Ambulance Billing

Reason for the report

The 2003/2004 Grand Jury received a complaint concerning the county operated Ambulance Billing Service (ABS).

Scope of the investigation

People interviewed

- Auditor-Controller
- Director, Public Health Department
- Health Insurance Counseling and Advocacy Program (HICAP)
- Medical Billing Supervisor, ABS
- Staff Members of ABS

Documents reviewed

- Auditor-Controller's compliance review report of ABS dated 5/06/04
- Billing records of various time periods
- Board of Supervisors Policy B-4, Collections Recovery Of Public Funds (9/02)
- Complaint
- Internal audit finding from ABS
- Letter from Marshall Hospital to Ambulance Billing Supervisor dated 02/06/03

Background

El Dorado County is the only county in the state of California that directly bills for services performed by county paramedics in the Ambulance Transport Service. HICAP is a volunteer based watchdog organization whose function is to serve the elderly and disabled regarding their rights on Medicare services, among other services. A complaint was received from HICAP regarding improper billing of multiple Medicare patients for services from the El Dorado County Ambulance Transport. The complaint alleged that Medicare patients were being sent bills for payment by ABS, and re-enforced by letters sent by County Counsel, demanding payment for services that were rightfully covered by Medicare Insurance. HICAP alleged that ABS did not pursue disputes in billing between the County and Medicare through resolution with Medicare officials, but rather forwarded these bills to the patient, demanding payment. A number of the disputed invoices were resolved in favor of the patient through the efforts of HICAP, and should not have been forwarded to the patient for payment.

HICAP officials presented early investigation results to the Director of Public Health and requests were made of County officials to look into the matter. Early findings by ABS uncovered deficiencies in employee training and problems with insurance procedures that were to blame for some of the improper billings of County patients. Continued audits by HICAP uncovered additional problems.

An audit of the situation was conducted by the Auditor-Controller, as requested by the Grand Jury in a letter dated 2/18/04.

Facts

1. ABS processes the billing for services provided by The Ambulance Transport Service.
2. Medicare uses the term "Denies" for all services which are disputed or not covered under the Medicare Insurance, and ABS is using the term "Rejected" on bills sent to the patient.
3. Medicare patient bills are sent by ABS to Medicare Insurance for payment.
4. Medicare Insurance sends disputed invoices back to ABS for clarification/correction.
5. Bills not paid in a reasonable time are referred to County Counsel for collection.
6. As quoted in Auditor-Controller compliance review report, "The Department does not have specific written policies and procedures that pertain to the billing of Medicare beneficiaries for Ambulance services."
7. Training by department staff is accomplished by on-the-job training rather than formal training.
8. Per Auditor-Controller compliance review report, ABS's unwritten policy is to refer bills to the County Counsel collections after 120 days.

Findings

1. Rejected/Denied Medicare bills were improperly sent to patients. Additional effort was required by county employees to resolve disputes between Medicare Insurance and ABS.

   Response to Finding 1: The respondent agrees with the finding.

2. ABS was requesting payments from patients through County Counsel even though the Medicare disputes were not resolved.

   Response to Finding 2: The respondent agrees with the finding.

3. A number of these disputed bills are not being resolved properly and patients are being billed.

   Response to Finding 3: The respondent disagrees wholly with the finding.
   There are no known ongoing disputes at the time of this response. All 21cases, which were the subject of this investigation, had been resolved by ABS (in June 2003) prior to the Grand Jury's review of the issue. There were no claims improperly paid by the beneficiary or the patient.

4. Different billing terminology between Medicare and ABS caused confusion among patients. These differences caused difficulty when patients called Medicare to resolve the disputes.

   Response to Finding 4: The respondent agrees with the finding.

5. Lack of written policies and procedures in ABS resulted in improper handling of ambulance transport claims.

Response to Finding 5: <u>The respondent disagrees wholly with the finding</u>. Ambulance Billing Service is guided by the written policies and procedures of the American Ambulance Association (AAA) as promulgated through their *Medicare Reference Manual*, an industry standard. AAA is a professional industry organization that retains staff and attorneys to review and update this important reference document as needed. When Medicare policies or procedures change, Ambulance Billing Service receives a notification from AAA with the updates. Any improper handling that occurred was due to incomplete training, not lack of written policies and procedures

6. Lack of training resulted in improper coding on Medicare forms.

Response to Finding 6: <u>The respondent agrees with the finding</u>. The 21 cases of erroneous billing to Medicare patients made in May 2003 were traced to a single recently hired ABS staff member who was not appropriately trained on existing policies and procedures.

<u>Recommendations</u>

1. ABS employees must be directed to resolve disputes with Medicare prior to billing the patients.

Response to Recommendation 1: <u>The recommendation has been implemented</u>. ABS staff are directed to resolve rejected claim disputes with Medicare on behalf of the patients. ABS only bills patients after Medicare has denied a claim or after Medicare has paid its portion of the ambulance bill and there is a remaining portion that is the patient's responsibility. ABS' role and responsibilities have been clarified and reinforced with ABS employees.

2. The County should exclude ABS from sending disputed payment notices to patients per Board of Supervisors' policy B-4 in collections.

Response to Recommendation 2: <u>The recommendation requires further analysis</u>. ABS follows the process outlined in Board of Supervisor's policy B-4 in referring to County Collections. This may include disputed payment notices. If the Board wishes to review and modify BOS policy B-4, ABS would follow Board direction.

3. County must resolve differences in terminology used by Medicare Insurance and ABS.

Response to Recommendation 3: <u>The recommendation has been implemented</u>. Ambulance Billing Service modified its monthly billing statements in February 2004 to clearly indicate the status of the patient's account and whether any payment or partial payment (e.g., patient co-payment) is being requested from the patient at this time. ABS terminology now conforms to that being used by Medicare.

4. The County must immediately direct ABS to develop and implement written policies and procedures for detailed processing of ambulance transport billing.

Response to Recommendation 4: ***The recommendation has not yet been implemented, but will be implemented by January 1, 2005***. The Chief Administrative Officer will work with the Public Health Department to update or revise current policies and procedures, and will bring a policy to the Board of Supervisors for adoption.

5. ABS employees must be trained on the coding of Medicare bills and on the County's written policies and procedures.

Response to Recommendation 5: ***The recommendation has been implemented***. ABS staff are trained in the proper coding of Medicare bills and applicable County policies and procedures. New ABS staff are now being trained at the time of hire. Updated training will be provided as needed by the ABS supervisor and will include any trends that are identified in a quarterly audit of all Medicare accounts and as recommended by the American Ambulance Association and changes in the Medicare Manual.