AMBULANCE BILLING AUDITS, COMPLIANCE, AND COMPLAINTS

Effective:	March 8, 2024
Scheduled Review:	March 8, 2027
Approved:	Fire Chief Mike Kennedy

I. PURPOSE

The purpose of this procedure is to verify that claims are properly coded to be submitted for payment or that proper payment was made for submitted claims, and to determine if appeals for denials or refunding of overpayments may be required.

The fire department will identify possible compliance risk areas and ensure proper controls are in place to prevent compliance problems in an effort to avoid a government investigation or other negative consequences for the City of Ann Arbor.

II. INTERNAL AUDITS

In accordance with the auditing and monitoring standards, to promote a positive compliance atmosphere, and to detect and prevent violations of the law, Medicare Program requirements, and our policies and procedures, the fire department will conduct periodic audits and reviews of claims and other Medicare requirements to ensure that proper coding and billing of services are being performed and that proper reimbursement is being pursued and received. Samples of pre- and / or post-submission claims will be audited to verify accuracy, check for any possible errors, and ensure that all Medicare coverage criteria are met. Auditing will be completed by the compliance officer (EMS coordinator) or other personnel as assigned by the fire chief.

Due to current relatively low volume of transports, all claims will be reviewed and audited for accuracy (self-audit).

Upon review of claims that have not yet been billed, a determination will be made as to whether each claim can be submitted for payment as prepared, or whether additional documentation is required, corrections must be made to address errors, or it cannot be billed at all. In each case, compliance with all Medicare coverage criteria should be evaluated.

Upon review of claims which have been paid, a determination will be made as to whether the claim was appropriately billed and paid, and whether an overpayment or underpayment exists. In each case, compliance with all Medicare coverage criteria should be evaluated. A denied or "downcoded" claim will be further reviewed and a decision made as to whether the claim should be appealed.

Information for each claim will be reviewed (including a review of the CMS 1500 claim form (or its electronic equivalent), the electronic remittance advice, the PCR, the PCS (if applicable), the CAD notes (or other dispatch instructions or information) if available, and all other available and relevant information.

The self-audit process will ensure that claims for ambulance transports of Medicare beneficiaries meet the requirements for a "covered transport" in accordance with CMS Manual 100-02 ("Medicare Benefit Policy Manual"), Chapter 10 ("Ambulance Services"), CMS Manual 100-04 ("Medicare Claims Processing Manual"), Chapter 15 ("Ambulance"), 42 CFR 410.40, 42 CFR 410.41, and 42 CFR 414.605 et seq.

In order to assess these criteria, we will use our Ambulance Claims Review Process to assist in performing a thorough review, which will be able to concisely demonstrate problem areas, and provide input for future corrective actions. Below is a table further describing the general categories and a brief explanation as to what to consider when assessing each area.

Patient Name	Verify that patient's name is spelled correctly and will be/was recognized by Medicare.
Date of Service	Ensure that the dates reported on the various forms, e.g., PCR, PCS, dispatch records, claim, are consistent and correct.
Was Medical Necessity Met?	Determine if the documentation reveals the medical or physical reason the patient needed an ambulance transport, and that other forms of transport were contraindicated.
Was the Transport Reasonable?	Determine if the patient required transport from the origin point to the destination point. Ensure that the service could not have been provided at less cost at the point of origin and that the destination was the closest appropriate destination.
Was There an Immediate Response?	For emergency transports, verify that there was a 911 dispatch or equivalent and that there was minimal delay between the dispatched and enroute times. If the time between dispatch and arrival is lengthy, verify that the PCR contains information explaining the delay and how the crew acted as quickly as possible to respond.
Are Modifiers Correct?	Verify that proper modifiers were used, including origin and destination modifiers, and possible payment related modifiers.
Does Destination Appear Appropriate?	Confirm that the destination facility is a covered destination, appropriate (to meet reasonableness standards) and that it is the closest appropriate facility to meet the patient's needs.

Was Patient Signature Obtained?	Confirm that a patient signature has been captured, or, where appropriate and permitted, that a representative signature has been obtained, or a lifetime signature is on file.
Was Zip Code Recorded?	Verify that the zip code of the point of pick–up is recorded.
Comments	Insert relevant comments, related to any of the review areas, or any other issues that may arise, including whether an overpayment or underpayment may exist.

III. RISK IDENTIFICATION AND RESPONSE

On a routine basis, we will perform a risk assessment which will include a review of potential risk areas identified by the Office of Inspector General (OIG) as well as other potential risks identified by the compliance officer as relevant to the organization in order to ensure that we are maintaining compliance with statutes, regulations and other requirements applicable to our ambulance service operations and that our compliance efforts are properly focused and effective.

During the initial development of the compliance program, and at least annually thereafter, the fire chief along with the compliance officer will conduct a risk assessment of the fire department. The risk assessment may be conducted with the assistance of legal counsel or consultants who have experience with compliance risks impacting ambulance services.

The risk assessment will include an evaluation of the risk areas identified by the OIG in its Compliance Program Guidance as well as other OIG publications and any other risk areas impacting the fire department. The fire chief and / or compliance officer may consider laws, regulations, policies and conduct as well as complaints or concerns reported by personnel, prior audits or lawsuits, and external audits and reviews among other factors when identifying areas of risk.

As part of the risk assessment, the fire chief and / or compliance officer may evaluate the fire department procedures, employee training, employee knowledge, the claims submission process, documentation practices, management structure and commitment to compliance, contractual arrangements, and technology relied upon in the claims submission process to identify areas where the fire department may be exposed to compliance risk.

After identifying potential risks, the fire chief and / or compliance officer will evaluate all of the identified potential risks along with the systems and controls fire department currently has in place to combat those risks. Compliance program efforts will be focused on the areas with greatest potential risk to fire department and those areas where fire department needs to improve systems and controls.

The fire chief and / or compliance officer may choose to implement a corrective action plan to address some of the identified risks to ensure risks are properly mitigated.

IV. COMPLAINT AND CONCERN REPORTING

All personnel will report good faith compliance concerns or suspected compliance violations without fear of retaliation.

Personnel will report any concern about conduct they believe to be improper including, but not limited to, conduct in violation of compliance programs or any conduct that could be seen as violating the principles or standards of our Compliance Program.

As a general rule, personnel should bring concerns to their immediate supervisor. If the concern is compliance related or if for any reason, personnel do not feel comfortable in reporting the concern to an immediate supervisor, personnel have the discretion to report any concern about our operations or personnel conduct any of the following:

- Compliance officer
- Assistant Chief or Fire Chief
- Call the confidential employee hotline at 877-647-3335, text RFR to 234-231-9005 or visit RedFlagReporting.com to report fraudulent activities. Employees will need to use Client Code "AnnArbor" when making a report. The confidential employee hotline service is a third party, anonymous hotline that employees can use to report suspected fraudulent activity.

Reports may be made in writing, but it is not required that concerns be placed in writing to be treated seriously. Any concern that could affect our compliance with the law will be investigated, even if it is not put in writing.