AMERICAN AMBULANCE ASSOCIATION

REPRESENTING EMS IN AMERICA

MEDICARE UPDATE PART II

Brian S. Werfel, Esq.

Texas Ambulance Association

April 12, 2019

EMERGENCY TRIAGE, TREAT, AND TRANSPORT MODEL

Emergency Triage, Treat, and Transport Model

- On February 14, 2019, CMS announced the creation of a new pilot program designed to give ambulance providers greater flexibility to treat low-acuity 911 calls
  - "Emergency Triage, Treat, and Transport Model"
  - ET3

Overview of Pilot Program

- On February 14, 2019, CMS announced the creation of a new pilot program designed to give ambulance providers greater flexibility to treat low-acuity 911 calls
  - "Emergency Triage, Treat, and Transport Model"
  - ET3
- Would permit Medicare reimbursement for:
  - Ambulance transportation to alternative treatment destinations
  - Treatment at the Scene

Voluntary Program

- Participation in ET3 is **voluntary!!**
  - There is no impact on reimbursement for ambulance transportation covered under the Medicare Ambulance Fee Schedule
  - Participants would be eligible for a 5% bump in their payments under the Model starting in Year 3

Program Participants

1. Ambulance providers and suppliers
2. Government agencies, their designees, or other entities that operate or have authority over 911 dispatch centers

Program Timeline

- Summer 2019 – CMS will put out Request for Participants (RFAs), giving ambulance providers and suppliers the opportunity to apply for inclusion in the program
- Fall 2019 – Ambulance providers and suppliers will be selected as "Participants"
- Fall/Winter 2019 – CMS will issue Notice of Funding Opportunity (NOFO), which will allow 911 dispatch centers to apply to participate
  - Participation limited to a total of 40 911 dispatch centers
  - Participation further limited to geographic areas in which one or more ambulance providers have been selected to participate

Transportation to Alternative Destinations

- Participating ambulance providers and suppliers would work with local regulatory agencies to develop a set of protocols that would allow the ambulance service to transport low-acuity patients to alternative treatment destinations
  - Up to the ambulance providers to designate what types of facilities (i.e., urgent care centers, behavioral health centers, physician offices, etc.) that would qualify as "alternative" destinations
  - "BLS emergency" payment plus mileage

This would likely make sense for…

1. Ambulance providers that are already permitted to transport patients to alternative destinations
2. Rural and super-rural providers that routinely transport patients long distances to the nearest hospital
   - Assuming there is a local Urgent Care Center
3. Ambulance providers that routinely experience "wall time" at the local EDs

This would likely not make sense for…

1. Situations where the patient's condition is such that they could be transported safely by other means
   - Whether to the ED or the alternative destination
   - On a March 28, 2019 Open Door Forum, CMS indicated that Medicare's medical necessity requirement would not be relaxed for transports to an alternative destination

Obvious Question: how would the patient get home from the alternative treatment site?

"Treat and Release"

- Participating ambulance providers and suppliers would work with local regulatory agencies to develop a set of protocols that would allow the ambulance service to treat certain low-acuity patients at the scene, without the need for transportation
  - In partnership with "Qualified Health Care Practitioner"
    - Physician, Nurse Practitioner, Physician's Assistant
    - Not Registered Nurses, Advanced Scope paramedics
  - Treatment would be rendered by the QHP either on-scene or via telehealth
    - Telehealth encounters require both audio and video
    - Telehealth provider would separately bill Medicare for their services

This would likely make sense for…

1. Situations where the patient's condition does not warrant further medical attention, but where the patient requires assurances from a physician
2. Situations where…

The Model is extremely attractive for telehealth providers, as it essentially provides them with a built-in referral source

This would likely not make sense for…

1. Situations where the costs of partnering with the QHP exceed the potential revenue
2. Any situation where the QHP is required to actually render the care on-scene
   - –Are your crews actually going to wait for the QHP to arrive on scene?

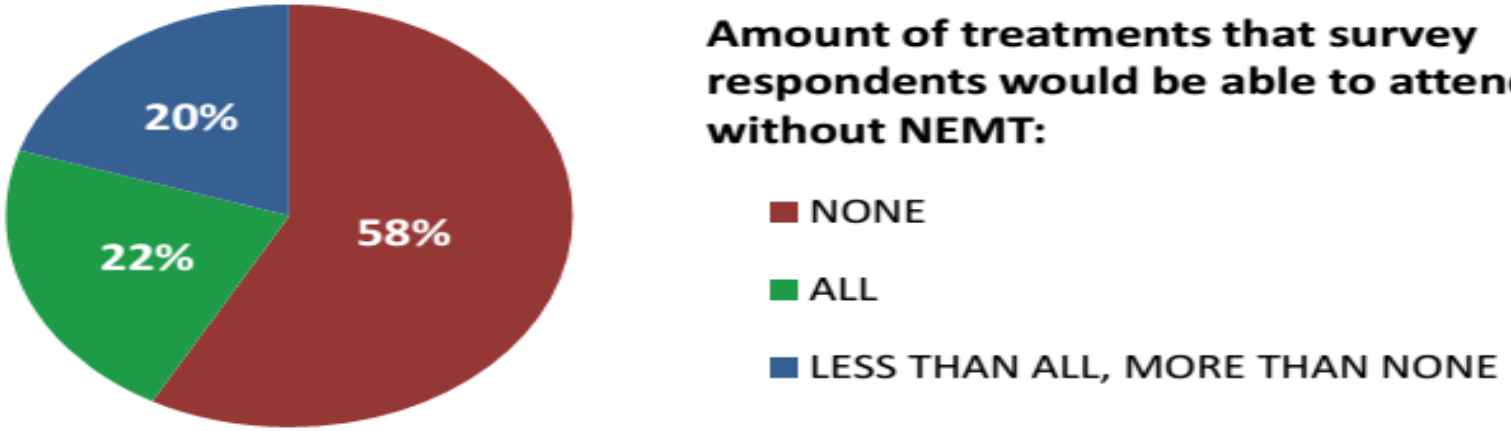
CMS properly identified one of the more prevalent negative incentives in the current Fee Schedule, but ultimately failed to provide the proper incentives to the EMS industry

Study on NEMT

- On August 1, 2018, the Medical Transportation Access Coalition (MTAC) released a study on the cost effectiveness of non-emergency medical transportation services
  - MTAC is a trade group founded by the three largest brokers of NEMT – LogistiCare Solutions, LLC, MTM, Inc. and Southeastrans, Inc.
- Key Findings:
  - $40 million/month – Estimated ROI for every 30,000 members receiving treatment for kidney disease, diabetic wound care, or substance abuse
    - $34.2 million/month for ESRD
  - 58% of surveyed beneficiaries reported that they would be unable to make medical appointments without access to NEMT

Access to Care

Survey Results

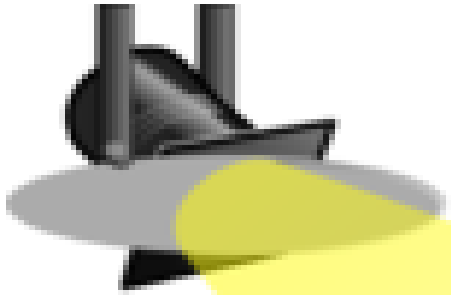


- Those **with access to public or private transportation** were twice as likely to report that they'd make their expected treatments per month than those without these options.
- In response to the *open-ended* question "what would happen if you did not have the transportation ride services you currently receive," **10% of respondents (n=103) reported that they would die or probably die.**

NEMT Study – Conclusions

- **Total ROI** for all three conditions per 30,000 members (10,000 in each condition) **per month** is **$39,553,373.**
- Extrapolated nationally, these figures would increase proportionately.

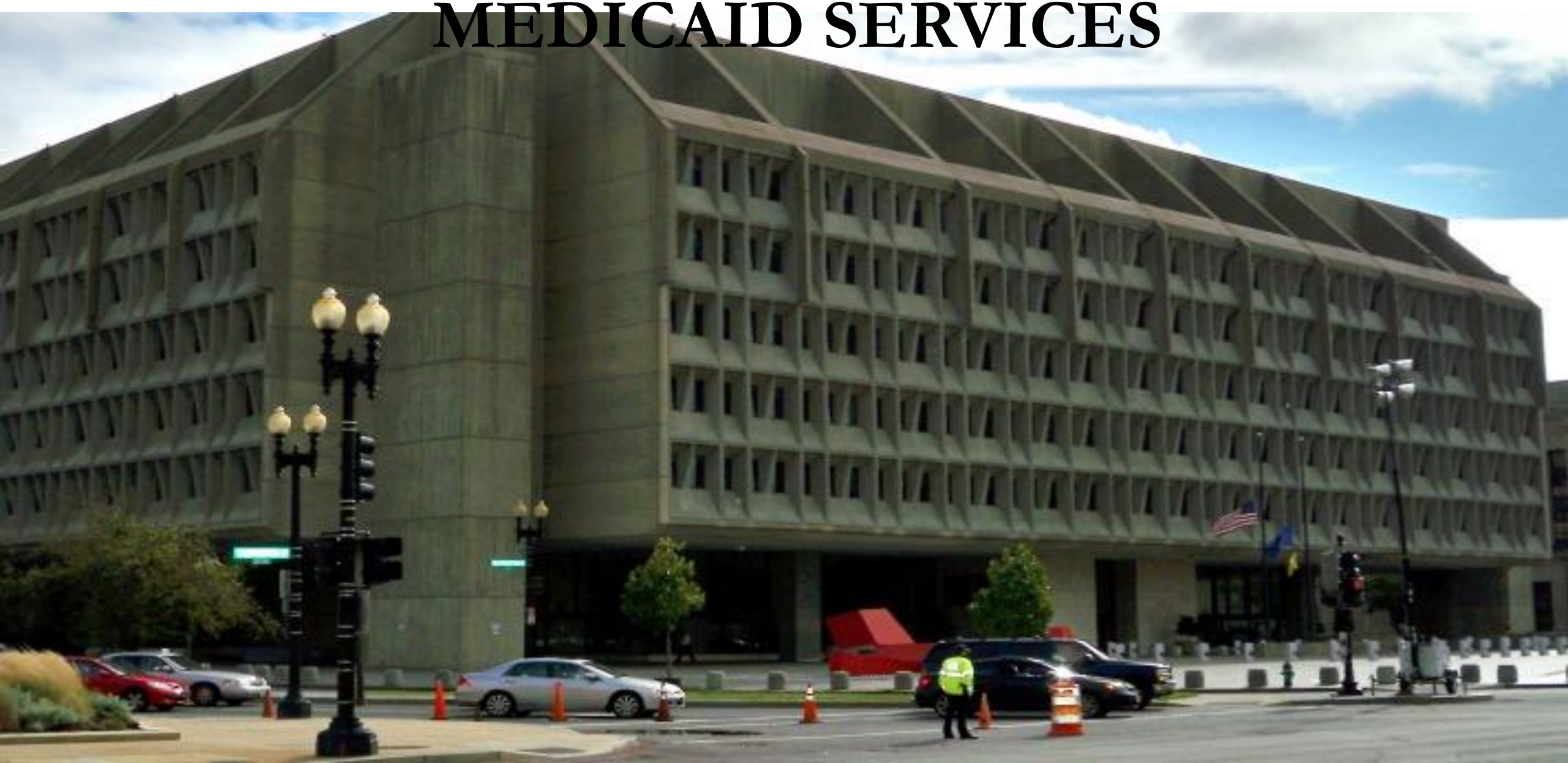
  (The precise number of Medicaid beneficiaries using NEMT with these conditions is not readily available)
- **NEMT pays for itself** as part of a care management strategy for people with certain chronic diseases.
  - ROI studies for other disease populations are worth studying, as well as a SUD-specific study that could measure both medical and non-medical costs avoided for treatment adherence.



Spotlight on Compliance

An Overview of the Compliance Challenges Facing EMS Providers

CENTERS FOR MEDICARE & MEDICAID SERVICES

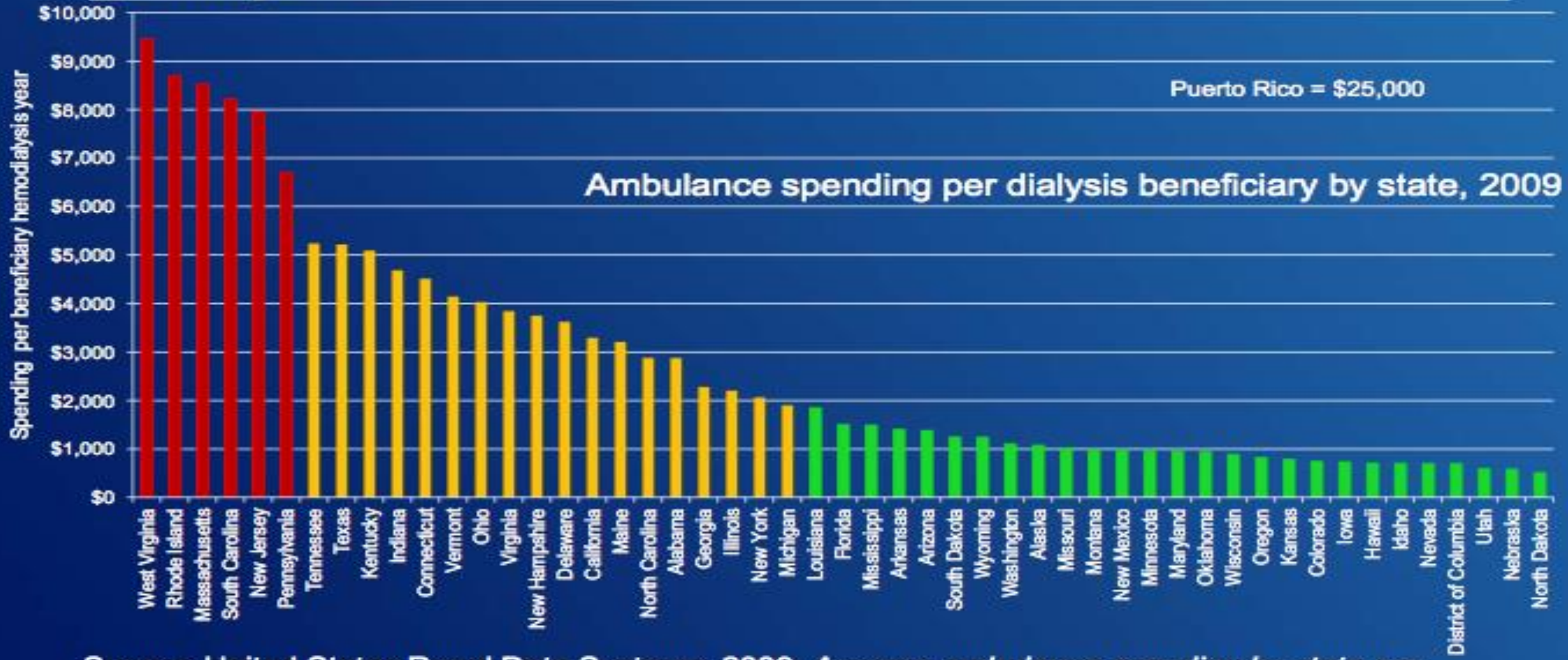


EFFECT OF PRIOR AUTHORIZATION

Extension of Prior Authorization Program

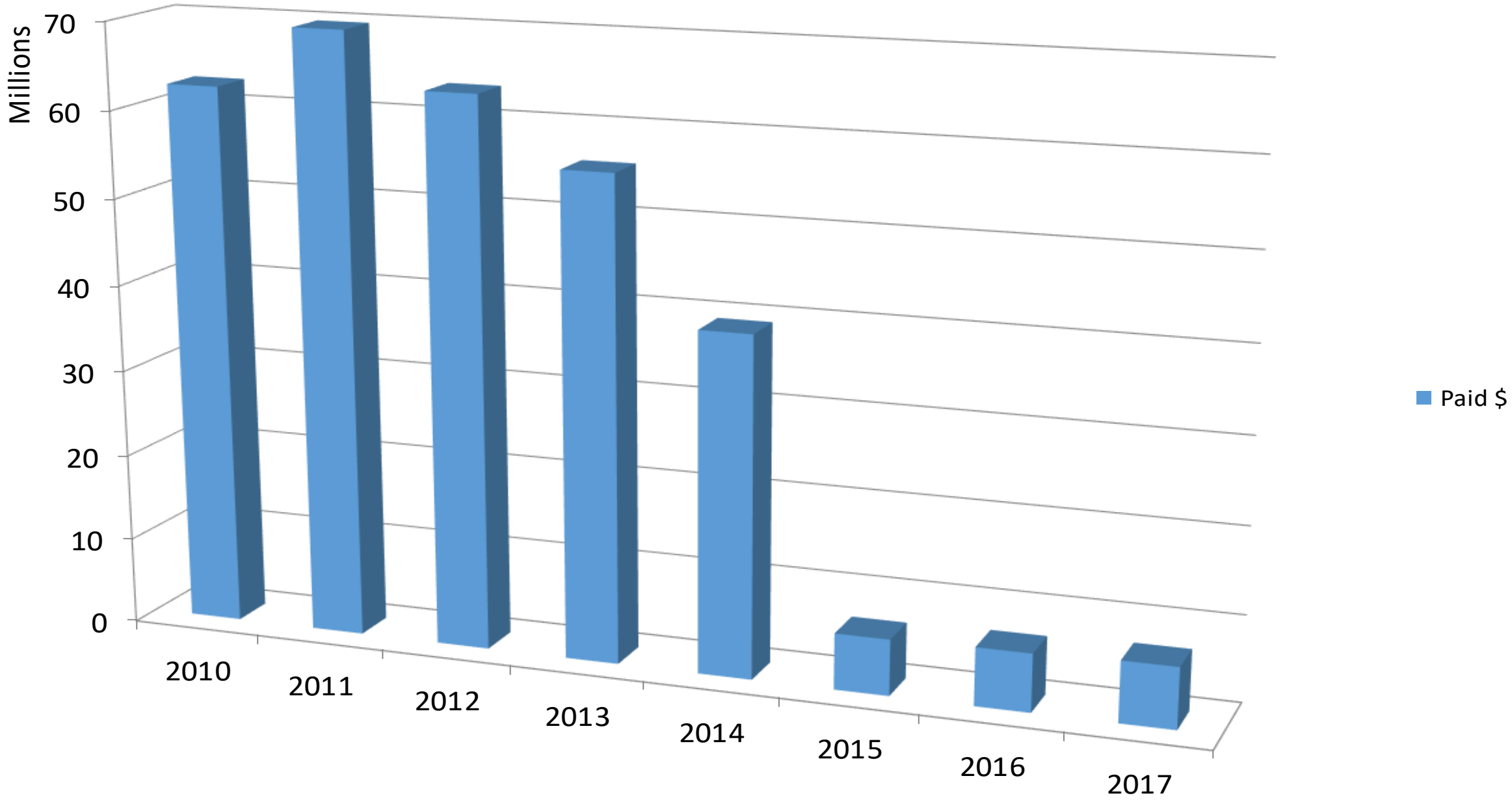
- On November 30, 2018, CMS announced that it would extend its existing prior authorization program for repetitive patients for another year
  - In effect in DE, MD, NJ, NC, PA, SC, VA, WV, and DC

Rapid increase in dialysis-related transports and inappropriate billing for non-emergency transports

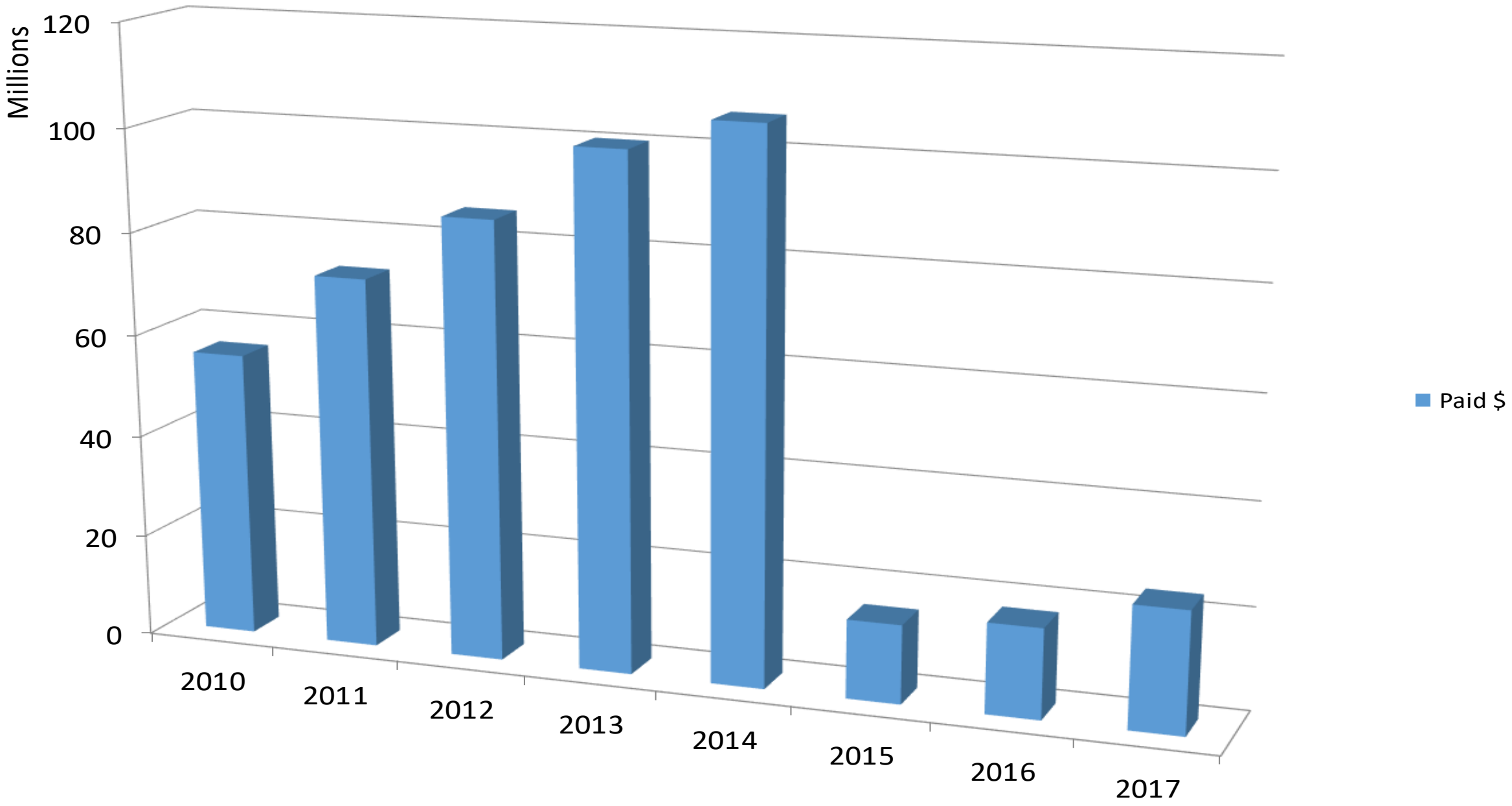


Source: United States Renal Data Systems, 2009, *Average ambulance spending by state per beneficiary hemodialysis year*

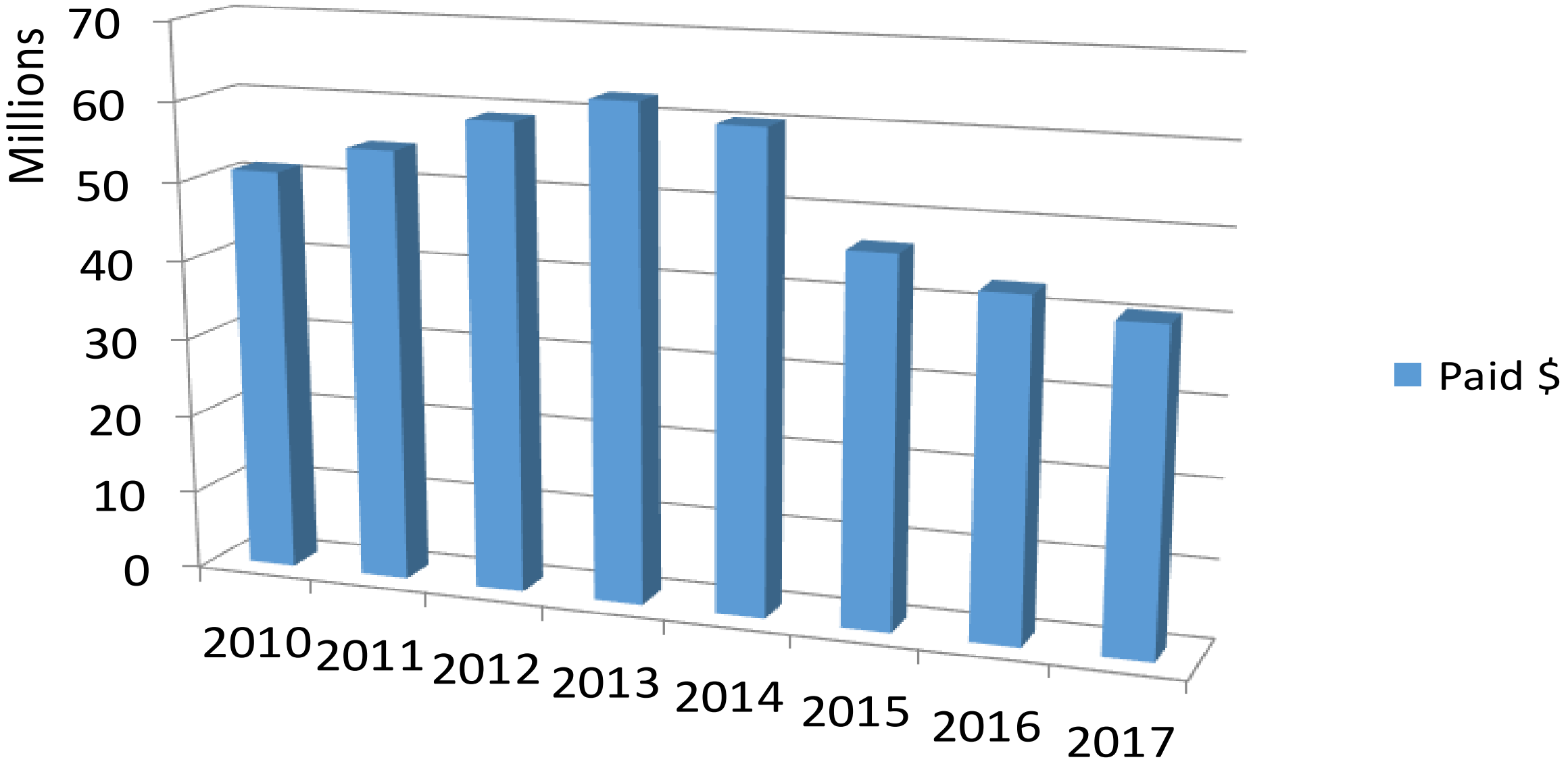
Pennsylvania Dialysis $



New Jersey Dialysis $



South Carolina Dialysis $



Prior Authorization First Interim Report

- February 28, 2018
- Mathematica Policy Research
- Key Findings:
  1. Prior authorization successfully reduced the utilization of ambulance for ESRD beneficiaries
     - Nearly 70% reduction in the 9 states
     - $171 million in Medicare savings
  2. Little quantitative evidence to suggest a negative impact on patient care
     - Anecdotal evidence that some beneficiaries had trouble obtaining alternative transportation
     - 15% increase in emergency dialysis utilization

GAO Report on Prior Authorization

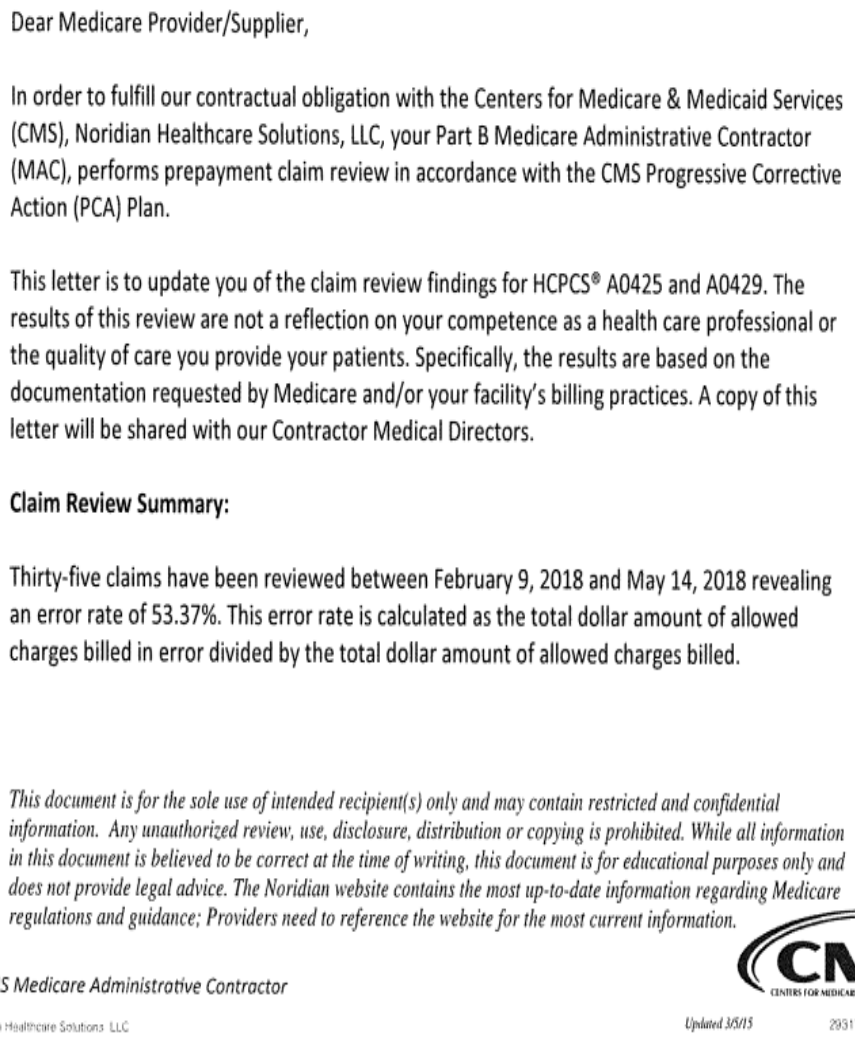
- May 21, 2018
- GAO examined the impact of prior authorization on total expenditures and the potential for additional savings for items or services subject to prior authorization
  - Power mobility devices (e.g., power wheelchairs)
  - Hyperbaric oxygen
  - Home health services
  - Non-emergency ambulance services

GAO Report on Prior Authorization

- Key Findings:
  - Prior authorization has effectively reduced Medicare expenditures
    - $1.1 - $1.9 billion in savings
  - Ambulance services (through March 2017):
    - MACs collectively handled more than 3,200 requests for prior authorization, including 2,620 initial requests
    - Affirmation rate during first 6 months was 28%
    - Affirmation rate rose to 66% during the most recent 6-month period
  - GAO estimated total savings for ambulance to be $387.5 million from December 2014 through March 2017
    - 90% of that savings coming from original 3 states

NATIONAL EXPANSION?

TARGETED PROBE & EDUCATION AUDITS



Dear Medicare Provider/Supplier,

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Noridian Healthcare Solutions, LLC, your Part B Medicare Administrative Contractor (MAC), performs prepayment claim review in accordance with the CMS Progressive Corrective Action (PCA) Plan.

This letter is to update you of the claim review findings for HCPCS® A0425 and A0429. The results of this review are not a reflection on your competence as a health care professional or the quality of care you provide your patients. Specifically, the results are based on the documentation requested by Medicare and/or your facility's billing practices. A copy of this letter will be shared with our Contractor Medical Directors.

Claim Review Summary:

Thirty-five claims have been reviewed between February 9, 2018 and May 14, 2018 revealing an error rate of 53.37%. This error rate is calculated as the total dollar amount of allowed charges billed in error divided by the total dollar amount of allowed charges billed.

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A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC

Updated 3/5/15

29317044 (3203) 4-13

- A majority of the Medicare Administrative Contractors are currently conducting Targeted Probe & Educate (TPE) audits
- Multi-round review of a particular base rate
  - Typically BLS non-emergency, but could be BLS emergency
- Focus on signature legibility and credentialing

Enrollment Moratoria

- On January 30, 2019, CMS indicated that had allowed all existing enrollment moratoria to expire
  - Included moratoria on the enrollment of new non-emergency ambulance providers in New Jersey and Pennsylvania

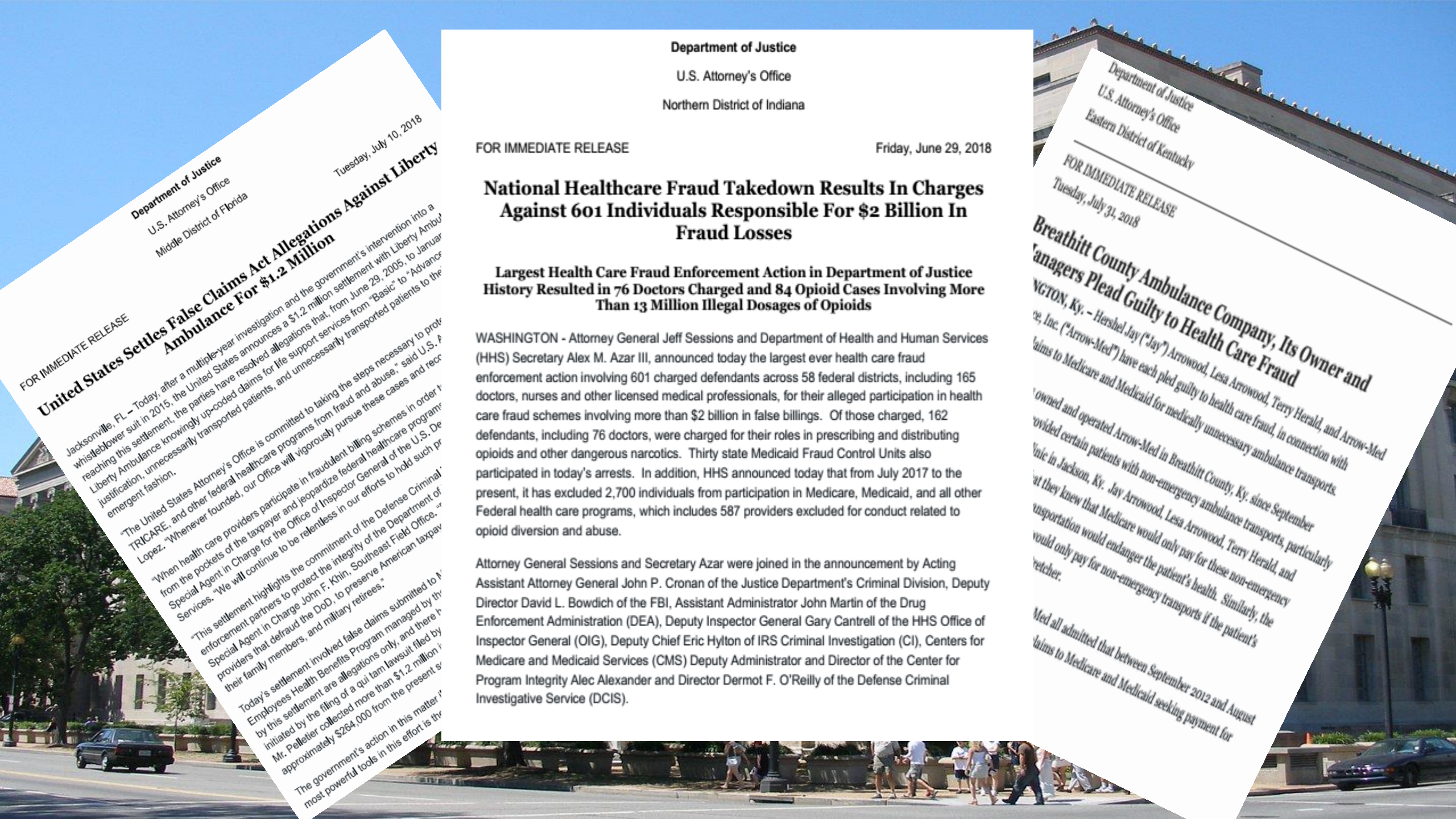
OIG Report on Non-Emergency Ambulance Transportation

- *"Medicare Improperly Paid Providers for Non Emergency Ambulance Transportation to Destination Not Covered by Medicare"*
- OIG concluded that CMS paid more than $8.6 million for non-emergency ambulance transportation (ALS or BLS) to non-covered destinations from 2014 through 2016
  - 59% of improper payments were to diagnostic or therapeutic sites ("D") that did not originate at an SNF
  - 31% to a residence or assisted living facility
  - 6% to the scene of an acute event ("S")
  - 4% to destination code not used for ambulance or no destination modifier
  - <1% to a physician's office

DEPARTMENT OF JUSTICE

2018 AM
ANNUAL CONFERENCE
& TRADE SHOW

Medicare Fraud Strike Force Locations



Department of Justice

U.S. Attorney's Office

Middle District of Florida

Tuesday, July 10, 2018

FOR IMMEDIATE RELEASE

United States Settles False Claims Act Allegations Against Liberty Ambulance For $1.2 Million

Jacksonville, FL – Today, after a multiple-year investigation and the government's intervention into a whistleblower suit in 2015, the United States announces a $1.2 million settlement with Liberty Ambu reaching this settlement, the parties have resolved allegations that, from June 29, 2005, to Januar Liberty Ambulance knowingly up-coded claims for life support services from "Basic" to "Advance justification, unnecessarily transported patients, and unnecessarily transported patients to the emergent fashion.

"The United States Attorney's Office is committed to taking the steps necessary to prote TRICARE, and other federal healthcare programs from fraud and abuse," said U.S. A Lopez. "Whenever founded, our Office will vigorously pursue these cases and reco

"When health care providers participate in fraudulent billing schemes in order t from the pockets of the taxpayer and jeopardize federal healthcare programs Special Agent in Charge for the Office of Inspector General of the U.S. De Services. "We will continue to be relentless in our efforts to hold such pr

"This settlement highlights the commitment of the Defense Criminal enforcement partners to protect the integrity of the Department of Special Agent in Charge John F. Khin, Southeast Field Office. " providers that defraud the DoD, to preserve American taxpay their family members, and military retirees."

Today's settlement involved false claims submitted to M Employees Health Benefits Program managed by th by this settlement are allegations only, and there h initiated by the filing of a qui tam lawsuit filed by Mr. Pelletier collected more than $1.2 million approximately $264,000 from the present s

The government's action in this matter most powerful tools in this effort is the

Department of Justice

U.S. Attorney's Office

Northern District of Indiana

FOR IMMEDIATE RELEASE

Friday, June 29, 2018

National Healthcare Fraud Takedown Results In Charges Against 601 Individuals Responsible For $2 Billion In Fraud Losses

Largest Health Care Fraud Enforcement Action in Department of Justice History Resulted in 76 Doctors Charged and 84 Opioid Cases Involving More Than 13 Million Illegal Dosages of Opioids

WASHINGTON - Attorney General Jeff Sessions and Department of Health and Human Services (HHS) Secretary Alex M. Azar III, announced today the largest ever health care fraud enforcement action involving 601 charged defendants across 58 federal districts, including 165 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving more than $2 billion in false billings. Of those charged, 162 defendants, including 76 doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics. Thirty state Medicaid Fraud Control Units also participated in today's arrests. In addition, HHS announced today that from July 2017 to the present, it has excluded 2,700 individuals from participation in Medicare, Medicaid, and all other Federal health care programs, which includes 587 providers excluded for conduct related to opioid diversion and abuse.

Attorney General Sessions and Secretary Azar were joined in the announcement by Acting Assistant Attorney General John P. Cronan of the Justice Department's Criminal Division, Deputy Director David L. Bowdich of the FBI, Assistant Administrator John Martin of the Drug Enforcement Administration (DEA), Deputy Inspector General Gary Cantrell of the HHS Office of Inspector General (OIG), Deputy Chief Eric Hylton of IRS Criminal Investigation (CI), Centers for Medicare and Medicaid Services (CMS) Deputy Administrator and Director of the Center for Program Integrity Alec Alexander and Director Dermot F. O'Reilly of the Defense Criminal Investigative Service (DCIS).

Department of Justice

U.S. Attorney's Office

Eastern District of Kentucky

FOR IMMEDIATE RELEASE

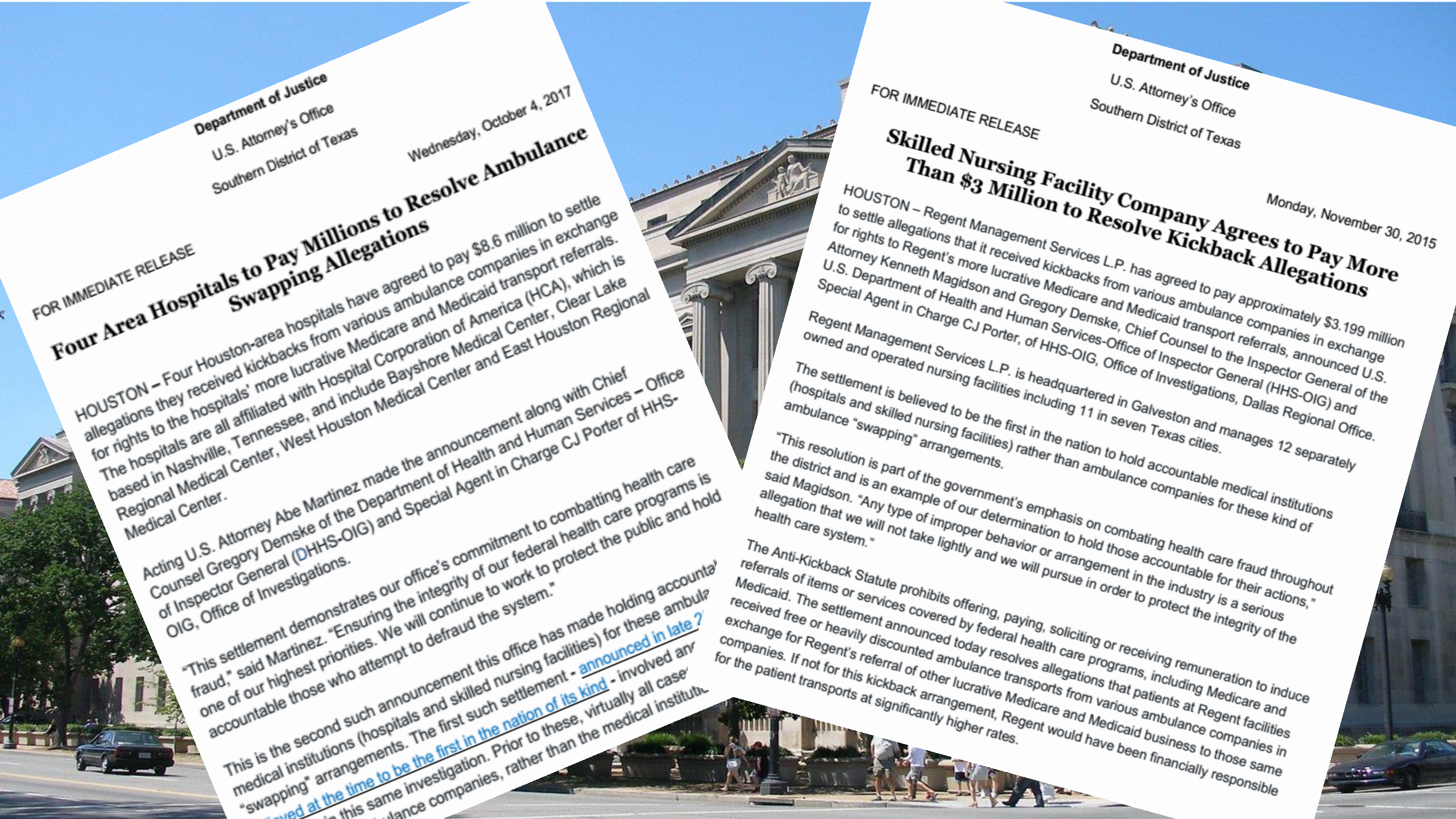
Tuesday, July 31, 2018

Breathitt County Ambulance Company, Its Owner and Managers Plead Guilty to Health Care Fraud

NGTON, Ky. – Hershel Jay ("Jay") Arrowood, Lesa Arrowood, Terry Herald, and Arrow-Med ce, Inc. ("Arrow-Med") have each pled guilty to health care fraud, in connection with laims to Medicare and Medicaid for medically unnecessary ambulance transports.

owned and operated Arrow-Med in Breathitt County, Ky. since September ovided certain patients with non-emergency ambulance transports, particularly linic in Jackson, Ky. Jay Arrowood, Lesa Arrowood, Terry Herald, and at they knew that Medicare would only pay for these non-emergency nsportation would endanger the patient's health. Similarly, the ould only pay for non-emergency transports if the patient's retcher.

Med all admitted that between September 2012 and August laims to Medicare and Medicaid seeking payment for



Department of Justice

U.S. Attorney's Office

Southern District of Texas

FOR IMMEDIATE RELEASE

Wednesday, October 4, 2017

Four Area Hospitals to Pay Millions to Resolve Ambulance Swapping Allegations

HOUSTON – Four Houston-area hospitals have agreed to pay $8.6 million to settle allegations they received kickbacks from various ambulance companies in exchange for rights to the hospitals' more lucrative Medicare and Medicaid transport referrals. The hospitals are all affiliated with Hospital Corporation of America (HCA), which is based in Nashville, Tennessee, and include Bayshore Medical Center, Clear Lake Regional Medical Center, West Houston Medical Center and East Houston Regional Medical Center.

Acting U.S. Attorney Abe Martinez made the announcement along with Chief Counsel Gregory Demske of the Department of Health and Human Services – Office of Inspector General (DHHS-OIG) and Special Agent in Charge CJ Porter of HHS-OIG, Office of Investigations.

"This settlement demonstrates our office's commitment to combatting health care fraud," said Martinez. "Ensuring the integrity of our federal health care programs is one of our highest priorities. We will continue to work to protect the public and hold accountable those who attempt to defraud the system."

This is the second such announcement this office has made holding accounta
medical institutions (hospitals and skilled nursing facilities) for these ambula
"swapping" arrangements. The first such settlement - announced in late 2
ved at the time to be the first in the nation of its kind - involved an
in this same investigation. Prior to these, virtually all case
lance companies, rather than the medical institut

Department of Justice

U.S. Attorney's Office

Southern District of Texas

FOR IMMEDIATE RELEASE

Monday, November 30, 2015

Skilled Nursing Facility Company Agrees to Pay More Than $3 Million to Resolve Kickback Allegations

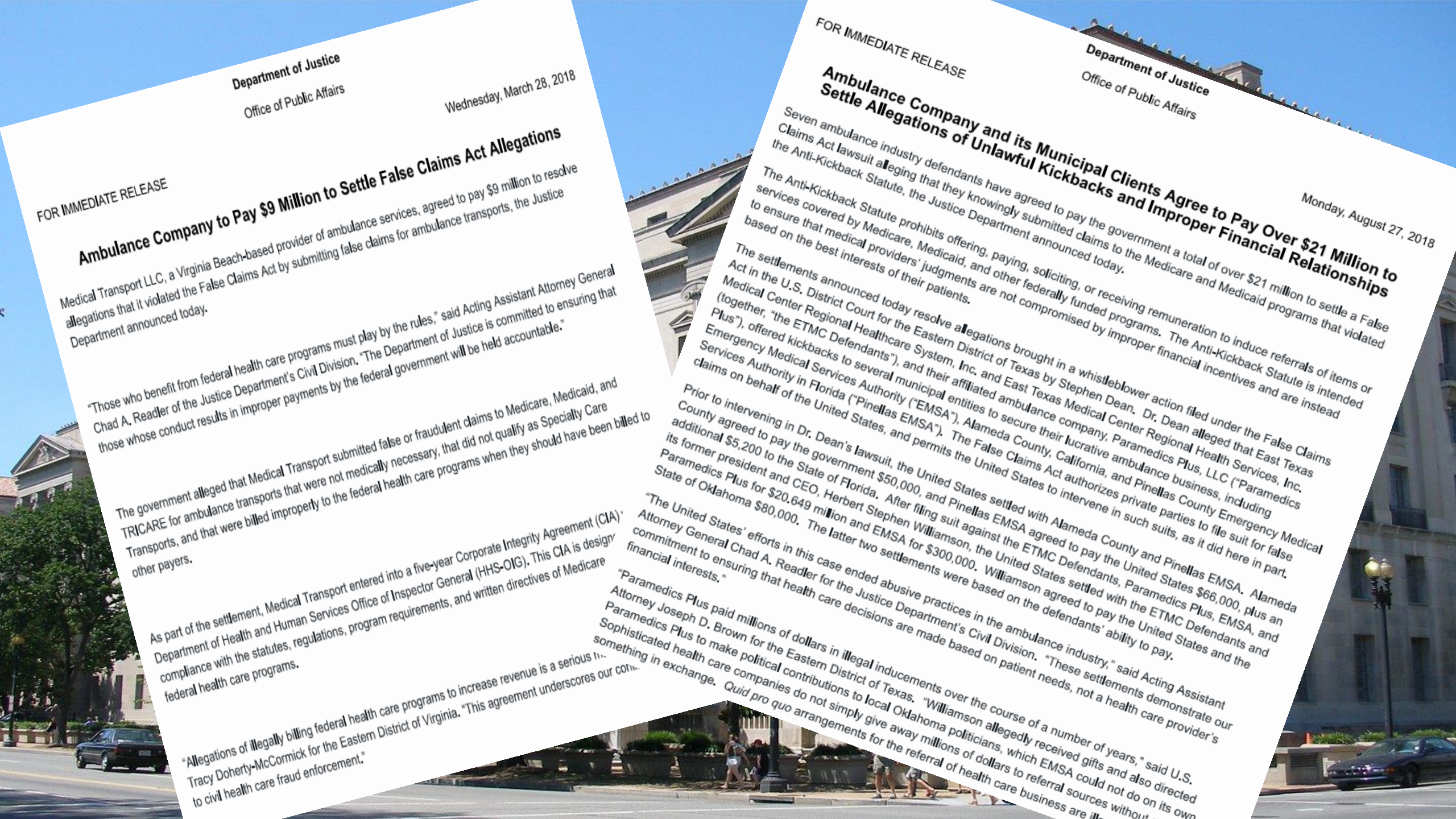
HOUSTON – Regent Management Services L.P. has agreed to pay approximately $3.199 million to settle allegations that it received kickbacks from various ambulance companies in exchange for rights to Regent's more lucrative Medicare and Medicaid transport referrals, announced U.S. Attorney Kenneth Magidson and Gregory Demske, Chief Counsel to the Inspector General of the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) and Special Agent in Charge CJ Porter, of HHS-OIG, Office of Investigations, Dallas Regional Office.

Regent Management Services L.P. is headquartered in Galveston and manages 12 separately owned and operated nursing facilities including 11 in seven Texas cities.

The settlement is believed to be the first in the nation to hold accountable medical institutions (hospitals and skilled nursing facilities) rather than ambulance companies for these kind of ambulance "swapping" arrangements.

"This resolution is part of the government's emphasis on combating health care fraud throughout the district and is an example of our determination to hold those accountable for their actions," said Magidson. "Any type of improper behavior or arrangement in the industry is a serious allegation that we will not take lightly and we will pursue in order to protect the integrity of the health care system."

The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by federal health care programs, including Medicare and Medicaid. The settlement announced today resolves allegations that patients at Regent facilities received free or heavily discounted ambulance transports from various ambulance companies in exchange for Regent's referral of other lucrative Medicare and Medicaid business to those same companies. If not for this kickback arrangement, Regent would have been financially responsible for the patient transports at significantly higher rates.



Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Wednesday, March 28, 2018

Ambulance Company to Pay $9 Million to Settle False Claims Act Allegations

Medical Transport LLC, a Virginia Beach-based provider of ambulance services, agreed to pay $9 million to resolve allegations that it violated the False Claims Act by submitting false claims for ambulance transports, the Justice Department announced today.

"Those who benefit from federal health care programs must play by the rules," said Acting Assistant Attorney General Chad A. Readler of the Justice Department's Civil Division. "The Department of Justice is committed to ensuring that those whose conduct results in improper payments by the federal government will be held accountable."

The government alleged that Medical Transport submitted false or fraudulent claims to Medicare, Medicaid, and TRICARE for ambulance transports that were not medically necessary, that did not qualify as Specialty Care Transports, and that were billed improperly to the federal health care programs when they should have been billed to other payers.

As part of the settlement, Medical Transport entered into a five-year Corporate Integrity Agreement (CIA) Department of Health and Human Services Office of Inspector General (HHS-OIG). This CIA is design compliance with the statutes, regulations, program requirements, and written directives of Medicare federal health care programs.

"Allegations of illegally billing federal health care programs to increase revenue is a serious Tracy Doherty-McCormick for the Eastern District of Virginia. "This agreement underscores our com to civil health care fraud enforcement."

FOR IMMEDIATE RELEASE

Department of Justice

Office of Public Affairs

Monday, August 27, 2018

Ambulance Company and its Municipal Clients Agree to Pay Over $21 Million to Settle Allegations of Unlawful Kickbacks and Improper Financial Relationships

Seven ambulance industry defendants have agreed to pay the government a total of over $21 million to settle a False Claims Act lawsuit alleging that they knowingly submitted claims to the Medicare and Medicaid programs that violated the Anti-Kickback Statute, the Justice Department announced today.

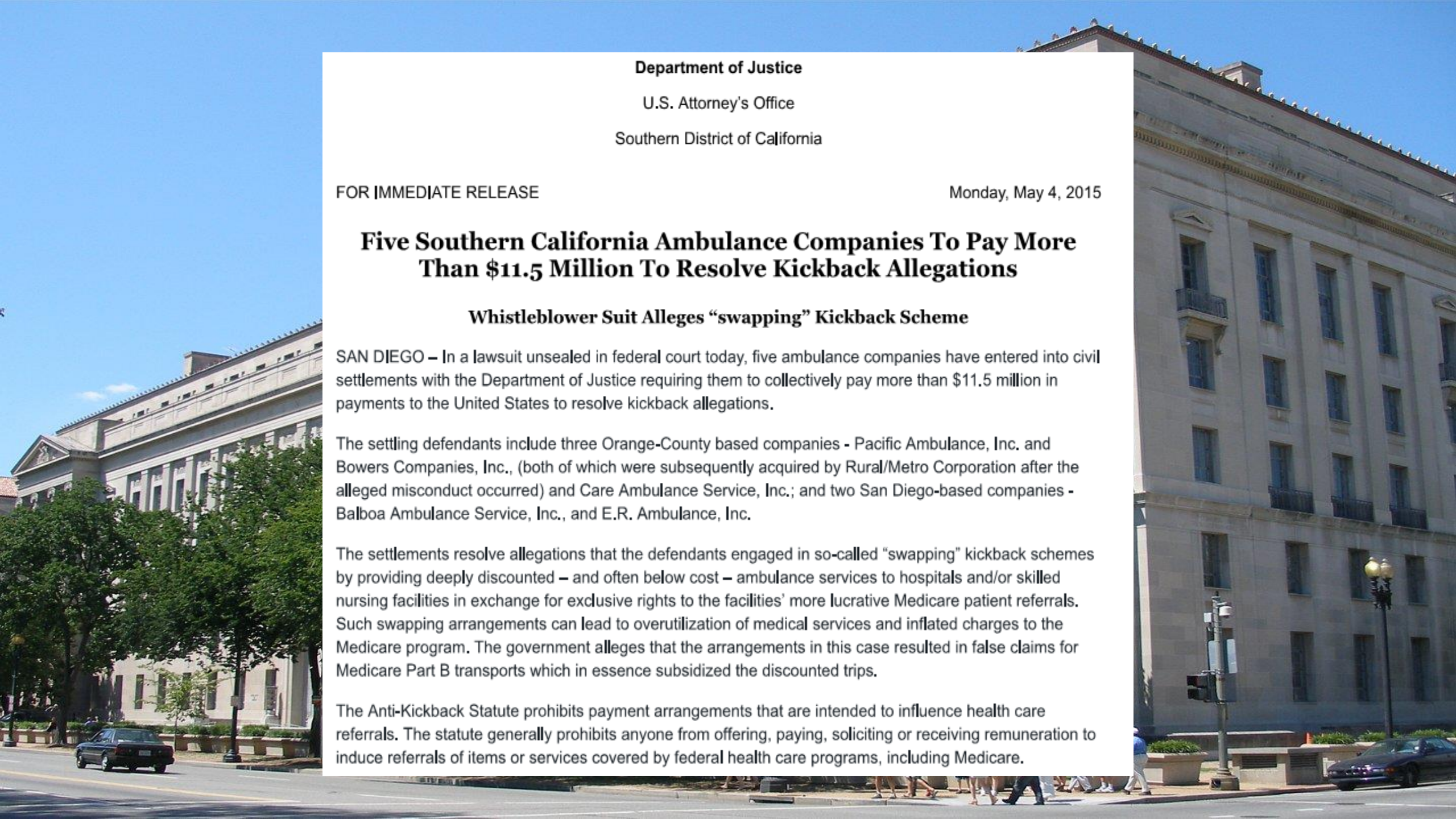
The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally funded programs. The Anti-Kickback Statute is intended to ensure that medical providers' judgments are not compromised by improper financial incentives and are instead based on the best interests of their patients.

The settlements announced today resolve allegations brought in a whistleblower action filed under the False Claims Act in the U.S. District Court for the Eastern District of Texas by Stephen Dean. Dr. Dean alleged that East Texas Medical Center Regional Healthcare System, Inc. and East Texas Medical Center Regional Health Services, Inc. (together, "the ETMC Defendants"), and their affiliated ambulance company, Paramedics Plus, LLC ("Paramedics Plus"), offered kickbacks to several municipal entities to secure their lucrative ambulance business, including Emergency Medical Services Authority ("EMSA"), Alameda County, California, and Pinellas County Emergency Medical Services Authority in Florida ("Pinellas EMSA"). The False Claims Act authorizes private parties to file suit for false claims on behalf of the United States, and permits the United States to intervene in such suits, as it did here in part.

Prior to intervening in Dr. Dean's lawsuit, the United States settled with Alameda County and Pinellas EMSA. Alameda County agreed to pay the government $50,000, and Pinellas EMSA agreed to pay the United States $66,000, plus an additional $5,200 to the State of Florida. After filing suit against the ETMC Defendants, Paramedics Plus, EMSA, and its former president and CEO, Herbert Stephen Williamson, the United States settled with the ETMC Defendants and Paramedics Plus for $20.649 million and EMSA for $300,000. Williamson agreed to pay the United States and the State of Oklahoma $80,000. The latter two settlements were based on the defendants' ability to pay.

"The United States' efforts in this case ended abusive practices in the ambulance industry," said Acting Assistant Attorney General Chad A. Readler for the Justice Department's Civil Division. "These settlements demonstrate our commitment to ensuring that health care decisions are made based on patient needs, not a health care provider's financial interests."

"Paramedics Plus paid millions of dollars in illegal inducements over the course of a number of years," said U.S. Attorney Joseph D. Brown for the Eastern District of Texas. "Williamson allegedly received gifts and also directed Paramedics Plus to make political contributions to local Oklahoma politicians, which EMSA could not do on its own. Sophisticated health care companies do not simply give away millions of dollars to referral sources without something in exchange. *Quid pro quo* arrangements for the referral of health care business are ill



Department of Justice

U.S. Attorney's Office

Southern District of California

FOR IMMEDIATE RELEASE

Monday, May 4, 2015

Five Southern California Ambulance Companies To Pay More Than $11.5 Million To Resolve Kickback Allegations

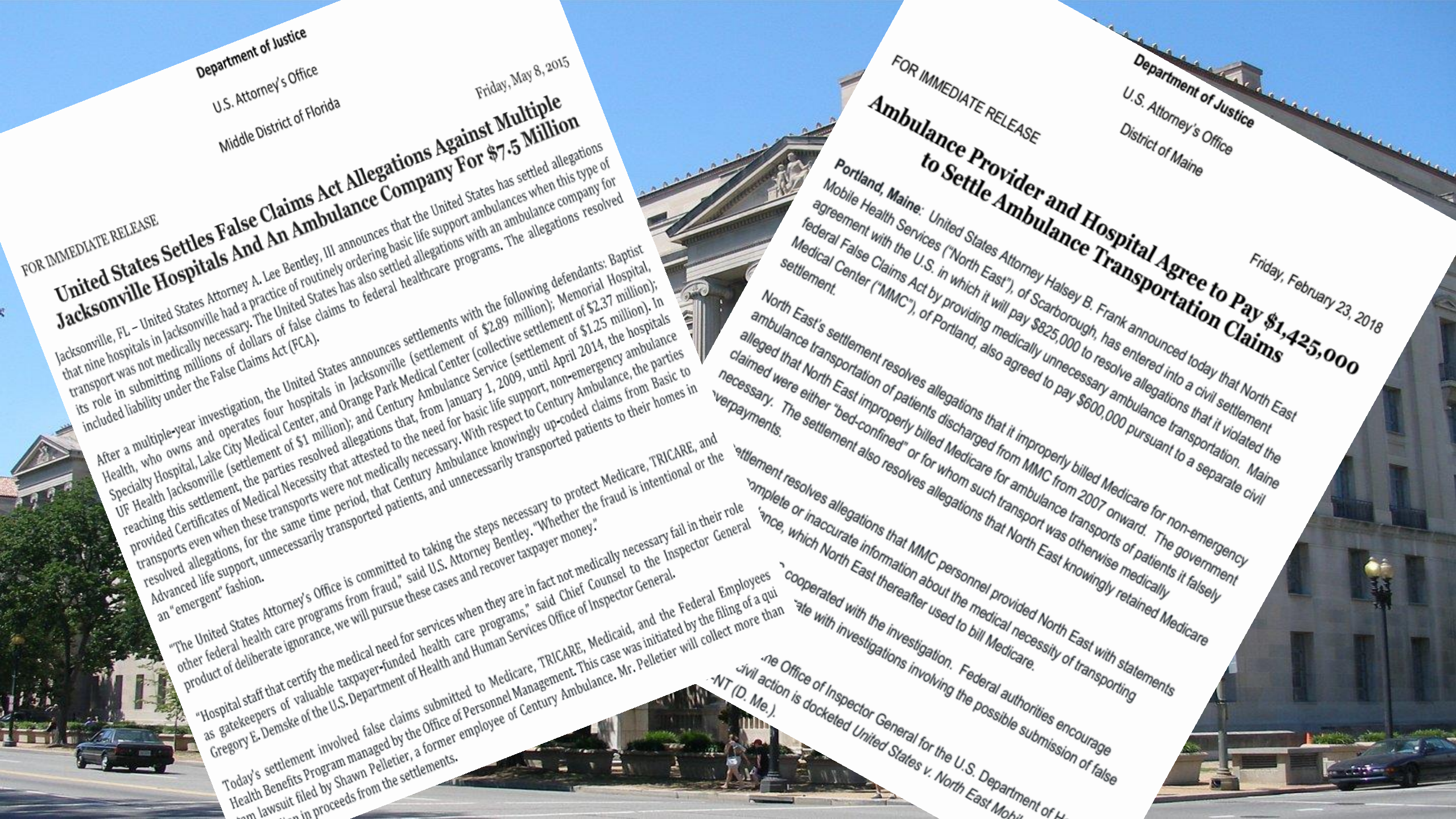
Whistleblower Suit Alleges "swapping" Kickback Scheme

SAN DIEGO – In a lawsuit unsealed in federal court today, five ambulance companies have entered into civil settlements with the Department of Justice requiring them to collectively pay more than $11.5 million in payments to the United States to resolve kickback allegations.

The settling defendants include three Orange-County based companies - Pacific Ambulance, Inc. and Bowers Companies, Inc., (both of which were subsequently acquired by Rural/Metro Corporation after the alleged misconduct occurred) and Care Ambulance Service, Inc.; and two San Diego-based companies - Balboa Ambulance Service, Inc., and E.R. Ambulance, Inc.

The settlements resolve allegations that the defendants engaged in so-called "swapping" kickback schemes by providing deeply discounted – and often below cost – ambulance services to hospitals and/or skilled nursing facilities in exchange for exclusive rights to the facilities' more lucrative Medicare patient referrals. Such swapping arrangements can lead to overutilization of medical services and inflated charges to the Medicare program. The government alleges that the arrangements in this case resulted in false claims for Medicare Part B transports which in essence subsidized the discounted trips.

The Anti-Kickback Statute prohibits payment arrangements that are intended to influence health care referrals. The statute generally prohibits anyone from offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by federal health care programs, including Medicare.



Department of Justice

U.S. Attorney's Office

Middle District of Florida

Friday, May 8, 2015

FOR IMMEDIATE RELEASE

United States Settles False Claims Act Allegations Against Multiple Jacksonville Hospitals And An Ambulance Company For $7.5 Million

Jacksonville, FL – United States Attorney A. Lee Bentley, III announces that the United States has settled allegations that nine hospitals in Jacksonville had a practice of routinely ordering basic life support ambulances when this type of transport was not medically necessary. The United States has also settled allegations with an ambulance company for its role in submitting millions of dollars of false claims to federal healthcare programs. The allegations resolved included liability under the False Claims Act (FCA).

After a multiple-year investigation, the United States announces settlements with the following defendants: Baptist Health, who owns and operates four hospitals in Jacksonville (settlement of $2.89 million); Memorial Hospital, Specialty Hospital, Lake City Medical Center, and Orange Park Medical Center (collective settlement of $2.37 million); UF Health Jacksonville (settlement of $1 million); and Century Ambulance Service (settlement of $1.25 million). In reaching this settlement, the parties resolved allegations that, from January 1, 2009, until April 2014, the hospitals provided Certificates of Medical Necessity that attested to the need for basic life support, non-emergency ambulance transports even when these transports were not medically necessary. With respect to Century Ambulance, the parties resolved allegations, for the same time period, that Century Ambulance knowingly up-coded claims from Basic to Advanced life support, unnecessarily transported patients, and unnecessarily transported patients to their homes in an "emergent" fashion.

"The United States Attorney's Office is committed to taking the steps necessary to protect Medicare, TRICARE, and other federal health care programs from fraud," said U.S. Attorney Bentley. "Whether the fraud is intentional or the product of deliberate ignorance, we will pursue these cases and recover taxpayer money."

"Hospital staff that certify the medical need for services when they are in fact not medically necessary fail in their role as gatekeepers of valuable taxpayer-funded health care programs," said Chief Counsel to the Inspector General Gregory E. Demske of the U.S. Department of Health and Human Services Office of Inspector General.

Today's settlement involved false claims submitted to Medicare, TRICARE, Medicaid, and the Federal Employees Health Benefits Program managed by the Office of Personnel Management. This case was initiated by the filing of a qui tam lawsuit filed by Shawn Pelletier, a former employee of Century Ambulance. Mr. Pelletier will collect more than [illegible] in proceeds from the settlements.

Department of Justice

U.S. Attorney's Office

District of Maine

FOR IMMEDIATE RELEASE

Friday, February 23, 2018

Ambulance Provider and Hospital Agree to Pay $1,425,000 to Settle Ambulance Transportation Claims

Portland, Maine: United States Attorney Halsey B. Frank announced today that North East Mobile Health Services ("North East"), of Scarborough, has entered into a civil settlement agreement with the U.S. in which it will pay $825,000 to resolve allegations that it violated the federal False Claims Act by providing medically unnecessary ambulance transportation. Maine Medical Center ("MMC"), of Portland, also agreed to pay $600,000 pursuant to a separate civil settlement.

North East's settlement resolves allegations that it improperly billed Medicare for non-emergency ambulance transportation of patients discharged from MMC from 2007 onward. The government alleged that North East improperly billed Medicare for ambulance transports of patients it falsely claimed were either "bed-confined" or for whom such transport was otherwise medically necessary. The settlement also resolves allegations that North East knowingly retained Medicare overpayments.

[illegible] settlement resolves allegations that MMC personnel provided North East with statements [illegible] complete or inaccurate information about the medical necessity of transporting [illegible] ance, which North East thereafter used to bill Medicare.

[illegible] cooperated with the investigation. Federal authorities encourage [illegible] ate with investigations involving the possible submission of false

[illegible] the Office of Inspector General for the U.S. Department of H[illegible] [illegible] civil action is docketed *United States v. North East Mobi[illegible]* [illegible] -NT (D. Me.).

STATE

Kentucky ambulance service defrauded Medicare with needless trips, government alleges

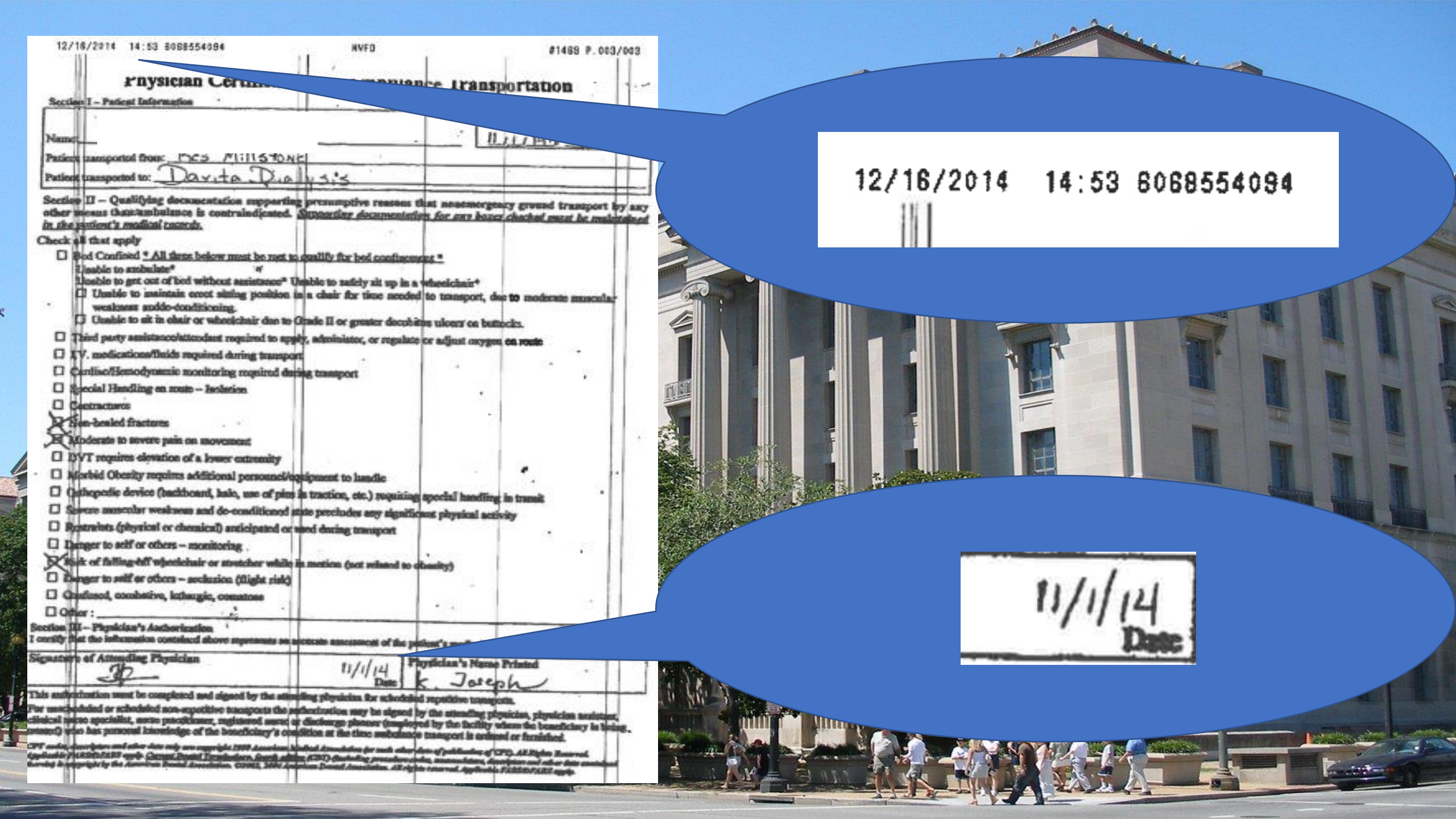
BY BILL ESTEP
bestep@herald-leader.com

September 14, 2018 04:44 PM

An ambulance service in Lee County defrauded taxpayer-funded health programs by submitting false claims for payment, the federal government alleged in a lawsuit filed Friday.

The service put information in reports that made it seem patients were in worse condition than they really were, so that the runs would qualify for federal reimbursement, the lawsuit charged.

Staffers also altered dates and forged doctors' names on forms included in reimbursement



12/16/2014 14:53 8068554094 NVFD #1489 P.003/003

Physician Certification Statement – Non-emergency Transportation

Section I – Patient Information

Name: [redacted]

Patient transported from: DCS MILLSTONE

Patient transported to: Davita Dialysis

Section II – Qualifying documentation supporting presumptive reasons that nonemergency ground transport by any other means than ambulance is contraindicated. *Supporting documentation for any boxes checked must be maintained in the patient's medical records.*

Check all that apply

- ☐ Bed Confined * All three below must be met to qualify for bed confinement *
  - Unable to ambulate* or
  - Unable to get out of bed without assistance* Unable to safely sit up in a wheelchair*
  - ☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and/or deconditioning.
  - ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medications/fluids required during transport
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Special Handling en route – Isolation
- ☐ Contractures
- ☒ Non-healed fractures
- ☒ Moderate to severe pain on movement
- ☐ DVT requires elevation of a lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others – monitoring
- ☒ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Danger to self or others – seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose
- ☐ Other: _____

Section III – Physician's Authorization

I certify that the information contained above represents an accurate assessment of the patient's [illegible]

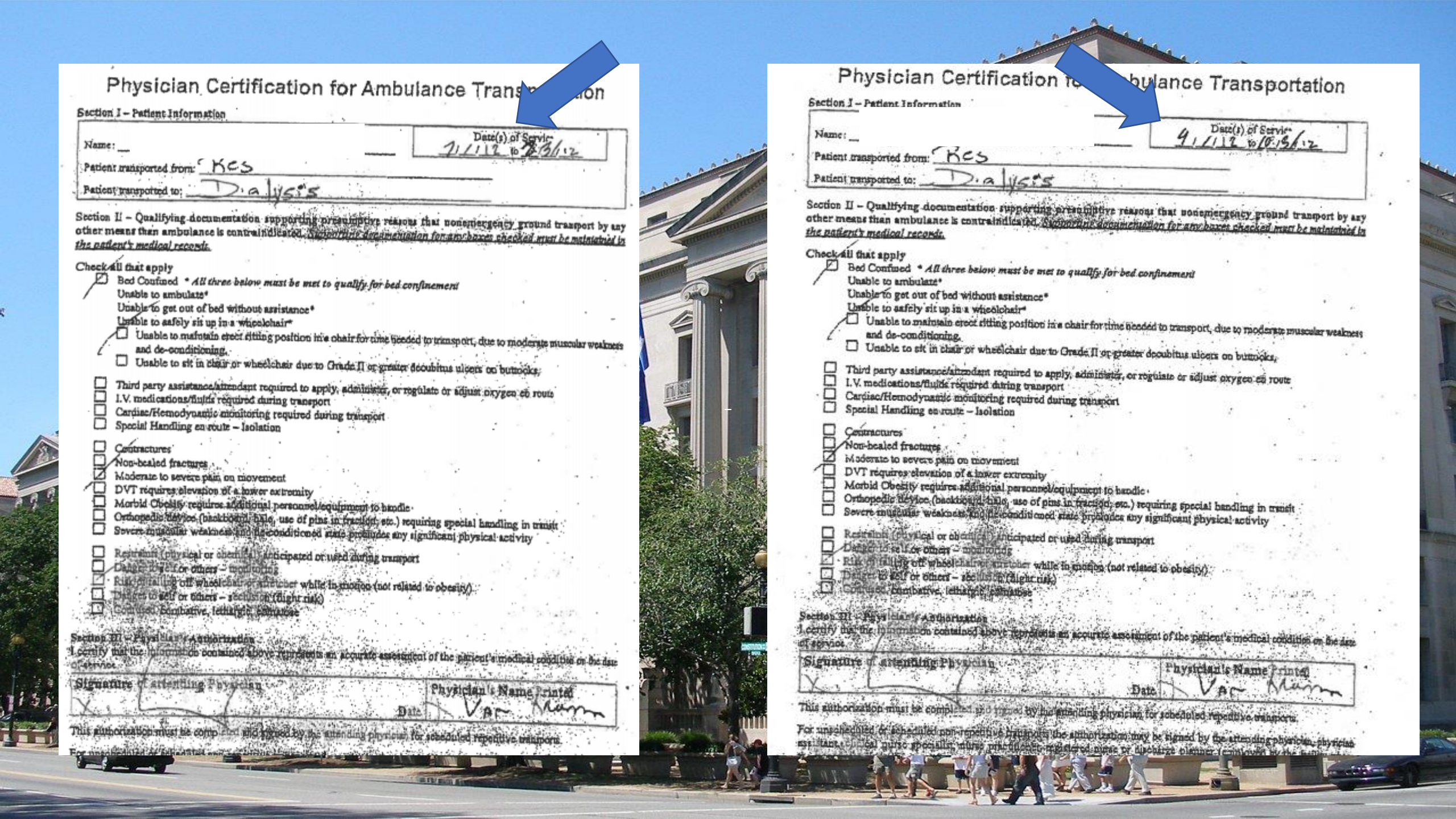
Signature of Attending Physician	Date	Physician's Name Printed
[signature]	11/1/14	K. Joseph

This authorization must be completed and signed by the attending physician for scheduled repetitive transports.

For unscheduled or scheduled non-repetitive transports the authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse or discharge planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.

12/16/2014 14:53 8068554094

11/1/14 Date



Physician Certification for Ambulance Transportation

Section I – Patient Information

Name: _____

Date(s) of Service: 7/1/12 to 8/31/12

Patient transported from: KCS

Patient transported to: Dialysis

Section II – Qualifying documentation supporting presumptive reasons that nonemergency ground transport by any other means than ambulance is contraindicated. *Supportive documentation for any boxes checked must be maintained in the patient's medical records.*

Check all that apply

- ☑ Bed Confined * *All three below must be met to qualify for bed confinement*
  - Unable to ambulate*
  - Unable to get out of bed without assistance*
  - Unable to safely sit up in a wheelchair*
    - ☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.
    - ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medications/fluids required during transport
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Special Handling en route – Isolation
- ☐ Contractures
- ☐ Non-healed fractures
- ☑ Moderate to severe pain on movement
- ☐ DVT requires elevation of a lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in fracture, etc.) requiring special handling in transit
- ☐ Severe muscular weakness and deconditioned state precludes any significant physical activity
- ☐ Restraint (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others – monitoring
- ☑ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Danger to self or others – seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose

Section III – Physician's Authorization

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.

Signature of attending Physician X	Date	Physician's Name Printed Dr. Mann

This authorization must be completed and signed by the attending physician for scheduled repetitive transports.

For unscheduled or scheduled non-repetitive transports the authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse or discharge planner (employed by the facility

Physician Certification for Ambulance Transportation

Section I – Patient Information

Name: _____

Date(s) of Service: 9/1/12 to 10/31/12

Patient transported from: KCS

Patient transported to: Dialysis

Section II – Qualifying documentation supporting presumptive reasons that nonemergency ground transport by any other means than ambulance is contraindicated. *Supportive documentation for any boxes checked must be maintained in the patient's medical records.*

Check all that apply

- ☑ Bed Confined * *All three below must be met to qualify for bed confinement*
  - Unable to ambulate*
  - Unable to get out of bed without assistance*
  - Unable to safely sit up in a wheelchair*
    - ☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.
    - ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medications/fluids required during transport
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Special Handling en route – Isolation
- ☐ Contractures
- ☐ Non-healed fractures
- ☑ Moderate to severe pain on movement
- ☐ DVT requires elevation of a lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
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- ☐ Severe muscular weakness and deconditioned state precludes any significant physical activity
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- ☐ Danger to self or others – monitoring
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Ambulance *Qui Tam*

- In January 2019, a federal district court judge dismissed a *qui tam* lawsuit that had been filed against Rural/Metro by two of its former employees
  - Employees had alleged that a 2014 decision by Rural/Metro to outsource certain coding functions to an outside agency resulted in the improper "upcoding" of certain claims

Ambulance *Qui Tam*

- In dismissing the case, the judge had to determine whether Rural/Metro "knowingly" permitting the submission of false claims
  - Under the FCA, this knowledge requirement can also include deliberate ignorance or reckless disregard of certain risks
  - Mere "negligence" is not sufficient to sustain a FCA case
- Judge determined that Rural/Metro was aware of the alleged issues related to its billing, and had taken steps to address these matters. As such, the judge determined that no reasonably jury could have held that Rural/Metro acted recklessly or with deliberate indifference

EXCLUSION SETTLEMENT

- DoJ reached a settlement with an ambulance company in Maine to resolve allegations that they improperly employed an individual that had previously been excluded from participation in federal health care programs
  - $16,776
- Individual was hired as a part-time administrative assistant
  - She had previously been excluded as the result of surrendering her pharmacy technician license for improperly diverting controlled substances

THANK YOU

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