Internal Audit Office

DATE: June 22, 2021

TO: Mario D'Agostino, Fire Chief

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

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

The City of El Paso has contracted Fitch & Associates, LLC to conduct a Professional Claims Review of ambulance transports billed to and paid by Federal and/or State healthcare providers. Fitch & Associates concluded their review of 50 transport claims with dates of service within the period of October 1, 2020 to December 31, 2020 (3 months). The review of the 50 claims identified an increase in error rates from the previous review conducted in July 2020 for modifiers, coding of charges, and crew member signatures.

The following table is a summary of the error rate quantification comparison for four (4) Claims Reviews conducted by Fitch & Associates, LLC:

Area Reviewed	November 2017 Error Rate Percentage	May 2019 Error Rate Percentage	July 2020 Error Rate Percentage	May 2021 Error Rate Percentage
Mileage	35%	78%	40%	0%
Medical Necessity	4%	0%	0%	2%
Reason for Transport	2%	N/A	N/A	2%
Modifiers	8%	0%	10%	22%
Coding of Charges	4%	2%	8%	26%
Diagnoses and Condition Coding	10.3%	5%	7%	8%
Certification Statements (new requirement for hospital to hospital transports: 1/1 hospital transport in sample)	N/A	N/A	N/A	100%
Medicare Beneficiary Signature	8%	24%	20%	6%
Crew Member Signatures	40%	6%	8%	24%

Significant increases were noted in the following areas:

1. Modifiers – Increase from 10% in July 2020 to 22% in May 2021.
2. Coding of Charges – Increase from 8% in July 2020 to 26% in May 2021.
3. Crew Member Signatures – Increase from 8% in July 2020 to 24% in May 2021.

In addition, starting January 1, 2022, there is a new requirement for Certification Statements for hospital to hospital transports. Fitch & Associates, LLC noted a 100% error rate in this category.

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The Fire Department should work with the City of El Paso's third-party billing agent, Digitech Computers, Inc to address the increased error rates. For more details on the Fitch & Associates, LLC Professional Claims Review, dated June 2021 please see "*Attachment*".

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

cc: Financial Oversight and Audit Committee
Tomas Gonzalez, City Manager
Dionne Mack – Deputy City Manager for Public Safety

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June 2021

Professional Claims Review

CONFIDENTIAL

Final

City of El Paso

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El Paso, TX 79901

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CLAIMS REVIEW

Professional Ambulance Claims Review
City of El Paso

Table of Contents

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 and/or State healthcare providers. *FITCH* is an emergency services consulting firm, not a legal entity and this report is not provided as legal counsel, rather it is a clarification of the applicable rules, regulations and laws governing the billing of medical transport services to Federal and/or State healthcare providers identified by *EL PASO* as responsible parties for reimbursement of services provided. *FITCH* serves in this 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 or State healthcare program, for medical transports provided by *EL PASO*. The sampling unit for the claims billed to a Federal or State health care program was drawn from a total population of claims billed to and paid by Medicare or 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, 2020 to December 31, 2020 for which *EL PASO* reportedly received reimbursement from the Federal or State healthcare programs of Medicare and Medicaid. The information provided indicated a population of 1,476 paid Medicare and Medicaid claims. This information was identified and provided by *EL PASO* and/or their contracted billing agent, *Digitech Computers, Inc.*

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, 2020 to December 31, 2020. In this case, the Sampling Frame for Medicare and Medicaid represents 1,476 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 1,476 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 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 *Digitech* 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
- Signature Form
- Claim Form (HCFA 1500)
- EOB from Primary Payor
- Secondary Claim Form or Invoice
- Proof of Secondary Payment (if received)
- Any other data or forms relevant to the billing and collection of these claims

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

Claims Review Objective

FITCH utilizes a robust review process to analyze each document provided. This process includes inspection of areas of risk acknowledged by the OIG in their Compliance Program Guidance for Ambulance Suppliers, as well as the rules and regulations outlined in the Medicare Claims Processing Manual, the Texas Medicaid Provider Procedures Manual Ambulance Services Handbook, in publications from the Centers for Medicare and Medicaid Services (CMS), and 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 areas:

- Accuracy of Reported and Billed Mileage
- Accuracy of Service Level Billed
- Documentation of Medical Necessity
- Appropriateness of Modifiers
- Appropriateness of Closest Facility
- 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 healthcare programs were appropriate, presented proper documentation, and were accurately 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 and LCD codes used to report the patients' signs, symptoms, and condition(s) at the time of transport and are they supported in the Hospital Care Report?
8. Was the amount reimbursed by the Federal or State health care programs appropriate?
9. Was the Medicare coinsurance appropriately billed to the patient or secondary insurance?
10. Was the coinsurance invoice paid?

Review Protocol

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

- Assigned Item Number
- Patient Name
- Account Number
- Program Billed
- Date of Service
- Origin and Destination
- Loaded Miles Billed for Reimbursement
- Determination of Mileage Supported by Documents and Verified by Mapping Software
- Procedure Codes Submitted (HCPCS) and Reimbursed
- Determination of Appropriate HCPCS if Different from Claim
- Determination of Whether Charges are Supported by Documentation
- Determination of Whether Documents Support Medical Necessity for Medicare/Medicaid
- Determination of Appropriateness of Modifiers
- Patient Signature Requirements Fulfilled

- ICD-10 and LCD codes on Claims and Determination of Appropriateness
- Accuracy of Total Charges
- Primary Federal Health Program that Reimbursed the Claims
- Primary Payments
- Allowed Amount for each Procedure Code
- Determination of Correct Allowed Amount and Comparison to Amount Paid
- Reimbursed Procedure Code if Different than Code Filed

The *FITCH* team 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 claims were examined in the order of the sequential selection from the RAT-STATs program, to determine if any claims were not paid by that specific Federal or State healthcare program. Of the initial 50 claims identified, all items met the criteria for inclusion in the review.

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

Claims Review Findings

Spares

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

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 $1/10^{th}$ of a mile for transports up to 100 miles. All 38 Medicare claims had mileage billed to the $1/10^{th}$ of a mile.

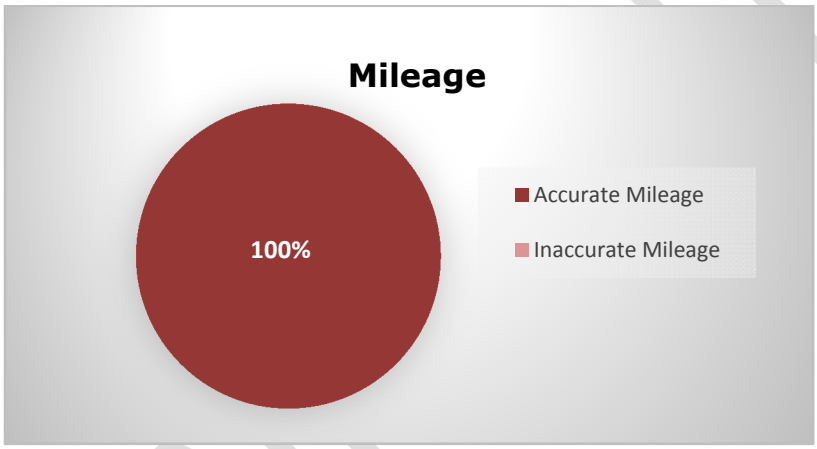
The Texas Medicaid Provider Procedures Manual, Section 2.2 says that mileage reported on the claim form must be the actual number of miles traveled. The 12 Medicaid claims were examined and verified to be accurately billed to the actual number of miles traveled.

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.

The mapping program was utilized 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. It was determined that all claims were billed correctly and within acceptable variance from the pickup to drop off locations.

Figure 1 below displays the graphically illustration of the mileage accuracy percentage rate for Medicare and Medicaid.

Figure 1: Mileage Accuracy Percentage for Medicare and Medicaid



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. Texas Medicaid's Ambulance Service Handbook, Section 2.2 also states the condition of the patient must be such that transportation by any other means is medically contraindicated. In any case in which some means of transportation other than an ambulance could be used without posing a danger to the patient's health, then no reimbursement will be made for the ambulance services. Medical necessity is not met simply because no other means of transport are currently available.

Documentation to support the medical necessity of an ambulance transport needs to provide a detailed description of the patient's condition at the time of transport, along with descriptions of interventions and the patient response to those interventions. Any additional documentation to support medical

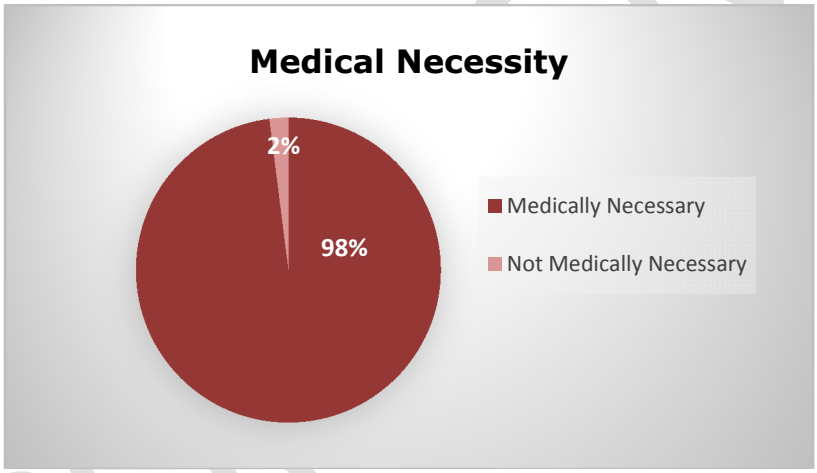
necessity and to validate that the patient could only be safely transported by ground ambulance would be appropriate for inclusion in the Hospital Care Report and is recommenced as best practice to ensure accuracy and mitigate risk.

Of the 50 Medicare and Medicaid claims reviewed for this report, one (1) was deemed inaccurate and did not provide enough information in the Hospital Care Report to support medical necessity. **Figure 2** provides the inaccurate claim and **Figure 3** displays the 98% accuracy rate for medical necessity of the claims reviewed.

Figure 2: Medical Necessity

Item #	Account Number	Payor	Comments
23	59022820	Medicaid	Patient had left hand pain with swelling, found sitting in a wheelchair. Was the patient's condition such that transportation in a wheelchair van would pose a danger to the patients' health? Could the patient had gone by wheelchair van to see a physician?

Figure 3: Medical Necessity Accuracy Percentage



Reason for Transport

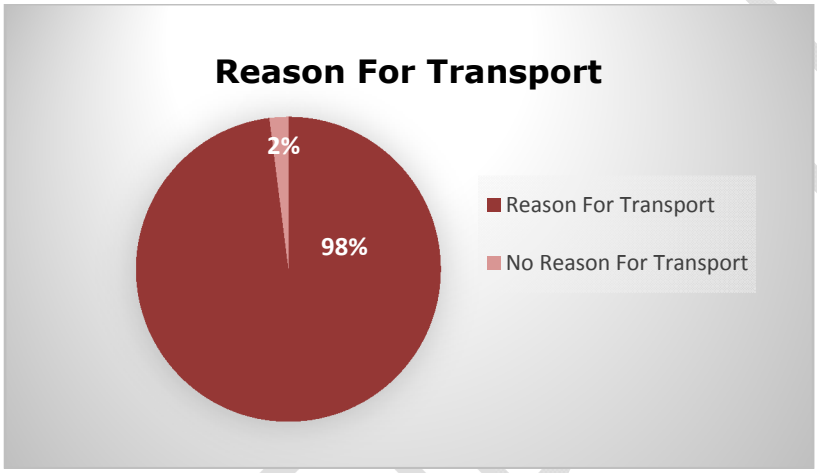
Transports from one facility to another requires documentation of the reason the patient must be moved from one hospital to another. This requires that the Hospital Care Report be detailed enough to clearly indicate the precise treatment, procedure, or if relevant, medical specialist that is available and required at the receiving facility (and not at the transferring hospital). Non-specific or vague statements (further evaluation, etc.) do not provide adequate information to support the transport of the patient. While supporting documentation, such a physician's statement, or memorandums of transfer, should provide this information, it is best practice to also record this information in the Hospital Care Report. It is vital information used in the billing process to decide if the trip meets the medical necessity requirements set by Medicare. Some Medicare Administrative Contractors (MACs) are more adamant in requiring that these reasons and details be recorded in the Hospital Care Report, even if they are

provided in other supporting documents. *Item* 28 provided a reason for transport of ROSC post CPR and continuous care but not the specific reason the patient was being transported to another facility.

Figure 4: Reason for Transport

Item #	Account Number	Payor	Comments
28	58932148	Medicare	ROSC post CPR was provided in the reason for transport section of the Hospital Care Report and narrative stated for continuation of care. The Hospital Care Report did not provide the service, procedure or medical specialist that was not available at the sending facility.

Figure 5: Reason for Transport



Modifiers

Claims filed for reimbursement to most all insurers, including Medicare and Medicaid, require that specific modifiers be utilized to identify both the point of origin and the destination of the ambulance transport. The first single digit modifier indicates the point of origin and the second single digit modifier indicates the destination. It is a requirement of both Medicare and Medicaid that transports be from and to a covered destination in order to be eligible for reimbursement. As an example, transports "to" a doctor's office are not considered a covered destination (with limited exception as outlined in the CMS rules and regulations), however, a transport "from" a doctor's office "to" a hospital may be covered if other conditions and requirements are met for the purposes of identifying the medical necessity of transport by ambulance to that destination and that the services to be received at the hospital are also medically necessary. During COVID some exceptions have been made as to accepted destinations for delivery of patients and such was taken into consideration during this review.

In Texas, Medicaid claims must be submitted with an ET modifier, preceding the origin and destination modifier, for each procedure code submitted for emergency transports. Any emergency transport procedure code without the ET modifier will be subject to prior authorization requirements. All Texas Medicaid claims reviewed accurately provided the ET modifier on both procedure codes. Modifiers may

not directly influence payment of a claim; however, they should be used to accurately support the origin and destination documented in the Hospital Care Report.

Figure 6 provides a list of the inaccurate modifiers for the claims reviewed. Inaccuracy in the use of modifiers can be an identifier of other documentation problems or errors that could cause billing errors and/or put the service at risk.

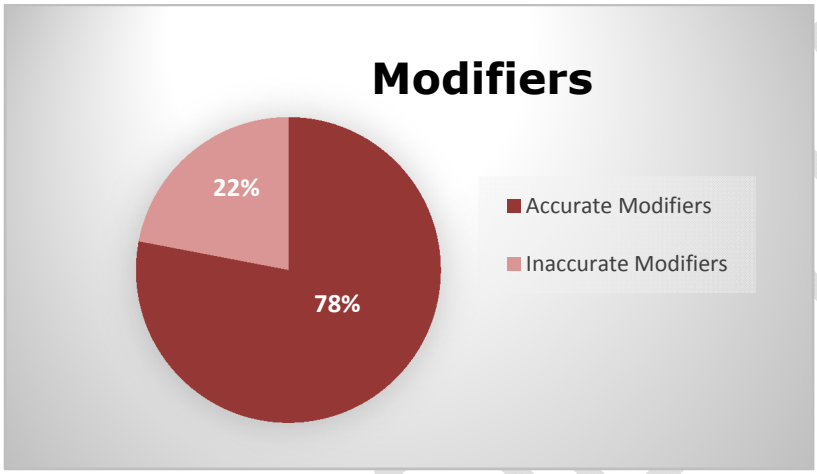
Figure 6: Inaccurate Modifiers

Item #	Account Number	Payor	Comments
5	58799108	Medicare	The modifier billed was HH (Hospital to Hospital). The patient was picked up from her doctor's office. The modifiers should be PH (Physician's Office to Hospital).
9	59126095	Medicare	The modifier billed as EH (Residential, domiciliary, or custodial facility). The narrative in the chart states nursing home. The modifiers should be NH (Nursing Home to Hospital).
17	58852645	Medicaid	The modifier billed as PH (Physician Office to Hospital) the chart does not provide information as to whether the patient was inpatient or outpatient status. A modifier of HH (Hospital to Hospital) would be more appropriate.
18	58885617	Medicare	The modifier billed as EH (Residential, domiciliary, or custodial facility). The narrative in the chart states nursing home. The modifiers should be NH (Nursing Home to Hospital).
25	58724720	Medicaid	The modifier billed as EH (Residential, domiciliary, or custodial facility). The narrative in the chart states nursing home. The modifiers should be NH (Nursing Home to Hospital).
28	58932148	Medicare	The modifier billed was PH (Physician's Office to Hospital). The patient was picked up at The Hospitals of Providence Northeast campus, this would be a HH (Hospital to Hospital).
35	59298686	Medicare	The modifier billed as EH (Residential, domiciliary, or custodial facility). The narrative in the chart states nursing home. The modifiers NH (Nursing Home to Hospital) would be more appropriate.
37	58907054	Medicare	The modifier billed was EH (Residential, domiciliary, or custodial facility). The pickup location is a nursing and rehabilitation center, the modifier should have been NH (Nursing Home to Hospital).
38	59040563	Medicare	The modifier billed was EH (Residential, domiciliary, or custodial facility). The pickup location is a skilled nursing and assisted living facility. The chart specifies nursing facility. The modifier should have been NH (Nursing Home to Hospital).
45	58816035	Medicare	The modifier billed was EH (Residential, domiciliary, or custodial facility). The pickup location address is for a children's specialty clinic and an infusion clinic. The chart is not clear on the location. This patient is 93 years old, the more appropriate modifier would have been PH (Physician Office to Hospital).

Item #	Account Number	Payor	Comments
49	58669591	Medicare	The modifier billed was EH (Residential, domiciliary, or custodial facility). The pickup location is a skilled nursing and assisted living facility. The chart specifies nursing facility. The modifier should have been NH (Nursing Home to Hospital).

Figure 7 provides a graphic of the error rate for the modifiers reviewed.

Figure 7: Modifiers Accuracy Percentage



Coding of Charges (Level of Service)

The claims reviewed for this report provided 100 charges associated with the 38 Medicare transports and 12 Medicaid transports. The breakdown of the charges were 50 base rates and 50 miles rates. **Figure 8** below graphically illustrates the base rates billed to the Federal health care provider and **Figure 9** details the State health care provider breakdown.

Figure 8: Medicare Base Rate Comparison

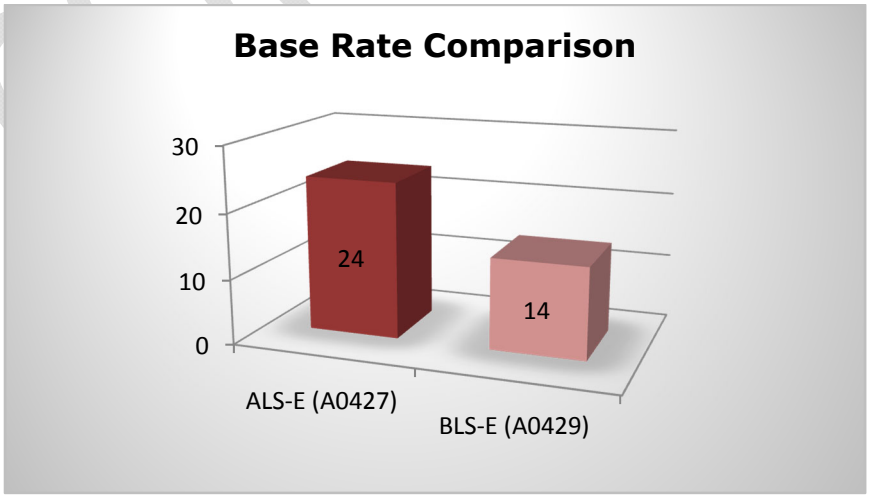
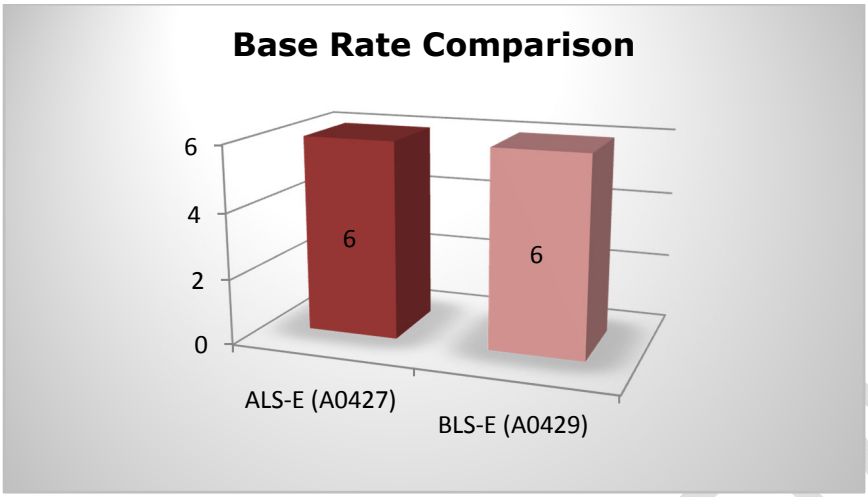


Figure 9: Medicaid Base Rate Comparison



The Texas Medicaid Provider Procedures Manual, Section 2.2.4 – Oxygen, states procedure code A0422 reimbursement for oxygen is limited to one billable code per transport. After review of the 12 Medicaid claims, four (4) Hospital Care Reports showed oxygen being provided to the patient in the medication section, but the CMS-1500 form sent to Medicaid does not show oxygen being billed. **Figure 10** provides the four (4) transports that had oxygen in the patient's medication section of the Hospital Care Report.

Figure 10: Oxygen

Item #	Account Number	Program	Original HCPSP Code	Correct HCPCS Code	Comments
10	59610539	Medicaid	None	A0422	Oxygen notated in the Hospital Care Report.
12	58742982	Medicaid	None	A0422	Oxygen notated in the Hospital Care Report.
20	58857587	Medicaid	None	A0422	Oxygen notated in the Hospital Care Report.
36	59222253	Medicaid	None	A0422	Oxygen notated in the Hospital Care Report.

The Medicaid manual also states in Section 2.4.2.1 reimbursement for BLS and ALS disposable supplies (procedure codes A0382 and A0398 respectively) is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport. Out of the 12 Medicaid claims reviewed none of the claims showed charges for ALS or BLS supplies. The Hospital Care Report does not breakdown each supply item utilized in the transport. The procedures and vital sections of the Hospital Care Report, in most of the charts, indicates that supplies were utilized (e.g., Glucose Check, IV started etc.) *EL PASO* should take the time to review the Texas Medicaid Provider Procedure Manual with its billing company to ensure that documentation provides adequate guidance

to ensure the proper charges are being applied for the claims billed to Medicaid in order to capture all allowable revenue.

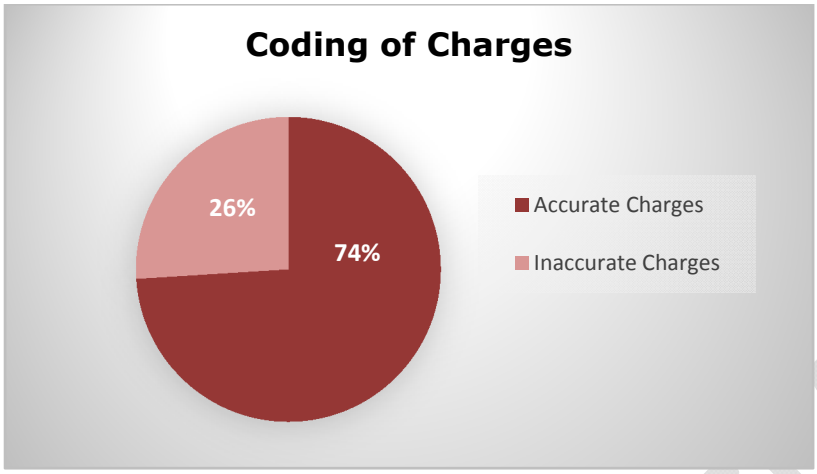
Of the Medicare and Medicaid claims reviewed, nine (9) were deemed inaccurate for coding of charges. **Figure 11** provides details for those nine (9) claims deemed inaccurate for coding of charges.

Figure 11: Coding of Charges

Item #	Account Number	Program	Original HCPSP Code	Correct HCPCS Code	Comments
2	59071994	Medicare	A0429	A0427	Patient complaining of shortness of breath and weakness along with high blood pressure, this would be an ALS level of service.
4	58977804	Medicare	A0429	A0427	Abnormal vital signs with or without symptoms is an ALS level of service. An additional symptom of headache was provided in the chart.
14	59520063	Medicare	A0429	A0427	High Glucose levels along with weakness and high blood pressure is an ALS level of service.
24	59590302	Medicaid	A0429	A0427	Pain at a severe level is an ALS level of service. The charts states 10 out of 10 with burning pain.
28	58932148	Medicare	A0427	A0426	The patient is being transported Hospital to Hospital. The patient is stable at the time of transport.
32	58857611	Medicaid	A0429	A0427	Chart states shortness of breath and hypotension which are both ALS level of services.
41	59138413	Medicaid	A0429	A0427	Patient states pain has been intolerable at 10/10 for the past few hours. Pain at a severe level is an ALS level of service.
42	58804024	Medicare	A0429	A0427	Primary symptom notated in the chart is weakness along with high blood pressure notated as the complaint. This would be an ALS level of service.
44	59247853	Medicare	A0429	A0427	Primary symptom notated in the chart is shortness of breath, oxygen provided to the patient. This would be an ALS level of service.

Figure 12 furnished a graphical representation of the accuracy percentage of the coding of charges versus the error rate. While there are 13 claims with errors, which would indicate an error rate of 26%, errors that would cost the service money in lost revenue due to billing at a lower level than allowable, or not billing charges at all, would not be looked upon unfavorably in a Federal or State payor audit. While these may be instances where the billing agent erred on the side of caution, this could indicate a need for additional training of the person(s) responsible for this aspect of coding and charge assignments.

Figure 12: Coding of Charges Accuracy Percentage

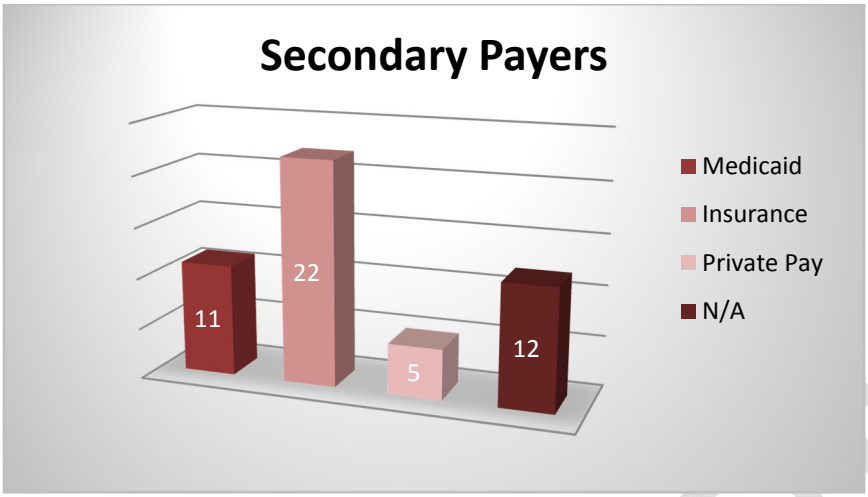


Secondary Payor Source

Medicare reimburses for EMS services based on 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 13** breaks down the different types of secondary payers used for this review.

Figure 13: Secondary Payer Breakdown



Diagnosis and Condition Coding

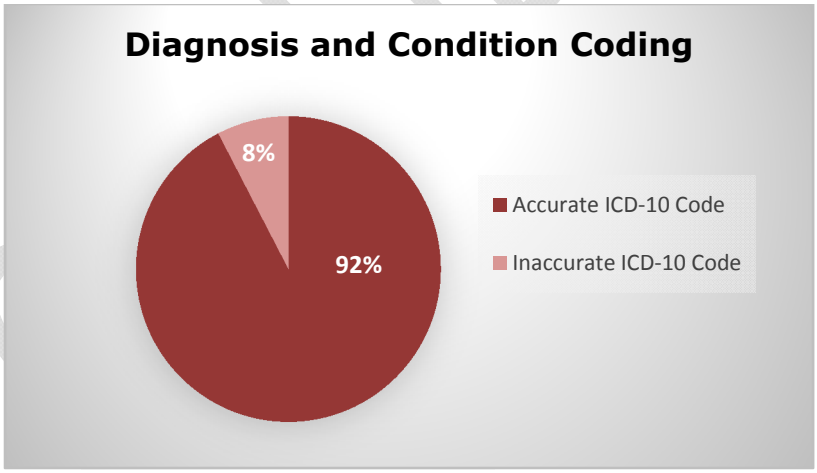
One hundred and five (105) condition/diagnosis codes were utilized in the billing of the 50 claims. The use of acceptable coding is demonstrated in 42 claims reviewed. **Figure 14** breaks down the ICD-10 codes that were deemed inaccurate or could have had a more definitive code assigned for the condition(s) charted. **Figure 15** demonstrates the accuracy rate of 92% for diagnosis and condition coding.

Figure 14: Diagnosis and Condition Coding

Item #	Account Number	Program	Comments
3	59500854	Medicare	E11.649 (Type 2 diabetes mellitus with hypoglycemia without coma) was selected at the primary code, which the patient does have a prior diagnosis of and is what is causing the patients altered mental status, which is the reason for transport of the patient. R41.82 (Altered mental status) would be a more appropriate primary code.
12	58742982	Medicaid	The tertiary code of Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases) is a questionable code, due to the Hospital Care Report states that the patient tested negative for COVID. The primary and secondary codes provided were accurate.
18	58885617	Medicare	The primary code R06.03 (Acute respiratory distress) was selected as the primary code, which is a diagnosis. The primary symptom notated in the Hospital Care Report was shortness of breath (R06.02), which would be an appropriate primary code.
23	59022820	Medicaid	Cutaneous abscess of left upper limb (L02.414) was the primary code selected. L02.414 is not listed in the Medicaid manual for the emergency medical condition codes that are required on all emergency ambulance claims. R52 (Pain, unspecified) is listed on the Medicaid manual list and would be an acceptable primary code.

Item #	Account Number	Program	Comments
44	59247853	Medicare	COVID-19 Virus identified (Lab Confirmed (U07.1) was selected as the primary code. A more acceptable primary code would have been the primary symptom of shortness of breath (R06.02). The U07.1 code would have been more appropriate utilized as the tertiary code.
46	59855644	Medicare	Z74.3 (Need for continuous supervision) was selected as primary and is on the Group 3 list from Novita's local coverage article A54574, but Z99.89 (Dependence on other enabling machines and devices) would be the more appropriate code as it indicates need for continuous IV fluid(s), "active airway management" or the need for multiple machines/devices. This transport provided oxygen, EKG and an IV to the patient.
47	59126056	Medicare	Z74.3 (Need for continuous supervision) was selected as primary and is on the Group 3 list from Novita's local coverage article A54574, but Z99.89 (Dependence on other enabling machines and devices) would be the more appropriate code as it indicates need for continuous IV fluid(s), "active airway management" or the need for multiple machines/devices. This transport notates EKG monitoring and an IV being established.
49	58669591	Medicare	Z74.3 (Need for continuous supervision) was selected as primary and is on the Group 3 list from Novita's local coverage article A54574, but Z99.89 (Dependence on other enabling machines and devices) would be the more appropriate code as it indicates need for continuous IV fluid(s), "active airway management" or the need for multiple machines/devices. This transport notates EKG monitoring and an IV being established.

Figure 15: Diagnosis and Condition Coding Accuracy Percentage



Certification Statements

The Center for Medicare and Medicaid Services (CMS) requires that ambulance services have a certification statement certifying that non-emergent ambulance transports are necessary when the patient is under the direct care of a physician. The certification statement must be present and appropriate for scheduled transports when the patient is bed confined or has some other medical

problem deemed medically necessary for non-emergent ambulance transport. Medicare does not provide ambulance providers with a specific format for the Physician Certification Statement (PCS forms), however, regardless of the format chosen, the information on the form must comply with Medicare guidelines for information that should be reported.

The Code of Federal Regulations 410.40 Coverage of Ambulance Services, provides information on the new PCS rule that went into effect beginning January 1, 2020. Below is an overview of the changes:

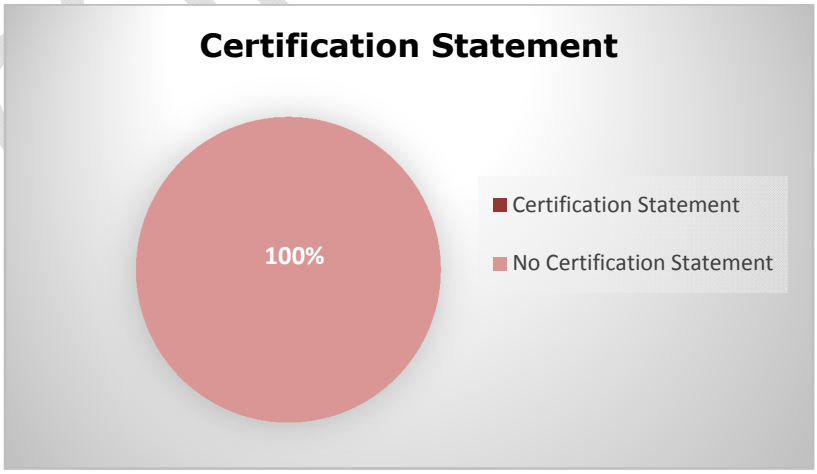
- Medicare separately defines Physician Certification Statement and Non-Physician Certification statement.
- Adds 3 new authorized signers for the "Non-PCS" (licensed practical nurse, social worker, and case manager).
- Clarifies that by submitting the claim, you are indicating you have the PCS on file "if required".
- Removes reference to a "physician's order".

The new rule had only minor changes, so the old forms would not be completely invalid, but it could be scrutinized or could be subjected to some degree of challenge by a Medicare reviewer, especially if a Non-Physician signs a document called a Physician Certification Statement. In this claims review, there was only one (1) transport that was Hospital to Hospital that required a certification statement. That transport did not provide a certification statement causing an error rate of 100%. F**igure 16** provides the claim that needed a certification statement and **Figure 17** displays the 100% error rate.

Figure 16: Certification Statement

Item #	Account Number	Program	Comments
28	58932148	Medicare	The pickup location was Hospital of Providence Northeast being transported to Hospital of Providence Sierra.

Figure 17: Certification Statement



Beneficiary Signatures

Medicare requires a signature from the patient, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. The Medicare Benefits Policy Manual, Chapter 10, Section 20.1.2 outlines the specific requirements that must be met for obtaining appropriate patient signatures for billing ambulance claims. Of the claims reviewed, three (3) did not provide the proper patient signature nor his or her representative.

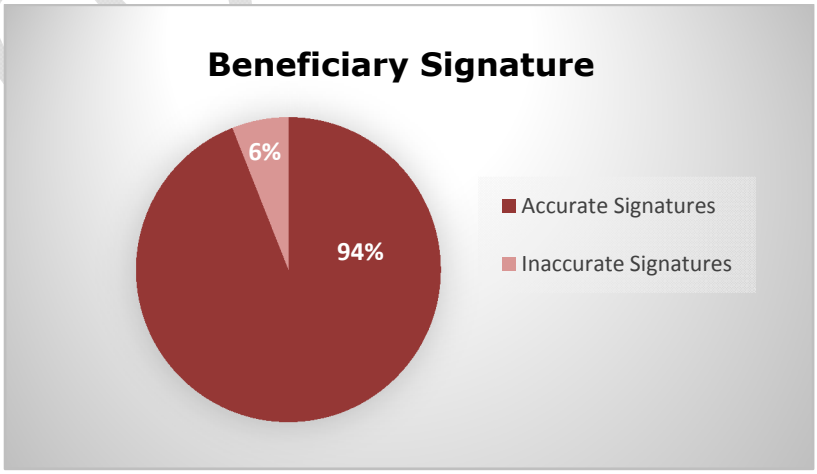
Figure 18 provides a list of the 3 claims that did not have patient signatures on the Hospital Care Report or provide the reason the patient was unable to sign the Hospital Care Report.

Figure 18: Beneficiary Signatures

Item #	Account Number	Program	Comments
3	58910804	Medicare	The patient was unable to sign the Hospital Care Report, the reason was not provided on the form. A crew member signed in the section stating that the patient was physically or mentally incapable of signing and no authorized representative was available or willing to sign. The Hospital Care Report did have a receiving facility signature notating the transfer of patient care.
12	58742982	Medicaid	The Hospital Care Report did not provide a patient signature section on the form nor is there a patient unable to sign section. The patient appeared to be able to sign based on the narrative of the chart.
49	58669591	Medicare	The Hospital Care Report did not provide a patient signature section on the form nor is there a patient unable to sign section. The patient appeared with a depressed level of consciousness based of the narrative of the chart. No signature was provided on behalf of the patient.

Figure 19 graphically displays a 94% accuracy rate and compliance for beneficiary signature requirements for the claims reviewed.

Figure 19: Beneficiary Signature Accuracy Percentage

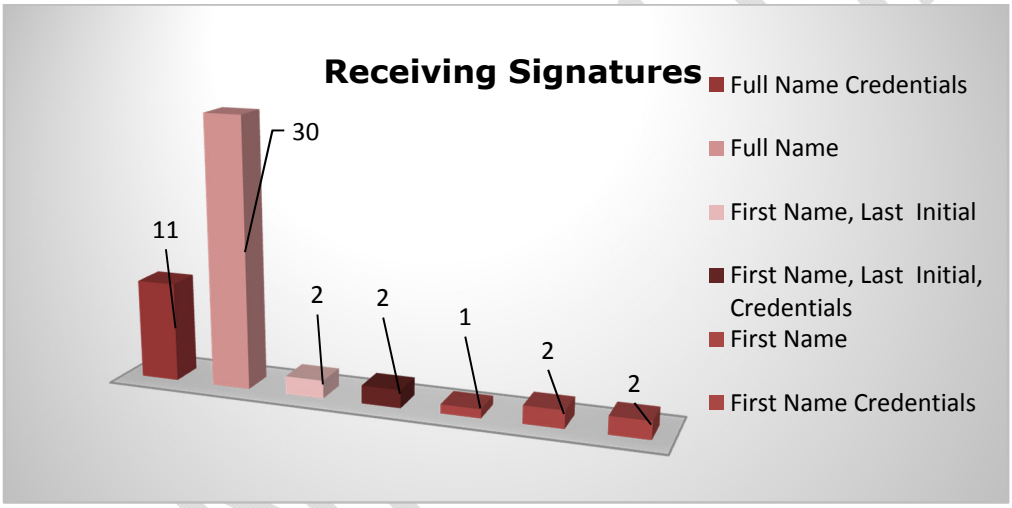


Receiving Facility Signatures

The Hospital Care Report should provide a signature section for the receiving facility representative to verify the transfer of care from the ambulance provider to the facility. It is best practice to obtain the signature, full printed name, and credentials of the receiving representative. A signature from the receiving facility was obtained on 48 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 20 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 20: Receiving Signature Breakdown



Crew Member Signatures

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 Hospital Care Reports should be signed by all members of the ambulance crew who are present during the patient transport, including the driver, and others who participated and provided care. All signatures must be legible, if not, a typed or printed signature or signature log must be available. In this case the printed name in the crew member section of the Hospital Care Report would determine the identity of the authors of the medical record.

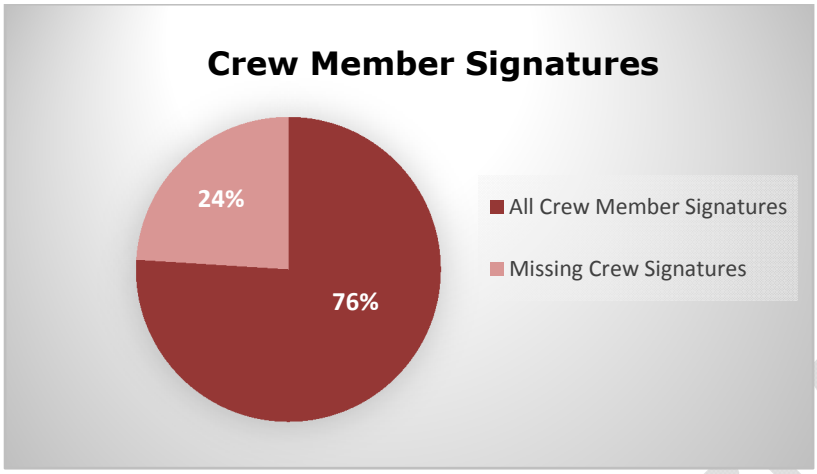
Figure 21 shows the claims that did not provide signatures for all crew members on the transport.

Figure 21: Crew Member Signatures

Item #	Account Number	Comments
1	59500854	One (1) printed name without signature.
2	59071994	Two (2) crew members were listed in the crew member section of the Hospital Care Report. One signature was provided.
3	58910804	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.
10	59610539	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.
12	58742982	Two (2) crew members were listed in the crew member section of the Hospital Care Report, two signatures were provided but only 1 printed name.
16	58910817	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.
20	58857587	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.
31	59152564	Two (2) crew members were listed on the Hospital Care Report. Two signatures appeared on the form, but the signatures were from the same crew member.
33	58826383	Two (2) crew members were listed in the crew member section of the Hospital Care Report. One signature was provided.
45	58816035	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.
49	58669591	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.
50	58961520	Two (2) crew members were listed in the crew member section of the Hospital Care Report, two signatures were provided but only 1 printed name.

Figure 22 displays the crew member signature accuracy percentage.

Figure 22: Crew Member Signature Accuracy Percentage



Error Quantification

Figure 23: Error Rate Quantification

Area Reviewed	Error Rate
Mileage	0%
Medical Necessity	2%
Reason for Transport	2%
Modifiers	22%
Coding of Charges	26%
Diagnoses and Condition Coding	8%
Certification Statement	100%
Medicare Beneficiary Signature	6%
Crew Member Signatures	24%

Findings Summary

For this report, mileage, medical necessity, and reason for transport all had an error rate of less than 5%. The areas of modifiers, coding of charges, diagnoses and condition coding, certification statement, beneficiary 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.

- **Modifiers:** It is very important that crew members document the precise pickup and drop off locations. Documenting the type of services provided at the pickup location will assist in making

sure the correct modifier is selected at the time of billing. 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:** CMS and the Office of the Inspector General (OIG) have placed special attention on claims that are billed for reimbursement at levels of service higher than that required by the patient at the time of transport and/or are contradictory to the information provided in the chart and the supporting documentation. Nine (9) of the claims found to be in error was due to billing using a recommenced conservative approach and were billed at a lower level of service than what was indicated in the Hospital Care Report. This information should be reviewed with the individuals responsible for assigning the codes and charges to ensure all parties are clear as to the responsibility to accurately report the level of service. Four (4) of the claims clearly showed that oxygen was provided to the patient in the Hospital Care Report but was not billed separately on the 1500 form to Medicaid.

  The Procedures and Vitals sections of the Hospital Care Report, in most of the charts, implies that supplies were utilized (e.g., Glucose Check, IV started etc.) *EL PASO* should take the time to review the Texas Medicaid Provider Procedure Manual with its billing company to ensure that documentation provides adequate guidance to ensure the proper charges are being applied for the claims billed to Medicaid to receive all allowable revenue.

- **Diagnoses and Condition Coding:** The specificity and detail are significantly expanded with the implementation of ICD-10 diagnosis coding. The crew member's documentation should be thorough, accurate and honest in reporting the patient's condition at the time of transport. This information is vital for the coders and billers to be able to correctly identify the need for transport, assign service levels, and support the medical necessity of the transport, especially since Texas Medicaid provides a specific list of emergency medical condition codes that are required on all Medicaid emergency ambulance claims. This specific list of codes can be found in The Medicaid Ambulance Service Handbook, Section 2.4.6.

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

format at another time). Training of field personnel and billing representatives as to the rules and requirements for obtaining appropriate signatures and recording is recommended.

- **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 Hospital Care Report. 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 chart, including the driver and others who participated and provided care.

Comparison

Comparing to the three previous audits, modifiers and coding of charges had the highest error rate in this review. Mileage, medical necessity, and beneficiary signatures has the lowest error percentage compared to all the reviews. Reason for transport was consistent with a 2 % error rate in both reviews that had hospital to hospital transports. Diagnoses and condition coding and crew member signature increased in the 2021 audit compared to the 2019 and 2020 audit results. Error rates for Coding of Charges increased significantly over previous reviews. This should be reviewed and addressed in an expedient manner as this poses a risk to El Paso for non-compliant billing that could lead to requirement of refunds/recoupments, additional audits, fines, and more.

Figure 24 provides the comparison table for all four (4) of the reviews.

Figure 24: Error Rate Quantification Comparison

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

Conclusion

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

Credentials

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

Attachment A

Compliance Review Worksheet

FITCH
& 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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Diagnosis Supported by Docs?	ICD-10 Code
1	59500854	CARE	12/17/2020	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Error	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R00.0
							A0425	Ground Mileage											$75.00	$38.10	$38.10	$30.48		Y	Z99.89
2	59071994	CARE	11/08/2020	7.2	Y	NA	A0429	BLS Emerg	A0427	N	Y	RH	Y		NA	Y	Error	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R53.1
							A0425	Ground Mileage											$108.00	$54.86	$54.86	$43.89		Y	Z74.3
																								Y	U07.1
3	58910804	CARE	10/25/2020	1.6	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Error	Error	$855.00	$432.90	$432.90	$346.32	CARE	N	E11.649
							A0425	Ground Mileage											$24.00	$12.19	$12.19	$9.75		Y	Z99.89
4	58977804	CARE	10/30/2020	2.3	Y	NA	A0429	BLS Emerg	A0427	N	Y	RH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	I16.9
							A0425	Ground Mileage											$34.50	$17.53	$17.53	$14.02		Y	Z74.3
5	58799108	CARE	10/14/2020	3.7	Y	NA	A0427	ALS 1 Emerg		Y	Y	HH	N	PH	NA	Y	Y	U	$855.00	$432.90	$432.90	$346.32	CARE	Y	R10.84
							A0425	Ground Mileage											$55.50	$28.19	$28.19	$22.55		Y	Z74.3
6	58821977	CARE	10/16/2020	2.5	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	S50.812A
							A0425	Ground Mileage											$37.50	$19.05	$19.05	$15.24		Y	Z74.3
7	58857567	CARE	10/02/2020	1.1	Y	NA	A0429	BLS Emerg		Y	Y	JH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R00.1
							A0425	Ground Mileage											$16.50	$8.38	$8.38	$6.70		Y	Z74.3
8	59211011	CARE	11/20/2020	3.5	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R52
							A0425	Ground Mileage											$52.50	$26.67	$26.67	$21.34		Y	Z74.3
9	59126095	CARE	11/13/2020	6.5	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	N	$855.00	$432.90	$432.90	$346.32	CARE	Y	R06.02
							A0425	Ground Mileage											$97.50	$49.53	$49.53	$39.62		Y	Z99.89
10	59610539	CAID	12/27/2020	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y		NA	Y	Error	Y	$855.00	$271.02	$285.28	$271.02	CAID	Y	R53.1

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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Diagnosis Supported by Docs?	ICD-10 Code
							A0425	Ground Mileage											$67.50	$22.37	$23.55	$22.37		Y	Z99.89
11	58768475	CAID	10/12/2020	2.4	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y		NA	Y	Y	Y	$855.00	$285.28	$285.28	$285.28	CAID	Y	O26.90
							A0425	Ground Mileage											$36.00	$11.30	$11.30	$11.30		Y	Z99.89
12	58742982	CAID	10/09/2020	6.7	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y		NA	Error	Error	N	$855.00	$271.02	$285.28	$271.02	CAID	Y	R06.02
							A0425	Ground Mileage											$100.50	$29.98	$31.56	$29.98		Y	Z74.3
																								N	Z20.828
13	59046660	CARE	11/03/2020	2.4	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R53.1
							A0425	Ground Mileage											$36.00	$18.29	$18.29	$14.63		Y	Z74.3
																								Y	U07.1
14	59520063	CARE	12/18/2020	4.1	Y	NA	A0429	BLS Emerg	A0427	N	Y	RH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R06.02
							A0425	Ground Mileage											$61.50	$31.24	$31.24	$24.99		Y	Z74.3
15	59711748	CARE	12/30/2020	7.2	Y	NA	A0429	BLS Emerg		Y	Y	EH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R53.1
							A0425	Ground Mileage											$108.00	$54.86	$54.86	$43.89		Y	Z74.3
16	58910817	CARE	10/25/2020	2.5	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Error	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R06.02
							A0425	Ground Mileage											$37.50	$19.05	$19.05	$15.24		Y	Z99.89
																								Y	Z20.828
17	58852645	CAID	10/19/2020	0.3	Y	NA	A0429	BLS Emerg		Y	Y	ETPH	N	ETHI	NA	Y	Y	Y	$855.00	$240.23	$240.23	$240.23	CAID	Y	T50.901A
							A0425	Ground Mileage											$4.50	$1.41	$1.41	$1.41		Y	Z74.3
18	58885617	CARE	10/22/2020	1.4	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	N	R06.03
							A0425	Ground Mileage											$21.00	$10.67	$10.67	$8.54		Y	Z74.3
19	58665265	CAID	10/02/2020	0.4	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETHH	Y		NA	Y	Y	Y	$855.00	$271.02	$240.23	$271.02	CAID	Y	R07.9
							A0425	Ground Mileage											$6.00	$4.47	$1.88	$4.47		Y	Z99.89

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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Diagnosis Supported by Docs?	ICD-10 Code
20	58857587	CAID	10/20/2020	0.5	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETSH	Y		NA	Y	Error	Y	$855.00	$285.28	$285.28	$285.28	CAID	Y	R56.9
							A0425	Ground Mileage											$7.50	$2.36	$2.36	$2.36		Y	Z99.89
21	59376270	CAID	12/05/2020	3.2	Y	NA	A0429	BLS Emerg		Y	Y	ETSH	Y		NA	Y	Y	U	$855.00	$240.23	$240.23	$240.23	CAID	Y	R10.9
							A0425	Ground Mileage											$48.00	$15.07	$15.07	$15.07		Y	Z76.89
22	58701308	CARE	10/06/2020	2.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R56.9
							A0425	Ground Mileage											$30.00	$15.24	$15.24	$12.19		Y	Z99.89
23	59022820	CAID	11/03/2020	5.7	Y	NA	A0429	BLS Emerg		Y	N	ETRH	Y		NA	Y	Y	Y	$855.00	$228.22	$240.23	$228.22	CAID	N	L02.414
							A0425	Ground Mileage											$85.50	$26.85	$26.85	$26.85		Y	Z74.3
24	59590302	CAID	12/25/2020	5.7	Y	NA	A0429	BLS Emerg	A0427	N	Y	ETRH	Y		NA	Y	Y	Y	$855.00	$228.22	$240.23	$228.22	CAID	Y	R52
							A0425	Ground Mileage											$85.50	$26.85	$26.85	$26.85		Y	Z74.3
25	58724720	CARE	10/07/2020	4.7	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CAID	Y	R53.1
							A0425	Ground Mileage											$70.50	$35.81	$35.81	$28.65		Y	Z74.3
26	59284963	CARE	11/25/2020	4.8	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R53.1
							A0425	Ground Mileage											$72.00	$36.58	$36.58	$29.26		Y	Z99.89
27	59455163	CARE	12/13/2020	3.1	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R10.9
							A0425	Ground Mileage											$46.50	$23.62	$23.62	$18.90		Y	Z74.3
28	58932148	CARE	10/26/2020	6.8		Y	A0427	ALS 1 Emerg	A0426	N	Y	PH	N	HH	N	Y	Y	N	$855.00	$432.90	$432.90	$346.32	CARE	Y	R41.82
							A0425	Ground Mileage											$102.00	$51.82	$51.82	$41.46		Y	Z99.89

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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Diagnosis Supported by Docs?	ICD-10 Code
29	59005916	CARE	11/02/2020	3.9	Y	NA	A0429	BLS Emerg		Y	Y	SH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	F41.9
							A0425	Ground Mileage											$58.50	$29.72	$29.72	$23.78		Y	Z74.3
30	59410121	CARE	12/08/2020	6.6	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	Y		NA	N	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R41.82
							A0425	Ground Mileage											$99.00	$50.29	$50.29	$40.23		Y	Z99.89
31	59152564	CARE	11/15/2020	3.5	Y	NA	A0429	BLS Emerg		Y	Y	RH	Y		NA	Y	Error	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	M79.604
							A0425	Ground Mileage											$52.80	$26.67	$26.67	$21.34		Y	Z74.3
32	58857611	CAID	10/20/2020	5.0	Y	NA	A0429	BLS Emerg	A0427	N	Y	ETRH	Y		NA	Y	Y	Y	$855.00	$228.22	$240.23	$228.22	CAID	Y	R06.02
							A0425	Ground Mileage											$75.00	$22.37	$23.55	$22.37		Y	Z74.3
33	58826383	CARE	10/16/2020	3.7	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Error	U	$855.00	$432.90	$432.90	$346.32	CARE	Y	R51.9
							A0425	Ground Mileage											$55.50	$28.19	$28.19	$22.55		Y	Z74.3
34	59108944	CARE	11/10/2020	3.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	U	$855.00	$432.90	$432.90	$346.32	CARE	Y	R41.82
							A0425	Ground Mileage											$45.00	$22.86	$22.86	$18.29		Y	Z99.89
35	59298686	CARE	11/29/2020	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	U	$855.00	$432.90	$432.90	$346.32	CARE	Y	R41.82
							A0425	Ground Mileage											$75.00	$38.10	$38.10	$30.48		Y	Z74.3
36	59222253	CAID	11/21/2020	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	ETRH	Y		NA	Y	Y	U	$855.00	$285.28	$285.28	$285.28	CAID	Y	R41.82
							A0425	Ground Mileage											$75.00	$23.55	$23.55	$23.55		Y	Z99.89
37	58907054	CARE	10/11/2020	1.9	Y	NA	A0429	BLS Emerg		Y	Y	EH	N	NH	NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	R53.1
							A0425	Ground Mileage											$28.50	$14.48	$14.48	$11.58		Y	Z74.3

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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Diagnosis Supported by Docs?	ICD-10 Code
38	59040563	CARE	11/06/2020	4.2	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R06.02
							A0425	Ground Mileage											$63.00	$32.00	$32.00	$25.60		Y	Z74.3
																								Y	U07.1
39	58793092	CARE	10/11/2020	7.8	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R06.02
							A0425	Ground Mileage											$117.00	$59.44	$59.44	$47.55		Y	Z74.3
40	59600882	CARE	12/25/2020	1.9	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R55
							A0425	Ground Mileage											$28.50	$14.48	$14.48	$11.58		Y	Z99.89
41	59138413	CAID	11/14/2020	5.4	Y	NA	A0429	BLS Emerg	A0427	N	Y	ETRH	Y		NA	Y	Y	U	$855.00	$228.22	$240.23	$228.22	CAID	Y	M54.9
							A0425	Ground Mileage											$81.00	$24.16	$25.43	$24.16			
42	58804024	CARE	10/15/2020	4.5	Y	NA	A0429	BLS Emerg	A0427	N	Y	RH	Y		NA	Y	Y	Y	$855.00	$364.55	$364.55	$291.64	CARE	Y	I10
							A0425	Ground Mileage											$67.50	$34.29	$34.29	$27.43		Y	Z74.3
43	59372124	CARE	12/05/2020	1.9	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R07.9
							A0425	Ground Mileage											$28.50	$14.48	$14.48	$11.58		Y	Z74.3
44	59247853	CARE	11/24/2020	1.0	Y	NA	A0429	BLS Emerg	A0427	N	Y	HH	Y		NA	Y	Y	U	$855.00	$364.55	$364.55	$291.64	CARE	N	U07.1
							A0425	Ground Mileage											$15.00	$7.62	$7.62	$6.10		Y	Z74.3
45	58816035	CARE	10/16/2020	0.1	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	PH	NA	Y	Error	U	$855.00	$432.90	$432.90	$346.32	CARE	Y	R41.82
							A0425	Ground Mileage											$1.50	$0.76	$0.76	$0.61		Y	Z99.89
46	58955644	CARE	10/22/2020	1.4	Y	NA	A0427	ALS 1 Emerg		Y	Y	SH	Y		NA	Y	Y	U	$855.00	$432.90	$432.90	$346.32	CARE	Y	R06.02
							A0425	Ground Mileage											$21.00	$10.67	$10.67	$8.54		N	Z74.3
																								Y	Z20.828
47	59126056	CARE	11/13/2020	3.5	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R56.9

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?	IRO Modifier If Differs	PCS	Receiving Section/Signature	Crew Signature	Pt Signature	Total Charges	Allowed Amount	Correct Allowed Amount	Primary Payments	Primary Payer	Diagnosis Supported by Docs?	ICD-10 Code
							A0425	Ground Mileage											$52.50	$26.67	$26.67	$21.34		N	Z74.3
48	58891164	CARE	10/23/2020	10.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	RH	Y		NA	Y	Y	Y	$855.00	$432.90	$432.90	$346.32	CARE	Y	R06.02
							A0425	Ground Mileage											$150.00	$76.20	$76.20	$60.96		Y	Z74.3
49	58669591	CARE	10/02/2020	5.0	Y	NA	A0427	ALS 1 Emerg		Y	Y	EH	N	NH	NA	Y	Error	N	$855.00	$432.90	$432.90	$346.32	CARE	Y	R41.82
							A0425	Ground Mileage											$75.00	$38.10	$38.10	$30.48		N	Z74.3
50	58961520	CARE	10/29/2020	7.1	Y	NA	A0429	BLS Emerg		Y	Y	SH	Y		NA	Y	Error	U	$855.00	$364.55	$364.55	$291.64	CARE	Y	F91.9
							A0425	Ground Mileage											$106.50	$54.10	$54.10	$43.28		Y	Z74.3

Attachment B

RAT STATS Printout

FITCH
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Windows RAT-STATS
Statistical Software
Random Number Generator

Date: 3/12/2021 **Time:** 13:16

Audit: El Paso Medicare & Medicaid

10/1/2020 to 12/30/2020 **Seed Number** 47815.77 **Frame Size** 1,476

Order	Value	Account Number	Date of Service	Payor
19	39	58665265	10/02/2020	**Medicaid**
12	158	58742982	10/09/2020	**Medicaid**
11	215	58768475	10/12/2020	**Medicaid**
17	363	58852645	10/19/2020	**Medicaid**
20	380	58857587	10/20/2020	**Medicaid**
32	382	58857611	10/20/2020	**Medicaid**
23	649	59022820	11/03/2020	**Medicaid**
41	828	59138413	11/14/2020	**Medicaid**
36	934	59222253	11/21/2020	**Medicaid**
21	1161	59376270	12/05/2020	**Medicaid**
24	1395	59590302	12/25/2020	**Medicaid**
10	1425	59610539	12/27/2020	**Medicaid**
49	31	58669591	10/02/2020	Medicare
7	34	58857567	10/02/2020	Medicare
22	95	58701308	10/06/2020	Medicare
25	117	58724720	10/07/2020	Medicare
39	185	58793092	10/11/2020	Medicare
37	187	58907054	10/11/2020	Medicare
5	243	58799108	10/14/2020	Medicare
42	253	58804024	10/15/2020	Medicare
45	281	58816035	10/16/2020	Medicare
6	286	58821977	10/16/2020	Medicare
33	290	58826383	10/16/2020	Medicare
18	412	58885617	10/22/2020	Medicare
46	421	58955644	10/22/2020	Medicare
48	431	58891164	10/23/2020	Medicare
3	456	58910804	10/25/2020	Medicare
16	458	58910817	10/25/2020	Medicare
28	484	58932148	10/26/2020	Medicare
50	538	58961520	10/29/2020	Medicare
4	563	58977804	10/30/2020	Medicare
29	621	59005916	11/02/2020	Medicare
13	644	59046660	11/03/2020	Medicare
38	691	59040563	11/06/2020	Medicare
2	730	59071994	11/08/2020	Medicare
34	764	59108944	11/10/2020	Medicare
47	802	59126056	11/13/2020	Medicare
9	806	59126095	11/13/2020	Medicare
31	836	59152564	11/15/2020	Medicare

8	916	59211011	11/20/2020	Medicare
44	974	59247853	11/24/2020	Medicare
26	992	59284963	11/25/2020	Medicare
35	1048	59298686	11/29/2020	Medicare
43	1152	59372124	12/05/2020	Medicare
30	1198	59410121	12/08/2020	Medicare
27	1258	59455163	12/13/2020	Medicare
1	1301	59500854	12/17/2020	Medicare
14	1317	59520063	12/18/2020	Medicare
40	1393	59600882	12/25/2020	Medicare
15	1459	59711748	12/30/2020	Medicare

Spares

Order	Value	Account Number	Date of Service	Payor
54	16	58646472	10/01/2020	**Medicaid**
56	1440	59626623	12/28/2020	**Medicaid**
57	1189	59398179	12/07/2020	**Medicaid**
51	392	58874495	10/21/2020	Medicare
52	920	59215958	11/20/2020	Medicare
53	1417	59610537	12/27/2020	Medicare
55	606	58993267	11/01/2020	Medicare
58	1121	59350551	12/03/2020	Medicare
59	300	58826388	10/17/2020	Medicare
60	237	58907057	10/13/2020	Medicare

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

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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