22	54984172	Medicare	The modifiers billed were EH (Residential, domiciliary, or custodial facility to Hospital). The facility services are rehabilitation and skilled nursing for the residents. This would be classified as Skilled Nursing Facility (NH).
26	54861458	Medicare	The modifiers billed were EH (Residential, domiciliary, or custodial facility to Hospital). The facility is a 120-bed skilled nursing home. This would be classified as Skilled Nursing Facility (NH).
34	55164330	Medicare	The modifier billed was RH (Residence to Hospital). The pickup location was a residence but not the patient's residence. The correct modifiers are SH (Scene to Hospital).
41	55361826	Medicare	Original modifier GY was utilized for this transport. If this transport was deemed that the services provided were not covered by Medicare, the GY

Item #	Account Number	Payor	Comments
			modifier should be used in the third and fourth position. The modifiers would have been RHGY. After review of the chart, it was deemed that the services provided were medically necessary and should have been billed to Medicare with the RH modifiers to receive payment for the transport.

Figure 9: Modifiers Accuracy Percentage



Coding of Charges (Level of Service)

The claims reviewed for this report provided 100 charges associated with 41 Medicare transports and 9 Medicaid transports. The breakdown of the charges were 50 base rates and 50 mileage rates. **Figure 10** below graphically illustrates the base rates billed to the Federal health care provider and **Figure 11** details the State health care provider breakdown.

Figure 10: Medicare Base Rate Comparison

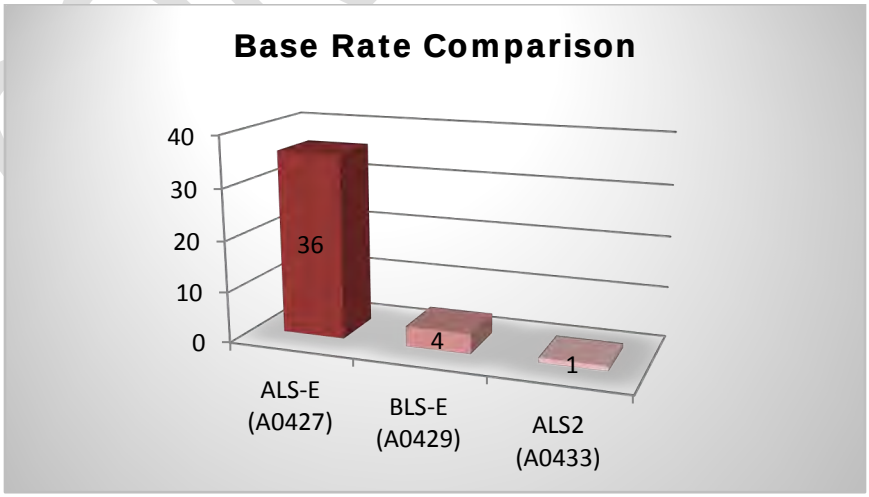
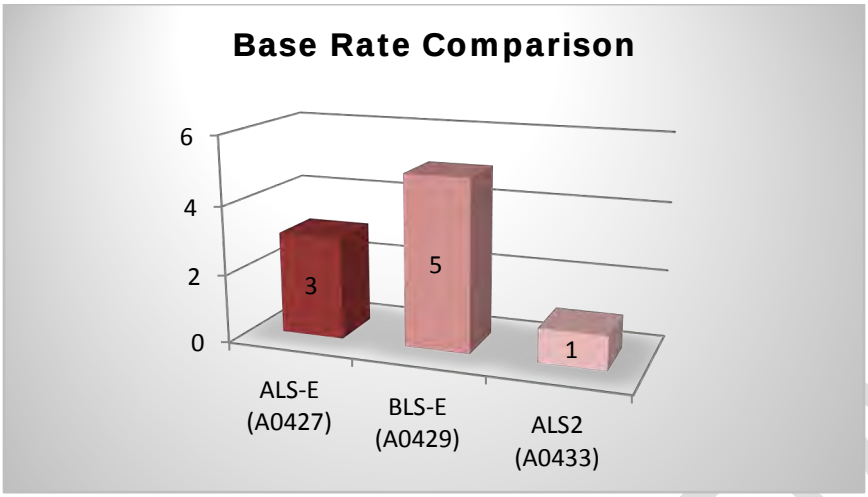


Figure 11: Medicaid Base Rate Comparison

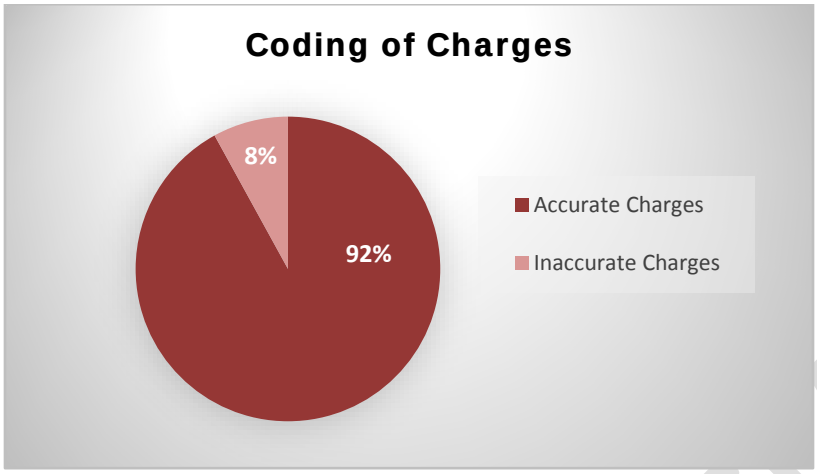


Of the 50 claims reviewed, 4 were deemed inaccurate for coding of charges. **Figure 12** provides detailed information about the claims deemed inaccurate and **Figure 13** furnishes a graphical representation of the accuracy percentage of the coding of charges versus the error rate. *Item 1* would be considered "upcoding" and would be recouped in an actual audit. *Item 41* would have also been "upcoding" except the GY modifier was utilized in error, so no payment was received for this transport.

Figure 12: Coding of Charges

Item #	Account Number	Program	Original HCPSP Code	Correct HCPCS Code	Comments
1	54773451	Medicaid	A0427	A0429	Suspected fracture/dislocation is a BLS level of service.
8	54443367	Medicare	A0429	A0427	Hemorrhage, active post-surgical bleeding is an ALS level of service.
30	54625881	Medicaid	A0429	A0427	Difficulty breathing is an ALS level of service.
41	55361826	Medicare	A0427	A0429	Suspected fracture/dislocation is a BLS level of service.

Figure 13: Coding of Charges Accuracy Percentage

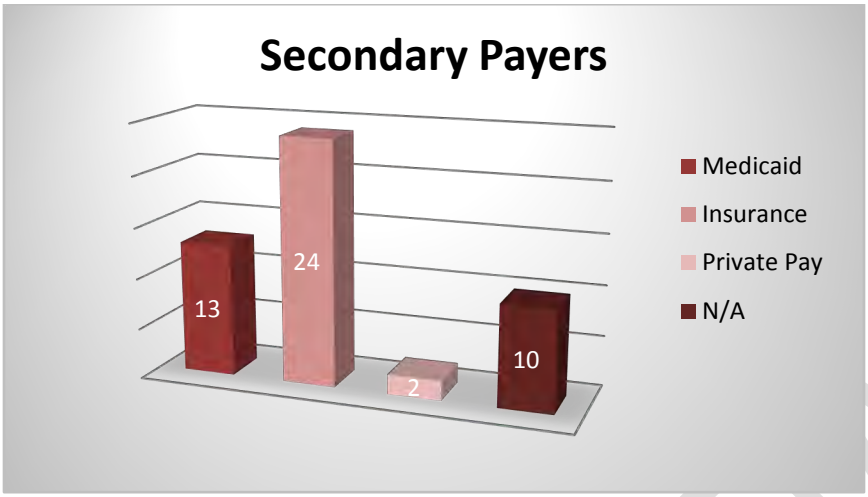


Secondary Payor Source

Medicare reimburses for EMS services based off of a published fee schedule. The fee schedule dictates the amount a service is "allowed" to collect with any amounts above that being considered a contractual amount that is uncollectable. Medicare reimburses 80% of the published rate and, with limited exceptions, requires that the coinsurance (20% balance) be billed to a secondary insurance or the Medicare Beneficiary. The secondary insurance may pay for some, or all, of the 20% coinsurance for Part-B covered services. It is a requirement that a reasonable effort be made to collect Medicare coinsurance balances in full. In all instances Medicare's allowed amount was billed correctly to the secondary payor or the guarantor for all claims requiring such in this review.

Medicaid, like Medicare is reimbursed at a published fee schedule rate. However, as Medicaid is considered a payor of last resort, there is no coinsurance or billable balance for secondary payers or to the patient. Any amount billed above the published fee schedule is a required contractual adjustment. "N/A" was utilized in this report to represent Medicaid claims which would not have a secondary billing requirement. **Figure 14** breaks down the different types of secondary payers used for this review.

Figure 14: Secondary Payer Breakdown



Diagnosis and Condition Coding

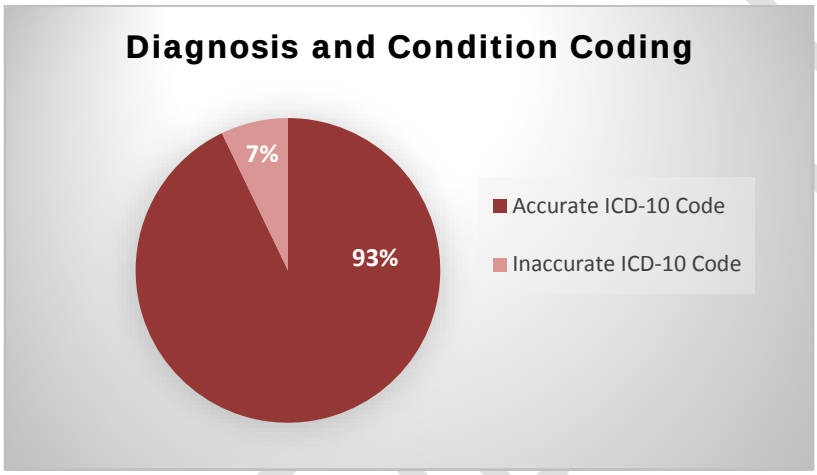
Ninety-eight (98) condition/diagnosis codes were utilized in the billing of the 50 claims. The use of acceptable coding is demonstrated in 44 claims reviewed. **Figure 15** breaks down the ICD-10 codes that were deemed inaccurate or could have had a more definitive code assigned for the condition(s) charted. **Figure 16** demonstrates the accuracy rate of 93% for diagnosis and condition coding.

Figure 15: Diagnosis and Condition Coding

Item #	Account Number	Program	Comments
10	55078923	Medicare	Primary code R07.9 (Chest Pain, unspecified) was the dispatch reason for the call. The chart notates that the patient is not experiencing any pain during the assessment exam. The crew notated R06.02 (Shortness of Breath) as the primary symptom in the patient condition section of the chart. This would be a more appropriate primary code.
17	54410501	Medicare	I44.0 (Atrioventricular Block, First Degree) was provided for the primary code, which was pulled from the EKG reading, the signs and symptoms for this transport would be the chest pain (R07.9) notated in the chart.
37	55518862	Medicare	I67.89 (Other Cerebrovascular Disease) was selected for the primary code. Elevated Blood Glucose Level (R73) would have been a more specific primary code for this transport.
39	54512546	Medicare	R03.0 (Elevated Blood Pressure reading, without Diagnosis of Hypertension) would be a more appropriate primary code than R53.1 (Weakness). The secondary code Z76.89 (Person Encountering Health Services in other specified circumstances) is not from the dual diagnoses list provided by Medicare. Z74.3 (Need for Continuous Supervision) would be the appropriate secondary code to denote cardiac monitoring required in route.

Item #	Account Number	Program	Comments
41	55361826	Medicare	The secondary code Z76.89 (Person Encountering Health Services in Other Specified Circumstances) is not from the dual diagnoses list provided by Medicare. Z74.3 (Need for Continuous Supervision) would be the appropriate secondary code to denote cardiac monitoring required in route.
43	54378381	Medicare	Primary code R06.82 (Tachypnea, not Elsewhere Classified) was utilized for the primary code, which was not notated in the chart. R53.1 (Weakness) was the primary impress from the crew and would be a more appropriate primary code.

Figure 16: Diagnosis and Condition Coding Accuracy Percentage



Beneficiary Signatures

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

Ambulance services are often provided to beneficiaries who are mentally or physically incapable of providing their own signatures. If the patient is unable to sign, the reason must be provided in the Hospital Care Report specifically saying the condition that prevented the patient from signing, and an appropriate alternate signature must be obtained. For this claims review, there were 16 beneficiaries that were unable to sign the Hospital Care Report, 15 provided the reason the patient was unable to sign as well as an alternative signature.

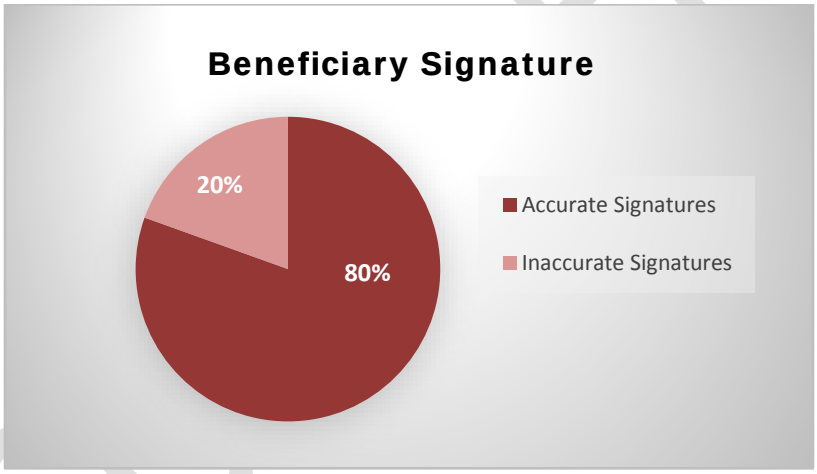
Figure 17 provides a list of the 8 claims that did not have patient signatures on the Hospital Care Report or provide the reason the patient was unable to sign the patient care report.

Figure 17: Beneficiary Signatures

Item #	Account Number	Program	Comments
2	55327397	Medicare	No patient signature
5	54491821	Medicare	No patient signature
14	54815712	Medicare	No patient signature
17	54410501	Medicare	No patient signature
20	55196707	Medicare	No patient signature
29	54539137	Medicare	No patient signature
33	54470738	Medicare	No patient signature
40	54431925	Medicare	Patient unable to sign, no reason provided in the patient representative section of the chart, an alternative signature was obtained.

Figure 18 graphically displays an 80% accuracy rate and compliance for beneficiary signature requirements for the claims reviewed.

Figure 18: Beneficiary Signature Accuracy Percentage

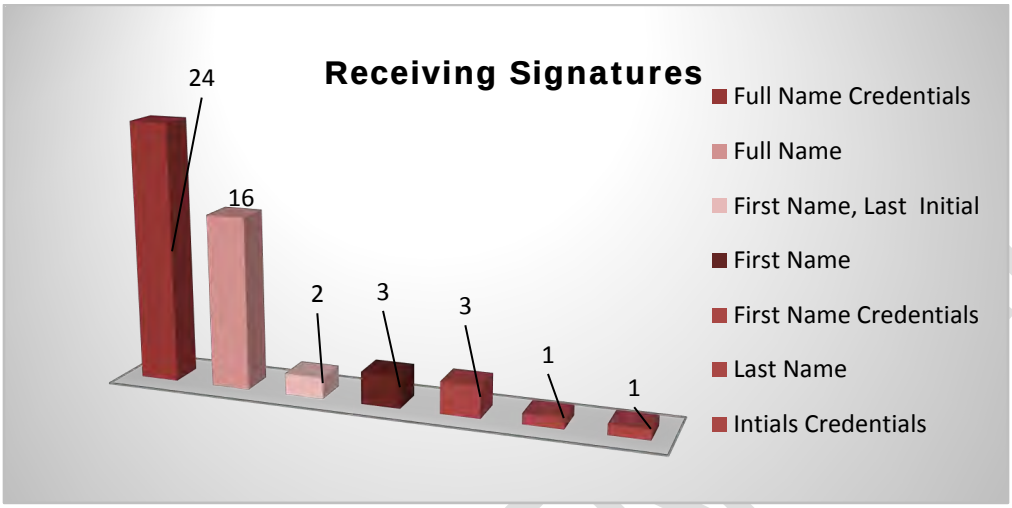


Receiving Facility Signatures

The Hospital 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. It is best practice to obtain the signature, full printed name, and credentials of the receiving representative. A signature from the receiving facility was obtained on 47 of the 50 claims reviewed. 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.

Figure 19 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 19: Receiving Signature Breakdown



Crew Member Signatures

One of the top issues for 2019 was crew member signatures; failure to obtain signature of all members reported in the chart. 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 area of the Hospital 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 Hospital Care Report.

Multiple crew members were assigned to some of these transports and mostly like do not need to have signed the Hospital Care Report if they did not provide patient care. *FITCH* notes these to bring *EL PASO's* attention that in the event additional crew members responding to the call provide any level of care, such should be documented, and the signature of that providing crew member be obtained in the Hospital Care Report.

Figure 20 shows the claims that did not provide signatures for all crew members on the transport.

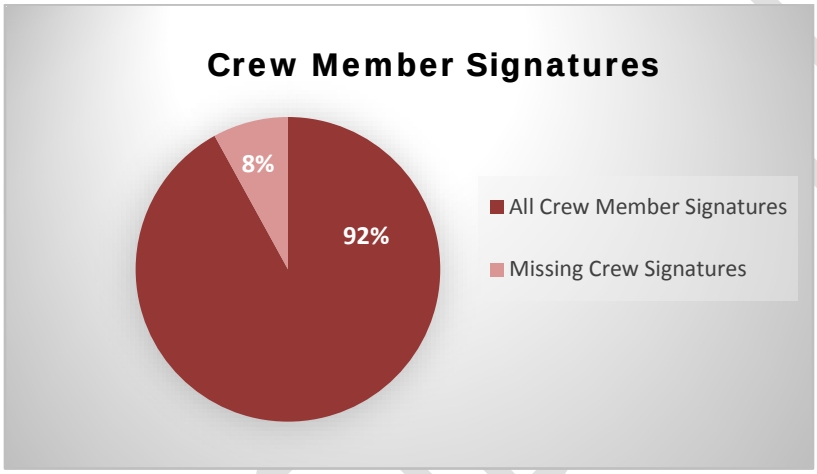
Figure 20: Crew Member Signatures

Item #	Account Number	Comments
13	54392090	Two (2) crew members were listed in the crew member section of the Hospital Care Report. One signature provided on the Hospital Care Report.

Item #	Account Number	Comments
22	54984172	Five (5) crew members were listed in the crew member section of the Hospital Care Report. Two signatures were provided on the Hospital Care Report.
25	55361855	Three (3) crew members were listed in the crew member section of the Hospital Care Report. Two signatures were provided on the Hospital Care Report.
38	54688108	Three (3) crew members were listed in the crew member section of the Hospital Care Report. Two signatures were provided on the Hospital Care Report.

Figure 21 displays the crew member signature accuracy percentage.

Figure 21: Crew Member Signature Accuracy Percentage



Error Quantification

Figure 22: Error Rate Quantification

Area Reviewed	Error Rate
Mileage	40%
Medical Necessity	0%
Modifiers	10%
Coding of Charges	8%
Diagnoses and Condition Coding	7%
Medicare Beneficiary Signature	20%
Crew Member Signatures	8%

Findings Summary

FITCH sets a benchmark of a 5% error rate. Any areas found to be in excess of that amount should be the focus of immediate examination and address, to include if necessary, additional and/or remedial training of clinical and/or billing staff. This aggressive goal is based upon the guidelines for acceptable error levels set by the Office of Inspector General when a service has been placed under a corporate integrity agreement (CIA). While EL PASO is not under such, it is important to maintain the highest levels of compliance at all times. For this report, Medical Necessity was the only area that had an error rate of less than 5%. The areas of Mileage, Modifiers, Coding of Charges, Diagnoses and Condition Coding, Beneficiary Signature, and Crew Member Signature had error rates higher than 5% and inasmuch could indicate the possibility of more serious issues which might require an increased evaluation of the population of claims.

- **Mileage:** Inconsistencies appeared to occur in between charted mileage, what is being billed, and calculated verifications from approved mapping programs. *EL PASO* will be well served to review the processes for recording, certification, and billing of mileage to all payers.

- **Modifiers:** There are specific modifiers for scene, hospitals, nursing homes and other locations. It is important to accurately identify these locations so the appropriate modifier may be assigned. Primary modifiers are used to identify the origin and destination of the transport. The secondary modifiers are used to add information to improve accuracy or specificity. While primary modifiers do not typically directly impact payment of a claim, an inaccurate reporting of modifiers can cause a claim denial.

- **Coding of Charges:** Inaccurate service level assignment as identified in 8% of the claims reviewed in this report. *FITCH* recommends the *EL PASO* continually provide training to the crews to create a patient care report that is a thorough, accurate and objective description of all signs and symptoms exhibited by the patient at the time of transport. The narrative section of the Hospital Care Report should be utilized to "paint a picture" of the patient's condition that may not otherwise be difficult to ascertain from the other information in the chart. Additionally, this information should be reviewed with the person(s) responsible for assigning the codes and charges to ensure all parties are clear as to the responsibility to accurately report the level of service.

- **Diagnoses and Condition Coding:** Even though ICD-10 coding does not directly impact reimbursement on the claims reviewed in this report, CMS is becoming increasingly more meticulous in the application of rules and regulations for ambulance claims processing. It is likely that this element of charting and billing could have an impression on reimbursement in the future. Additionally, inaccuracies in the reporting and/or assignment of ICD-10 codes could result in erroneous charges being assigned. Coding assignment should be specific and based on the information contained in the Hospital Care Report. It should indicate the patient's condition

at the time of transport. Inaccurate and unsupported use of codes should be noted as a concern and could be a sign of bigger issues when combined with errors from other areas.

- **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. The error rate of 20% shows an area requiring additional focus by the service. 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.

- **Crew Member Signature:** Each crew member participating in a patient transport has responsibilities that include attesting to the duties they performed, and the facts reported in the patient care report. Failure on behalf of all crew members to analyze the patient 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 of issues. These include but are not limited to, non-compliance with Federal health care provider rules and regulations. Medicare requires that all medical records be authenticated by the author. This requirement is fully met by having all crew members involved in rendering services to the patient sign the patient care report. If additional crew members on the transport are there for observation only and do not participate in the provision of treatment or care, their signatures would not be required.

Comparison

Comparing this review to both the November 2017 and May 2019 reviews, the error percentage shows consistency, below 5% in only the Medical Necessity section. Modifiers, Coding of Charges, and Diagnoses and Condition Coding increased in the 2020 audit from the 2019 audit results. While mileage errors and concerns did decrease in this review, they are still far above reasonable error rate expectations. **Figure 23** provides the comparison table for all three of the reviews.

Figure 23: Error Rate Quantification Comparison

Area Reviewed	November 2017 Error Rate Percentage	May 2019 Error Rate Percentages	July 2020 Error Rate Percentage
Mileage	35%	78%	40%
Medical Necessity	4%	0%	0%
Modifiers	8%	0%	10%
Coding of Charges	4%	2%	8%
Diagnoses and Condition Coding	10.3%	5%	7%
Medicare Beneficiary Signature	8%	24%	20%
Crew Member Signatures	40%	6%	8%

Conclusion

High quality documentation is a critical component of all patient transports. Developing a clear picture of the patient's condition at the time of transport and recording facts that present the medically necessary need for the transport is crucial. Accurate, objective, complete, thorough, honest, and factual documentation is not only important in establishing reimbursement but will also be helpful to the organization and crew in the event a claim is questioned at any level in the future. *EL PASO* is encouraged to maintain documentation competency through ongoing training and monitoring for accuracy and quality.

EL PASO should take the time to review the Hospital Care Report to account for its completion, quality, and overall necessity. As a best practice, *EL PASO* should continue to review all its internal processes including patient care, compliance, and documentation. This review process should include Quality Assurance/Quality Improvement programs that involve all aspects of patient care to assure appropriate compliance. *EL PASO* should not only monitor identified errors, but also evaluate the source or cause of the errors. Upon further evaluation, it may be determined that the errors were a result of inadequate documentation or processes, a need for training, communication failures, or other issues at critical points in the process. Further evaluation may reveal that the documentation deficiencies involved a limited number of individuals who work on a specific shift. It is *EL PASO'S* responsibility to identify such weaknesses or individuals and work with them to correct these issues promptly.

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
& ASSOCIATES

Item #	Account Number	Incident 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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by Docs?	ICD-10 Code
1	54773451	19-0073033	CAID	11/01/2019	11.0	Y	NA	A0427	ALS 1 Emerg	A0429	N	Y	ETSH	Y		NA	Error	Y	U	$885.00	$285.28	$285.28	CAID	$0.00	NA	$0.00	Y	S59.912A
								A0425	Ground Mileage											$165.00	$51.81	$51.81					Y	Z99.89
2	55327397	19-0083720	CARE	12/16/2019	12.6	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Error	Y	N	$855.00	$426.23	$334.16	CARE	$85.25	INS	$0.00	Y	R06.02
								A0425	Ground Mileage											$189.00	$95.13	$74.58		$19.03			Y	Z99.89
3	55450226	19-0086080	CARE	12/26/20019	3.4	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	U	$885.00	$426.23	$428.77	CARE	$0.00	NA	$0.00	Y	R41.82
								A0425	Ground Mileage											$165.00	$25.67	$25.33					Y	Z74.3
4	54551302	19-0068694	CARE	10/14/2019	2.9	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	N	Y	U	$855.00	$426.23	$334.16	CARE	$0.00	CAID	$89.63	Y	R07.9
								A0425	Ground Mileage											$4,350.00	$21.90	$17.17					Y	Z74.3
5	54491821	19-0067185	CARE	10/14/2019	2.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	N	$885.00	$426.23	$334.16	CARE	$88.27	Self	$0.00	Y	R06.00
								A0425	Ground Mileage											$30.00	$15.10	$11.84					Y	Z99.89
6	54688107	19-0071074	CARE	10/24/2019	3.1	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$885.00	$426.23	$334.16	CARE	$89.93	CAID	$0.00	Y	R11.2
								A0425	Ground Mileage											$46.50	$23.41	$18.36					Y	Z99.89
7	55242740	19-0082079	CARE	12/09/2019	5.1	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$92.95	INS	$89.93	Y	R41.82
								A0425	Ground Mileage											$38.51	$38.51	$30.19					Y	Z74.3
8	54443367	19-0066784	CARE	10/19/2019	13.0	Y	NA	A0429	BLS Emerg	A0427	N	Y	RH	Y		NA	Y	Y	Y	$855.00	$358.93	$281.40	CARE	$92.33	INS	$0.00	Y	N99.820
					13.6			A0425	Ground Mileage											$204.00	$102.68	$80.50					Y	Z74.3
9	55456000	19-0085965	CARE	12/25/2020	8.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$90.38	INS	$0.00	Y	S09.90XA
					3.4			A0425	Ground Mileage											$51.00	$25.67	$20.13					Y	Z74.3
10	55078923	19-0078897	CARE	11/26/2019	10.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	PH	Y		NA	Y	Y	Y	$855.00	$426.23	$428.77	CARE	$100.35	INS	$0.00	N	R07.9
								A0425	Ground Mileage											$150.00	$75.50	$74.40					Y	Z99.89
11	54545207	19-0068664	CARE	10/14/2019	3.7	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$90.84	INS	$0.00	Y	R07.9
								A0425	Ground Mileage											$55.50	$27.94	$21.90					Y	Z99.89

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12	54785784	19-0073142	CARE	11/01/2019	5.8	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	U	$855.00	$426.23	$428.77	CARE	$94.01	INS	$0.00	Y	R06.02
								A0425	Ground Mileage											$87.00	$43.79	$43.21					Y	Z74.3
13	54392090	19-0065880	CARE	10/02/2019	6.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Error	Y	$855.00	$426.23	$334.16	CARE	$92.65	INS	$0.00	Y	R53.1
					4.9			A0425	Ground Mileage											$73.50	$37.00	$29.01					Y	Z74.3
14	54815712	19-0073798	CARE	11/04/2019	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	N	$855.00	$426.23	$428.77	CARE	$92.80	Self	$0.00	Y	R41.82
								A0425	Ground Mileage											$75.00	$37.75	$37.25					Y	Z74.3
15	55177644	19-0080674	CARE	12/04/2019	4.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$885.00	$426.33	$334.16	CARE	$92.80	CAID	$0.00	Y	R40.1
					5.0			A0425	Ground Mileage											$75.00	$37.75	$29.60					Y	Z74.3
16	55348323	19-0084051	CARE	12/17/2019	2.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	U	$855.00	$426.23	$334.16	CARE	$87.82	CAID	$0.00	Y	R06.02
					1.7			A0425	Ground Mileage											$25.50	$12.84	$10.06					Y	Z74.3
17	54410501	19-0066149	CARE	10/03/2019	6.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	N	$855.00	$426.23	$334.16	CARE	$89.63	INS	$0.00	N	I44.0
					2.9			A0425	Ground Mileage											$43.50	$21.90	$17.17					Y	Z99.89
18	55462533	19-0086306	CAID	12/27/2019	2.2	Y	NA	A0429	BLS Emerg		Y	Y	ETSH	Y		NA	Y	Y	Y	$855.00	$240.23	$240.23	CAID	$0.00	NA	$0.00	Y	R52
								A0425	Ground Mileage											$33.00	$10.36	$10.36						
19	55277240	19-0082609	CAID	12/11/2019	2.9	N	NA	A0429	BLS Emerg		Y	Y	ETRH	Y		NA	Y	Y	Y	$855.00	$228.22	$228.22	CAID	$0.00	NA	$0.00	Y	J95.03
					3.0			A0425	Ground Mileage											$43.50	$13.42	$13.42					Y	Z74.3
20	55196707	19-0081004	CARE	12/05/2019	3.0	Y	NA	A0433	ALS 2		Y	Y	RH	Y		NA	Y	Y	N	$855.00	$616.91	$483.66	CARE	$127.91	INS	$0.00	Y	I46.9
								A0425	Ground Mileage											$45.00	$22.65	$17.76					Y	Z99.89
21	54722254	19-0071877	CARE	10/28/2019	7.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$97.33	INS	$0.00	Y	R06.02
					8.0			A0425	Ground Mileage											$120.00	$60.40	$47.35					Y	Z99.89

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22	54984172	19-0077133	CARE	11/18/2019	3.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Error	U	$855.00	$426.23	$334.16	CARE	$90.99	INS	$0.00	Y	R40.1
								A0425	Ground Mileage											$57.00	$28.69	$22.49					Y	Z99.89
23	55149291	19-0080228	CARE	12/02/2019	9.2	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	U	$855.00	$426.23	$334.16	CARE	$99.14	CAID	$0.00	Y	R41.82
								A0425	Ground Mileage											$138.00	$69.46	$54.46					Y	Z99.89
24	55439677	19-0085894	CARE	12/25/2019	3.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$88.87	CAID	$0.00	Y	R41.82
					2.4			A0425	Ground Mileage											$36.00	$18.12	$14.21					Y	Z74.3
25	55361855	19-0084167	CARE	12/18/2019	9.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Error	U	$855.00	$426.23	$304.94	CARE	$91.38	INS	$0.00	Y	S99.911A
								A0425	Ground Mileage																		Y	Z74.3
26	54861458	19-0074618	CARE	11/07/2019	2.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	U	$855.00	$426.23	$334.16	CARE	$87.82	CAID	$0.00	Y	R41.82
					1.5			A0425	Ground Mileage											$22.50	$11.33	$8.88					Y	Z99.89
27	54735614	19-0069869	CAID	10/19/2019	8.0	Y	NA	A0429	BLS Emerg		Y	Y	ETSH	Y		NA	Y	Y	U	$855.00	$240.23	$240.23	CAID	$0.00	NA	$0.00	Y	T14.8XXA
					5.0			A0425	Ground Mileage											$75.00	$23.55	$23.55					Y	Z74.3
28	54722289	19-0071928	CAID	10/28/2019	1.0	Y	NA	A0433	ALS 2		Y	Y	ETRH	Y		NA	Y	Y	U	$855.00	$412.90	$412.90	CAID	$0.00	NA	$0.00	Y	I46.9
								A0425	Ground Mileage											$15.00	$4.71	$4.71						
29	54539137	19-0068571	CARE	10/13/2019	10.0	N	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	N	$855.00	$426.23	$334.16	CARE	$94.34	INS	$0.00	Y	R41.82
								A0425	Ground Mileage											$150.00	$75.50	$21.90					Y	Z99.89
30	54625881	19-0070176	CAID	10/20/2019	10.0	Y	NA	A0429	BLS Emerg	A0427	N	Y	ETRH	Y		NA	Y	Y	Y	$855.00	$228.22	$228.22	CAID	$0.00	NA	$0.00	Y	R06.02
					5.9			A0425	Ground Mileage											$88.50	$26.40	$26.40					Y	Z99.89
31	56076823	19-0074417	CARE	11/07/2019	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$101.56	INS	$0.00	Y	R53.1
					10.8			A0425	Ground Mileage											$162.00	$81.54	$63.93					Y	Z74.3
32	55202885	19-0081126	CARE	12/05/2019	4.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$91.29	CAID	$0.00	Y	R51
								A0425	Ground Mileage											$60.00	$30.20	$23.68					Y	Z74.3

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33	54470738	19-0067256	CAID	10/08/2019	4.0	N	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y		NA	Y	Y	N	$855.00	$285.28	$285.28	CAID	$0.00	NA	$0.00	Y	O26.93
								A0425	Ground Mileage											$60.00	$18.84	$18.84					Y	Z74.3
34	55164330	19-0079807	CARE	11/30/2019	11.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	N	SH	NA	Y	Y	U	$855.00	$426.23	$334.16	CARE	$101.86	INS	$0.00	Y	S06.9X9A
								A0425	Ground Mileage											$83.05	$83.05	$65.11					Y	Z74.3
35	54615633	19-0069918	CARE	10/19/2019	2.7	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$89.33	INS	$0.00	Y	I10
								A0425	Ground Mileage											$40.50	$20.39	$15.98					Y	Z99.89
36	55209544	19-0078798	CARE	11/25/2019	0.5	Y	NA	A0429	BLS Emerg		Y	Y	EH	Y		NA	Error	Y	Y	$855.00	$358.93	$281.40	CARE	$72.55	CAID	$0.00	Y	R53.81
								A0425	Ground Mileage											$7.50	$3.78	$2.96					Y	Z74.3
37	55518862	19-0085757	CARE	12/24/2019	3.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	U	$855.00	$426.23	$334.16	CARE	$87.21	CAID	$0.00	N	I67.89
					1.3			A0425	Ground Mileage											$19.50	$9.82	$7.70					Y	Z99.89
38	54688108	19-0071214	CARE	10/25/2019	4.0	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y		NA	Y	Error	Y	$855.00	$358.93	$281.40	CARE	$71.53	INS	$0.00	Y	R53.1
					3.8			A0425	Ground Mileage											$57.00	$28.69	$22.49					Y	Z74.3
39	54512546	19-0067977	CARE	10/11/2019	16.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Error	Y	U	$855.00	$426.23	$334.16	CARE	$102.01	CAID	$0.00	N	R53.1
					11.1			A0425	Ground Mileage											$166.50	$83.81	$65.71					N	Z76.89
40	54431925	19-0066518	CARE	10/05/2019	9.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	U	$855.00	$426.23	$334.16	CARE	$98.84	INS	$0.00	Y	I95.9
								A0425	Ground Mileage											$195.00	$67.95	$53.27					Y	Z74.3
41	55361826	19-0084210	CARE	12/18/2019	6.7	Y	NA	A0427	ALS 1 Emerg	A0429	N	Y	GY	N		NA	Y	Y	Y	$855.00							Y	S49.90XA
								A0425	Ground Mileage											$100.50							N	Z76.89
									No Payment																			
42	55190326	19-0080940	CARE	12/05/2019	3.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$89.78	INS	$0.00	Y	R06.00
								A0425	Ground Mileage											$45.00	$22.65	$17.76					Y	Z74.3

Item #	Account Number	Incident 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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Primary Payments	Primary Payer	Secondary Payments	Secondary Payer	Account Balance	Diagnosis Supported by Docs?	ICD-10 Code
43	54378381	19-0065618	CARE	10/01/2019	5.0	Y	NA	A0429	BLS Emerg		Y	Y	EH	Y		NA	Y	Y	U	$855.00	$358.93	$281.40	CARE	$88.10	INS	$0.00	N	R06.82
					10.8			A0425	Ground Mileage											$162.00	$81.54	$63.93					Y	Z74.3
44	55450216	19-0085899	CARE	12/25/2019	2.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$88.27	INS	$0.00	Y	R55
								A0425	Ground Mileage											$30.00	$15.10	$11.84					Y	Z74.3
45	55202873	19-0081230	CARE	12/06/2019	6.6	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$95.22	INS	$0.00	Y	R06.02
								A0425	Ground Mileage											$99.00	$49.83	$39.06					Y	Z99.89
46	54504388	19-0067830	CARE	10/10/2019	3.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$426.23	$334.16	CARE	$89.78	CAID	$0.00	Y	R06.00
								A0425	Ground Mileage											$45.00	$22.65	$17.76					Y	Z99.89
47	54599143	19-0069533	CARE	10/18/2019	4.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	Y	Y	Y	$885.00	$426.23	$334.16	CARE	$91.29	CAID	$0.00	Y	E11.65
								A0425	Ground Mileage											$60.00	$30.20	$23.68					Y	Z99.89
48	54849041	19-0074054	CARE	11/05/2019	4.1	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$655.00	$358.93	$281.40	CARE	$77.98	INS	$0.00	Y	R53.1
								A0425	Ground Mileage											$61.50	$30.96	$24.23					Y	Z74.3
49	54932748	19-0075907	CAID	11/13/2019	5.2	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y		NA	Y	Y	Y	$855.00	$271.02	$271.02	CAID	$0.00	NA	$0.00	Y	R07.9
								A0425	Ground Mileage											$78.00	$22.37	$22.37					Y	Z74.3
50	54586355	19-0069378	CAID	10/17/2019	0.6	N	NA	A0427	ALS 1 Emerg		Y	Y	ETEH	Y		NA	Y	Y	Y	$885.00	$271.02	$271.02	CAID	$0.00	NA	$0.00	Y	R56.9
					1.0			A0425	Ground Mileage											$9.00	$4.47	$4.47					Y	Z99.89

Attachment B

RAT STATS Printout

FITCH
& ASSOCIATES

Windows RAT-STATS
Statistical Software
Random Number Generator

Date:	5/26/2020	**Time:**	10:45	**Seed Number**	**Frame Size**
Audit:	El Paso 2019 Sample			38709.35	2,146

Order	Value	Account Number	Date of Service
43	12	54378381	10/1/2019
13	34	54392090	10/2/2019
17	69	54410501	10/3/2019
40	93	54431925	10/5/2019
8	113	54443367	10/6/2019
33	159	54470738	10/8/2019
5	194	54491821	10/8/2019
46	213	54504388	10/10/2019
39	235	54512546	10/11/2019
29	281	54539137	10/14/2019
11	305	54545207	10/14/2019
4	310	54551302	10/14/2019
50	387	54586355	10/17/2019
47	394	54599143	10/18/2019
35	434	54615633	10/19/2019
30	455	54625881	10/20/2019
6	547	54688107	10/24/2019
38	548	54688108	10/25/2019
21	604	54722254	10/28/2019
28	616	54722289	10/28/2019
27	655	54735614	10/19/2019
1	726	54773451	11/1/2019
12	740	54785784	11/1/2019
14	808	54815712	11/4/2019
15	831	54828856	11/5/2019
48	882	54849041	11/5/2019
26	900	54861458	11/7/2019
49	1023	54932748	11/13/2019
22	1116	54984172	11/18/2019
10	1288	55078923	11/26/2019
23	1413	55149291	12/2/2019
34	1431	55164330	11/30/2019
42	1475	55190326	12/5/2019
20	1500	55196707	12/5/2019
45	1514	55202873	12/6/2019
32	1516	55202885	12/5/2019
36	1524	55209544	11/25/2019
7	1588	55242740	12/9/2019
19	1667	55277240	12/11/2019
2	1767	55327397	12/16/2019
16	1800	55348323	12/17/2019

41	1819	55361826	12/18/2019
25	1825	55361855	12/18/2019
24	1948	55439677	12/25/2019
44	1970	55450216	12/25/2019
3	1972	55450226	12/26/2019
9	1992	55456000	12/25/2019
18	1996	55462533	12/27/2019
37	2108	55518862	12/24/2019
31	2147	56076823	11/7/2019

Attachment C

Curriculum Vitae

FITCH
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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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