

INTERNAL AUDIT REPORT

CITY OF MANCHESTER

NEW HAMPSHIRE



**City of Manchester
AMR Ambulance Contract
September 2012**

**Prepared by
The Office of the Independent Auditor**

**INTERNAL AUDIT REPORT
CITY OF MANCHESTER, NEW HAMPSHIRE
AMR AMBULANCE CONTRACT
SEPTEMBER 2012**

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*Committee on Accounts, Enrollment and Revenue Administration
City of Manchester, New Hampshire
Honorable Aldermen: O'Neil, Arnold, Long, Corriveau, and Shaw*

Dear Honorable Committee Members:

At the June 18, 2012 Committee on Accounts meeting a request was made of the Office of the Independent City Auditor (OICA) to conduct an audit of the certain elements of the contract between American Medical Response (AMR) and the City of Manchester to provide ambulance service within the city limits.

AMR initiated its own internal audit following the receipt of complaints from two city workers. During this initial internal review, AMR discovered 323 ambulance trips that were found to have been overcharged and corrected these trips. Additionally, the City received several complaints lodged by Manchester Residents who felt they were being overcharged or mischarged by AMR.

My office was asked to perform an audit to determine if all over charges were discovered and all patients were properly refunded of their accounts credited for the over charge.

Conclusion

My testing revealed that one trip out of the 166 emergency ambulance trips tested the patient was over charged by AMR and not discover by their internal audit review. I also discovered other issues with AMR that are disclosed in the report and recommendations for corrections are included.

The draft audit report was sent to the management of AMR for their review and comment. Observation 1 was also sent to Anthem for their review and comment. The observations generated and the auditee written responses are included in the report. The auditee responses indicate general agreement with the report recommendations and states that corrective action will be or has been taken. We appreciate the courtesy and cooperation of the staff and administration of AMR and the Manchester Fire Department on this assignment. The management of AMR was very forth right and cooperative with the audit and I believe have or are working to fix the problems noted.

Kevin M, Buckley, CPA
Independent City Auditor

September 28, 2012

INTRODUCTION

AUDIT BACKGROUND

At the June 18, 2012 Committee on Accounts meeting a request was made of the Office of the Independent City Auditor (OICA) to conduct an audit of the certain elements of the contract between American Medical Response (AMR) and the City of Manchester to provide ambulance service within the city limits. The contract allows AMR to be the sole emergency transportation service in the City of Manchester.

The contract was executed on June 29, 2010 and covers the period from January 1, 2011 through December 21, 2012 with an option for two – one year extensions. The contract has clauses in it that dictate certain performance objectives as well as the cost AMR is allowed to charge for its emergency services to Manchester transports.

During the course of the first year of operations Aldermen and the Fire Department (who monitors the contract) received complaints from constituents that they were being over charged or mis-charged for emergency ambulance transportation. One of the Deputy Fire Chiefs has the responsibility of monitoring the contract and conducted an investigation of the complaints. He found that AMR had mis-charged City residents and brought it to the attention of AMR. Management at AMR ordered an internal audit done and discovered that due to a lack of training at the payment center 323 incorrect billings were processed. AMR claimed that they had identified all incorrect charges, repaid or credited all residents who were charged in error and instituted policy and procedures changes in the billing department to prevent the billing errors from occurring in the future.

The COA has asked the OICA to conduct a separate independent audit to verify their results. The request was passed by the COA unanimously.

I conducted my audit in accordance with auditing standards applicable to performance audits contained in *Government Auditing Standards*, Issued by the Comptroller General of the United States. Those standards require that I plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for my findings and conclusions based on my audit objectives. I believe that the evidence obtained provides a reasonable basis for my findings and conclusions based on my audit objectives.

BACKGROUND OF AUDITEE

American Medical Response, Inc. (AMR) was founded in 1992 when several ambulance providers consolidated into a single company. AMR continued to expand through 1997 when it merged with Med Trans and became the largest ambulance service provider in the country. Since that time it has continued to grow and now provides services to more than 2,100 communities in 38 states and the District of Columbia.

AMR's Manchester unit provides both emergency and non-emergency medical transport services to the City and surrounding communities. AMR Manchester employs approximately 75 paramedics and EMTs and handles on average 18,000 transports annually.

AMR's mission as stated on their web site is to make a difference by caring for people in need..

AMR was awarded the contract for emergency transportation services by the City of Manchester on June 29, 2010 and amended on December 3, 2010. The contract calls for AMR to be the sole provider of 911 emergency services for the City of Manchester. The term of the agreement was for two years starting January 1, 2011 through December 31, 2012 (amended to start December 18, 2010) with the option for two one year terms. AMR is to provide:

- No fewer than 4 ambulances manned 24 hours a day plus one emergency backup available within 10 minutes.
- Assist in the development and implementation of a training system for certification of Police and Fire Department personnel in emergency medical procedures
- Maintain the mass casualty incident (MCI) trailer and the equipment to support it
- Execution of at least 1 MCI drill per year
- Provide oxygen replenishment for Fire and Police Department oxygen cylinders
- Replace all disposable medical equipment and supplies used by the Fire Department
- Perform monthly patient satisfaction surveys.

AMR is required to pay the City of Manchester \$235,000 and \$243,000 for calendar years 2011 and 2012 respectively as reimbursement for emergency 911 dispatch services being provided pursuant to the agreement.

AUDIT SCOPE AND OBJECTIVES

The audit was a contract compliance audit of certain sections of the contract between the City of Manchester and AMR Inc, specifically the audit was designed to determine if AMR correctly calculated and charged Manchester transports no more than 135% of Medicare part b rates for emergency transportation services, in cases where customers were overcharged that AMR paid back the overcharges and has improved procedures to reduce or eliminate over charges. The audit period was the 16 months ended April 30, 2012.

Methods used:

- Interviews with management at Fire Department, AMR and NH Insurance Commission.
- Internet searches.
- Request for information from ALGA Listserv website to seek information about other municipality ambulance operations and other ambulance service audits.
- Obtain a database from AMR of emergency trips in the City and reconcile to 911 system reports to ensure completeness.
- Select a sample of trips found to contain errors by AMR internal audit and recalculate amount of refund/adjustment due. Trace to payment of refund or adjustment to account receivable.
- Select a sample of trips AMR internal audit determined to be free of audit errors and recalculate amount due to determine if there were any undiscovered over payments.

- Obtain a database from Anthem BC/BS of City employees or dependent payments for AMR emergency ambulance trips. Determine if correct amount was paid for the ambulance service.
- Solicit complaints from City employees and the general public and determine the cause and reconciliation of the complaints.

CONCLUSIONS

Management is responsible for establishing and maintaining effective internal controls to help ensure that appropriate goals and objectives are met; resources are used effectively, efficiently, and economically, and are safeguarded; laws and regulations are followed; and reliable data is obtained, maintained and fairly disclosed. I am responsible for using professional judgment in establishing the scope and methodology of my work, determining the tests and procedures to be performed, conducting the work, and reporting the results.

The results of my test work have revealed that:

- Of 39 refunds tested there were no errors detected in the calculation of refunding/crediting of the patient accounts
- Of 20 employee health care payments to AMR it was determined that a lack of provider agreement between Anthem and AMR is causing the City to pay a higher than necessary amount for emergency ambulance service
- Of 60 trips tested one (1) trip was overpaid and not discovered by AMR in the course of their internal audit, and several trips were sent to collections at the higher usual and customary charge instead of the contract allowable amount for emergency trips of City residents. In most cases, however, the charges remained at usual and customary due to the receipt of full payment by the patient from their carrier.
- Of the 47 complaints investigate the majority were for the high cost of ambulance service and problems encountered with AMR billing personnel. No actual overcharge errors were noted however the billing seems to be confusing for most patients and time delays between billing and collection of Medicare/insurance payments are causing confusion with patients. This confusion makes it appear to the patients that they are being over charged.
- Changes in billing procedures appear to be eliminating over payment errors.

The results of my testing, recommendations and observations are included in the report that follows.

TESTING RESULTS

RECENT AMBULANCE HISTORY IN MANCHESTER

The City of Manchester ambulance service had been run by the Police Department and then the Fire Department until 1985. The City at the time found it very expensive to run the service due to high cost and a low collection rate. In 1985 a private joint venture was formed called Stat Care that took over emergency ambulance service in 1985. Stat Care was replaced by Chalk Ambulance then in 1993 Rockingham Ambulance took over the service. Rockingham was a local ambulance service that, according to a February 2011 study by the State of NH Hampshire Insurance Department, was the largest ambulance provider in the State in both number of transports and total charges. In the last year of their contract with the City of Manchester Rockingham provided 19% of all transports (emergency and non-emergency) and 14% of total billings. After winning the bid to provide emergency service in Manchester American Medical Response (AMR) started providing service to Manchester in December of 2010.

AMERICAN MEDICAL RESPONSE (AMR)

AMR was founded in 1992 when several regional ambulance providers consolidated into a single company. AMR has quickly grown over the years by merging and/or acquiring other regional ambulance services to become the largest US private ambulance provider.. Today AMR services over 2,100 communities in 38 states and the District of Columbia. AMR in Manchester NH provides emergency and non-emergency medical transport service for the city and surrounding communities. AMR Manchester employs 75 paramedics and EMTs and handles over 18,000 transports annually.

AMBULANCE BILLING

Ambulance billing and collection can be a very confusing subject. The factors that will determine what the billing will be include: what kind of insurance a patient has, what deductibles, where the patient lives, the type of care needed and other factors. In an emergency situation when 911 is called to dispatch an ambulance it is often impossible at the time of service to determine who will be paying and how much a service will cost. Emergency service providers are required to provide service regardless of the patient's ability to pay. All of these factors must be taken into account when the rates are set to provide service.

In order to calculate the base or usual and customary charge (UCC) You need to take into consideration the estimated number of trips reduced by the number of trips where transport is not required or refused (currently around 35% of 911 trips) to arrive at a base of chargeable emergency trips. This is divided into the variable costs such as salaries of drivers and emergency personnel plus fixed cost, overhead and expected profit margin.

In order to cover the cost per trip, base revenue needs to be set high enough to cover the number of people without insurance or any ability to pay. In calendar year 2011 3,528 trips were for patients who self paid. AMR had to write off approximately 40% of the amount billed for self pay patients that year.

In addition Medicaid/Medicare was the payer for 6,150 or 55% of the emergency trips. Medicare/Medicaid are Federal/State government programs that insure the elderly, disabled and poor population. By federal and state law emergency ambulance providers are only allowed to charge a set fixed rate for these trips. During calendar year 2011 Medicaid paid \$145 and \$175 for basic life saving and advanced life saving trips respectively while Medicare paid \$352.81 and \$418.96 per trip respectively.

Insurance companies will contract directly with the ambulance services to set a discount on the amount they will pay. According to a study done by the NH Insurance Department discounts can run from 1% up to 23% depending on the carrier. The insurance carrier makes direct payments to the service provider in exchange for this discount.

Some insurance providers do not have a contract agreement with the ambulance company. Typically the insurance company will pay the ambulance company a fixed amount in accordance with the agreement between the insurer and the insured. They will pay the insured directly who will then be responsible for paying the ambulance company the full amount of the bill. Bills under this arrangement are for the full base rate. For example the insurance company agrees to pay \$800 for an advanced life saving (ALS) ambulance trip to the insured. AMR charged \$1,575 for an ALS trip in calendar year 2011. The patient would get a check from the insurance company for \$800 and have to pay AMR \$1,575. The difference of \$775 between what the insurance company paid and what AMR charged is the responsibility of the patient.

In addition by the contract with the City of Manchester AMR can only charge Manchester transports 135% of the Medicare rate. The 135% rate is the maximum that the resident is personally held responsible for after all other payments are collected. So in the example above the patient would get a check for \$800 from the insurance company and have to write a check to AMR for \$1,365.60. The payment consists of the \$800 that came from the insurance company and 135% of the Medicare ALS rate or \$565.60.

In addition to the base rate for the ambulance trip there is a mileage rate (\$28.88 per mile in CY 2011 and \$34.37 per mile in CY 2012) plus other charges such as cardiac monitor, oxygen, IV therapy and any medication or medical supplies used during the trip. These charges are greatly reduced by Medicare/Medicaid or excluded entirely by the programs. They are also subject to any contracted insurance discounts and the maximum charges allowed to Manchester transports per the contract.

Because so many of the trips are heavily discounted the UCC is set high to cover the costs that the discounted programs do not cover.

These factors have caused much confusion in the bills that a patient receives. For example:

The 911 system calls for an ambulance in the City of Manchester. When the ambulance arrives the patient is unresponsive so very little information is obtained by the ambulance other than the name and address which indicates that the patient is a City resident. Because of the City transport provision in the contract the first bill sent out could look like this:

CODE	DESCRIPTION	UNITS	UNIT CHARGE		TOTAL
1151	ALS1 EMERGENCY	1	1,630.13		578.39
2150	ALS MILEAGE	3	34.37		28.47
3001	OXYGEN	1	149.43		.00
5005	CARDIAC MONITOR	1	298.86		.00
5002	IV THERAPY	1	191.27		.00
5001	SUPP/DEFB/MEDS/ETC	1	251.04		.00
	TOTAL CHARGES DUE				606.86

The unit charge column shows the usual and customary charge (UCC) per unit. The total column shows the extended charges at 135% of Medicare part B rates as dictated by the contract for emergency services. Notice that Medicare does not pay for anything other than the transport cost and mileage so a city transport is not charged for them either.

The patient then pays the entire amount due. Later AMR is informed by the patient's insurance carrier that they will be paying for the service. The insurance carrier does not have an agreement with AMR so they will be charged the UCC. The patient will then get a bill that looks like this:

CODE	DESCRIPTION	UNITS	UNIT CHARGE		TOTAL
1151	ALS1 EMERGENCY	1	1,630.13		1,630.13
2150	ALS MILEAGE	3	34.37		103.11
3001	OXYGEN	1	149.43		149.43
5005	CARDIAC MONITOR	1	298.86		298.86
5002	IV THERAPY	1	191.27		191.27
5001	SUPP/DEFB/MEDS/ETC	1	251.04		251.01
	PAYMENTS			606.86	
	TOTAL CHARGES DUE				2,016.98

The bill now reflects that the non-contract insurance company was charged the UCC as allowed by the contract. The insurance company paid the patient the entire \$2,623.84 directly so the patient is responsible for paying the entire amount due to AMR.

The above example is from an actual complaint received by this office. As the patient had yet to receive payment from the insurance provider they could not understand why they were being charged again after they paid the entire prior bill.

Let's assume however that AMR had a preferred provider agreement with the patient's health insurance provider and the patient had a \$100 deductible. The second billing should show the discounted amount of \$2,361.46 in the total column, a payment of \$606.86 from the patient, a payment of \$2,261.46 from the insurance company and a rebate due of \$506.86 (payment of \$606.86 less deductible of \$100).

Anthem is the largest health insurance provider in the City and has no preferred provider agreement with AMR. As such Anthem had been sending payments directly to the patient and had not, in all cases, been informing AMR that they are covering the patient and have paid them directly or the amount that they had paid. Anthem had been paying the patient the amount they would have paid if they had an agreement. Our testing has uncovered several instances where a lack of a preferred provider agreement has been causing billing confusion and errors.

OBSERVATION 1 - LACK OF PROVIDER AGREEMENT WITH ANTHEM CAUSING PROBLEMS

Observation:

A preferred provider agreement outlines the price discount allowed by an ambulance company (the provider) and an insurance company. These agreements reduce the cost of a service to the members of the insurance product and insure the provider gets paid quickly and directly for services rendered.

Anthem BC/BS is one of the largest private health insurers in the City of Manchester. Anthem is the insurer of approximately 32% of all ambulance trips that are reimbursed through private insurance. Anthem is also the third party administrator for the City of Manchester self funded health insurance program.

Anthem BC/BS does not have a preferred provider agreement with AMR. Due to this AMR charges the City of Manchester's self insured health program at the usual and customary charge (UCC). UCC is the highest rate charged to patients. During CY 2011 Anthem paid the entire UCC. From a report on Ground ambulance transportation conducted by the State of NH Insurance Commission insurance carriers typically require a discount ranging from 1% to 23%. Anthem requires the deepest average discount of 23%. Using a conservative discount rate of 10% if Anthem had a preferred Provider Agreement with AMR the City would have saved \$3,705 in calendar year 2011 on ambulance costs to AMR. As of the date of this report there is no preferred provider agreement in place.

During CY 2012 Anthem changed its policy from sending checks directly to the patient to sending checks directly to AMR. AMR would send a billing to a patient showing the UCC in the invoice's per unit column then in the total charge column would show the contractual allowable amount for Manchester transports on a 911 call of 135% of the Medicare part b rate. Anthem was then sending checks to the patient for the discounted amount as if a provider agreement was in place. After receiving the check from anthem the patient would send the amount received from Anthem to AMR. AMR would balance bill the patient for the remainder. After receiving many complaints from its patients Anthem has been sending the patient a check for the remaining amount. AMR would not be notified of these further payments and due to the many complaints would adjust the patient's account down to the discounted amount. My testing revealed that five

out of 10 CY 2012 City of Manchester employee bills tested showed payments to patients in excess of the final AMR bill. Per AMR this is money owed to them as they would not have written down the billing if they knew insurance was paying. In four of the items tested Anthem only reimbursed the discounted rate, one of the four was processed correctly and in one instance the patient sent a check in for the full amount after Anthem reimbursed them and AMR (not aware of the insurance payment) then refunded the employee \$984.49 in error.

Recommendation:

AMR and Anthem should seek to formalize a preferred provider agreement.

AMR Response:

AMR's initial response to the RFP to provide 911 services for the city of Manchester included a clear demonstration of our ability to respond to the complexity of providing high caliber Emergency Medical Services for the residents of Manchester. This demonstration was heavily driven by the historic and longstanding reimbursement practices of our payment sources; specifically Anthem and all other 3rd party insurers. Since award of the bid, AMR has increased our rate charges on an annual basis of 3%; keeping in line with the overall inflation rates of operating expenses. Contrary to historical precedence, Anthem unilaterally decided to begin sending AMR payments directly to patients in 2011. Following the passing of New Hampshire HB 31, which became effective January 1st, 2012, Anthem complied with house bill direction, but reduced the amount sent to AMR to Anthem's internal UCR, which is marginally above Medicare. AMR maintains a willingness to discuss a contractual relationship with Anthem, but should not be expected to provide services below our cost of operations.

AMR has reached out to Anthem on several occasions to try and reach an amicable agreement. Like all emergency ambulance providers in New Hampshire, AMR is not opposed to entering into an agreement with Anthem, provided the agreement satisfactorily compensates for the high cost of readiness associated with providing emergency ambulance coverage and response.

Although we have not been successful to date, we are still engaged in active conversations with Anthem to join their network.

There are several samples reviewed during this audit that serve as good examples of the difficult position in which AMR is placed due to Anthem's practice of paying the patient directly and not providing AMR with any payment information. One example is trip # 502-28589629-00. In this case, the provider made two payments on the trip, one to AMR initially and then a later payment directly to the patient. The payment from the patient made to AMR for the amount of \$1,581.86 produced a credit of \$984.49 after the trip's balance was reduced to 135% Medicare allowable. Since AMR was not aware of the total paid to the patient by Anthem (Anthem will no longer provide this information to out-of-network providers), the patient was only being held liable by AMR for charges equaling 135% Medicare allowable. A refund, therefore, of \$984.49 was sent to the patient after receipt of their payment. The auditor's impression that this was a refund sent in error appears to indicate his awareness of an additional payment made directly to the patient by Anthem; AMR, however, was not aware of any payment nor the amount sent to the patient (nor has AMR received an EOB to confirm), so the refund was deemed as appropriate when administered.

Anthem Response:

Prior to January 1, 2012, Anthem reimbursed members directly for out-of-network ambulance services. On January 1, 2012, HB 31 took effect, requiring Anthem to make payment directly to out of network ambulance providers. Because NH law now requires carriers to reimburse out of network ambulance providers directly, there is less incentive for out-of-network ambulance companies to enter into provider contracts as prior to the enactment of HB 31, the only way to receive direct payment, was to enter into a contract.

With regard to Anthem contracting with AMR, Anthem is always willing to entertain discussions with an out of network provider and more specifically, with AMR. Anthem has in fact talked with AMR about the possibility of becoming a contracted provider in New Hampshire. While we have followed up on the discussions several times, AMR has not submitted an executed contract, nor have they proposed any alternatives for contracting with Anthem.

While Anthem cannot compel a provider to become contracted, we remain interested in working with AMR should they become willing to do so.

AMR BILLING ISSUES

During the course of the first year of operations Aldermen and the Fire Department (who monitors the contract) received complaints from constituents that they were being over charged or mis-charged for emergency ambulance transportation. One of the Deputy Fire Chiefs has the responsibility of monitoring the contract and conducted an investigation of the complaints. He found that AMR had mis-charged City residents and brought it to the attention of AMR. Management at AMR ordered an internal audit done and discovered that due to a lack of training at the payment center 323 incorrect billings were processed.

According to AMR the billing errors were a result of the interpretation of the contract by the AMR billing office in Akron Ohio. In many cases, the result was in favor of the patient, who received charges lower than contractually permitted.

(Costs used below are used for example and are not the actual costs of service)

The Akron office processes all billing for their entire nation wide operation and Manchester billings are done differently then all the others. For some municipalities when a patient is billed they are billed the difference between the cost charged to the insurance company and the amount paid by the insurance company. For example the cost is negotiated with the insurance company at \$1,000. The insurance company will pay 80% or \$800 and the patient will be billed for the remaining \$200.

If the patient has no insurance they would be charged the full AMR price at \$1,500.

In cases where the patient is unable to provide insurance information at the time of service they will be billed the full charge (\$1,500) and when insurance is provided they will be given a new bill showing the credit for the insurance company negotiated price, a credit for the insurance company's share of costs (\$800) and a bill for the remainder of \$200.

Manchester has a cap on charges to uninsured patients who are Manchester transports on an emergency call set at 135% of the Medicare allowable rate. For CY 2012 the amount is set at \$476.29 for Basic emergency service and \$565.60 for advanced emergency services. If you have insurance the difference between the amount the insurance company pays and the amount the patient is billed can not exceed 135% of the Medicare part b amount. This is the provision in the contract that was causing the over billing errors.

AMR did an internal review of Q1 to Q3 of 2011 and found a 4.4% error rate (127 out of 2,873 trips) with total over charges of \$244,742.92. Quarter 4 of 2011 and quarter 1 of 2012 were reviewed and AMR internal audit found 196 out of 2,089 trips over billed (9.38%) with over billed amounts of \$206,000.

AMR claims that they have identified all incorrect charges, repaid or credited all residents who were charged in error and instituted policy and procedures changes in the billing department to fix the billing errors in the future.

In order to determine if AMR had uncovered and properly reimbursed all over payments I obtained a database of all billing of ambulance trips that AMR charged for in the City of Manchester. I then sampled the database to verify AMR's internal audit assertions.

In order to determine if AMR recalculated and repaid/adjusted customers correctly I selected all 39 trips where refunds were issued plus 30 of the 296 remaining trips that were found to contain errors by AMR internal audit and recalculated the amount of refund/adjustment due. I then traced the amount calculated to the payment of the refund or an adjustment to the accounts receivable record.

In order to determine if all trips over paid were discovered I then selected a sample of 30 of 751 trips AMR internal audit determined could have been subject to over payment but were found to be free of audit errors and recalculated the amount due to determine if there were any undiscovered over payments.

In order to determine if city employee claims to the self insured health program were processed correctly I obtained a database from Anthem BC/BS of all city employees or dependent payments for AMR emergency ambulance trips. Determined if the correct amount was paid for the ambulance service and traced the Anthem payment to the AMR database to ensure that it was posted correctly. (See observation 1 in prior section)

In order to further ensure that all over payments were handled correctly and to discover any overpayments occurring since AMR changed its procedures I solicited complaints from city employees and the general public in order to determine the cause and reconciliation of the complaints.

The result of my testing is as follow:

REFUND TESTING

Tested all refunds processed by Internal Audit and found that they were all correctly calculated and refund checks sent in a timely manner.

TEST OF POPULATION DETERMINED TO BE ERROR FREE

AMR's internal audit tested and determined that 752 of the trips they tested were correctly processed and contained no errors. In order to test the effectiveness of their testing I retested a sample of the trips. Out of a sample of 30 trips tested I noted the following conditions:

OBSERVATION 2 - BALANCES GREATER THEN CONTRACT ALLOWABLE SENT TO COLLECTIONS

Observation:

AMR Internal Audit performed testing on a population of all trips in the City of Manchester. The population was first reduced by eliminating all Medicare/Medicaid eligible trips leaving a population of non-contracted insurance, private pay and contracted insurance. Non-emergency trips were excluded. From this data set all invoices sent that were in excess of 135% of Medicare part b allowable amount were tested.

In order to ensure that no over billed accounts were erroneously determined to be error free I examined a sample of 30 trips out of 752 tested by Internal Audit and found to be error free. From the sample of 30 items selected for testing I found 10 trips that were inappropriately sent to collections at the usual and customary charge instead of the contractually reduced amount. In addition when I tested a sample of 30 out of 335 trips that AMR Internal Audit determined to have billing errors I found 3 additional trips were handled in the same manner.

While most of the trips were later reduced to the correct contractually reduced rate, by sending them to collections at the full usual and customary charge AMR causes a person's credit rating to be negatively affected by an exaggerated amount.

Testing also revealed a few instances where a bill was sent to collections that was in the process of being paid by either insurance or Medicare and was later paid in full. This also unnecessarily affects a person's credit rating.

Recommendation:

AMR should adjust its billing practices to ensure that only the actual amount of the allowable billing be sent to collections after all efforts of collecting from insurance or Medicare are exhausted.

Auditee Response:

Only 12 of the 20 trips noted in the initial observation as being in collections at full Usual and Customary Charges were confirmed per AMR's follow-up audit. All other trips were already adjusted appropriately previous to this audit.

In 6 of the remaining 12 cases, AMR is aware that the patient was paid in full by their insurance provider. Therefore, these trips will remain at full Usual and Customary Rates (UCR) until compensation is made to AMR by the patient.

AMR reserves the right, per the city contract, to collect any payments received by patients from their insurance provider as a result of services provided by AMR. Due to current out-of-network provider practice, AMR is no longer capable of knowing what, if any, payments have been made directly to the patient. As a courtesy to the remaining 6 patient trips found at full UCR in collections, AMR has adjusted their remaining outstanding balance to 135% Medicare allowable. It is important to note, however, that if full UCR payment has been made to these patients by their payor, AMR is not aware at this time. As a result, if full payment was made to the patient, the patient is being held accountable for an amount well below the amount they have received from their carrier for services provided by AMR.

OBSERVATION 3 - CHARGES IN EXCESS OF CONTRACT ALLOWABLE

Observation:

AMR Internal Audit performed testing on a population of all trips in the City of Manchester. The population was first reduced by eliminating all Medicare/Medicaid eligible trips leaving a population of non-contracted insurance, private pay and contracted insurance. Non-emergency trips were excluded. From this data set all invoices sent that were in excess of 135% of Medicare part b allowable amount were tested.

In order to ensure that no over billed accounts were erroneously determined to be error free I examined a sample of 30 trips out of 752 tested by Internal Audit and found to be error free. From the sample of 30 items selected for testing I found one trips that appears to have been overpaid and no refund appears to have been paid.

Recommendation:

It appears that not all of the trips that were determined to have been error free were in fact error free. One additional error was found by my office. AMR Internal Audit did not look at accounts that had a zero balance and thereby missed this error. AMR should re-audit all zero balance accounts in this population to determine that no similar issues have occurred. In addition while it appears that changes to billing practices may have eliminated billing errors it still appears that communication between patients and AMR over billing questions do not appear to be resolve in a timely or effective manner. I am therefore recommending that AMR open a billing operation in the Manchester area that would be responsible for the unique requirements of the contract with the City of Manchester as well as NH laws and regulations.

Auditee Response:

A follow-up review between the city auditor and AMR that occurred on 10/10/12 reduced the number of errors identified in this observation to only one. This trip (selection #2) required a refund of \$116.62, which was completed on 9/27/12. Although an error, this trip did not fall within the initial AMR audit criteria.

Below is a summary for the remaining selections:

Selection #21 is not an error as a refund was sent to the patient on 3/29/12.

Selection #22 is a trip that was paid in full to the patient by the patient's insurance provider, so no refund is due.

Selection #19 is an auto insurance trip in which the patient was paid in full by their auto carrier. The patient is currently making payments on this account.

Selection #7 is a very good example of the timing and complexity of medical billing. The trip was billed and denied by Medicare initially stating no medical necessity in November 2011. The patient decided to appeal with Medicare while making \$25.00 monthly payments to AMR. The patient paid a total of \$125.00 until receipt of a Medicare payment in July 2012. Upon posting the Medicare payment, an overpayment on the account occurred and a refund in the amount of \$38.05 was sent to the patient on 9/6/12.

Backup documentation for these trips has been provided to the auditor in addition to this response.

TEST OF TRIPS WHERE ERRORS WERE FOUND

I tested a sample of 30 out of the 335 trips that AMR Internal Audit found over payment errors and found that all the over payments were recalculated correctly and the accounts adjusted correctly.

COMPLAINT TESTING

During the course of the audit I received many complaints concerning the audit billing. A large percent of the complaints were concerns that the usual and customary charges shown on the bill appeared to be way too high. Several of the people registering complaints had used the previous ambulance service and recalled how much lower the charges were. Several of the people lodging complaints were either out-of-town residents or took non-emergency related trips that are outside of the contract provisions being tested.

Forty-seven trips made the criteria of being City emergency transport. Of the 47 trips 30 complaints were determined to be correctly billed or the complaint was for other than over charging. Of the 17 trips investigated further it was determined that many were the result of the lack of a provider agreement between Anthem and AMR as noted in Observation 1. Two employees received checks from the insurance companies that appeared to be in excess of the

billed amount but were actually correct as AMR was unaware of the insurance payment and adjusted the bill down to the contractually allowed amount. Because it was an insurance paid trip with a non-contracted insurance provider the UCC amount was appropriate and the money is owed to AMR.

Another common complaint was the difficulty of dealing with AMR service reps. The service reps are in Ohio, were difficult to get a hold of and in many cases the patient found the responses uninformative or in a couple of cases rude and hostile.

There is also a time lag between when a payment check is cleared by the bank and posted to the patient's account. This caused instances where a check had cleared but the patient would get a bill that still showed that they owed money.

Insurance payments also tend to be slow in getting to AMR or posted to the patient's account causing them to get notices that they were in danger of being sent to collections when they were waiting on the insurance to get resolved. This is a particular problem with Medicare. Medicare on some occasions would deny a payment at first then after an appeal process the payment. This could take up to a month or more to resolve itself and during the appeal process the account would be sent to collections. See observation 2.

OTHER ISSUES

OBSERVATION 4 – NON-EMERGENCY TRANSPORTS

Observation:

The contract with AMR only governs emergency service. Medical transports that are not of an emergency are outside of the contract and are subject to AMR's usual and customary charges. According to the survey done by the New Hampshire Insurance Department on ground ambulance transports AMR was noted to be in the top 10 of high cost for emergency ambulance services.

When someone is transported to an emergency room on a 911 call AMR is restricted by the contract with the City and Medicare/Medicaid as to what they are allowed to charge. If an elderly resident is sent to the emergency room, stabilized and then sent to another facility for care not available at the receiving hospital or to a rehab facility it is no longer considered an emergency service and therefore falls outside the contract provisions. Because they have the contract with the City of Manchester for the emergency services it appears to be routine for the hospital to give the business for the non-emergency transport to AMR. Patients do not appear to be given a choice or at least informed of the cost and alternatives to transport by AMR. In Addition Medicare/Medicaid will not pay for the non-emergency transport. It was noted during the testing of citizen complaints that an elderly person would be transported to the emergency room which is picked up by Medicare and cost the patient approximately \$80 for the trip. They then are transported a couple of miles to a rehab facility on a non-emergency trip that is not covered by Medicare and are responsible for a bill well over \$1,000. If they had called another medical transport company the bill could possibly have been \$100 to \$200 dollars.

Recommendation

The Board of Mayor and Aldermen should seek legislation through its representatives in Concord to require hospitals to inform patients of the costs and alternatives for non-emergency transportation services from the hospital to other facilities. The Board should also consider adding non-emergency ambulance services to its Compass incentive program.

Auditee Response:

The Centers for Medicare and Medicaid Services (CMS) govern the rules and regulations for ambulance providers with regarding to reimbursement for services provided to Medicare beneficiaries and Medicaid recipients. Both Medicare and Medicaid have reimbursement benefits for both emergency and non-emergency ambulance services when the coverage criteria of the beneficiary's / recipient's plan have been met. AMR provides both emergency and non-emergency ambulance services based on requests for services as they are called in either through the 911 system, a private caller or a staff member of a healthcare facility. For the non-emergency ambulance services, documentation must support that the patient could not have traveled safely by other modes of transportation (i.e. wheelchair – gurney van). AMR continues to partner with healthcare facilities regarding education and ensuring that the facility has the

tools to determine if the correct mode of transportation is provided for the patient prior to contacting providers of services.

This provides another example of the unique and complex nature of ambulance billing and demonstrates the need for billing expertise to ensure appropriate billing of all payors.)