



FINAL REPORT FOR
CITY OF SANTA MONICA
AMBULANCE CONTRACT BILLING REVIEW

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I. OVERVIEW

As part of the City of Santa Monica's internal audit work plan, the City requested an internal audit engagement of the service contract with its ambulance billing services provider, AmeriCare (the Contractor). The engagement took place between December 2015 and July 2016.

The engagement included the following objectives:

- Assess the overall compliance and effectiveness of the Contractor's ambulance billing and collections for services and fees for all ambulance calls;
- Assess the completeness, accuracy, and timeliness of the Contractor's remittance of payment to the City for services and fees;
- Assess compliance with contract requirements regarding aging accounts and collections process;
- Assess the completeness, accuracy, and timeliness of the Contractor's remittance to the City of payments recovered through Collections; and
- Review the City's monitoring and reconciliation practices.

We conducted this review under the consultancy standards of the American Institute of Certified Public Accountants (AICPA). As such, this work was not an audit of internal controls or compliance that resulted in a formal opinion or other form of assurance. The specific methods used for testing controls over cash assets are presented in the *Methodology* sections. Moss Adams would like to thank the staff of the Fire Department, the Finance Department, and the Contractor for their cooperation and assistance during our review.

A. BACKGROUND

The City of Santa Monica has a contract with the Contractor for ambulance operator services, as well as ambulance billing services, which has been in place since August 2011. Within the City, the Fire Department responds to all 911 calls that are medical related. Immediately after the Fire Department is dispatched, the ambulance Contractor is dispatched. After assessing the nature of the medical situation, the Fire Department determines the appropriate course of action, which could include:

- No transportation is required.
- Transportation is medically advised but the patient refuses and signs Against Medical Advice (AMA).
- The patient requires transportation with basic life support services (BLS).
- The patient requires transportation with advanced life support services (ALS).

Most patients that require transportation are transported in the Contractor's ambulances. For BLS calls, the Contractor's Emergency Medical Services (EMS) personnel provide basic life support care during transport. If ALS transport is required, the Fire Department paramedics ride in the ambulances to provide an advanced level of care.

Figure 1: Ambulance Call Volume by Year for the City

Year	Ambulance Calls
2013	6,553
2014	5,290
2015	4,540
Total	16,383

As outlined in the City’s contract, the Contractor bills patients for all ambulance calls, except those that do not require transportation. The Contractor bills and collects revenue for its own services, as well as for some of the services provided by the Fire Department.

For BLS calls, the Contractor issues an invoice and collects revenue for its services and ambulance transportation. Depending on the type of medical care provided, the Contractor is supposed to issue an invoice on behalf of the City for the ALS services provided. For most ALS calls, the Contractor issues two invoices. One invoice is issued on behalf of the City for the medical care provided by City paramedics and presence during transportation. The Contractor collects this revenue and remits it to the City. Another invoice is issued and collected by the Contractor for its own services and ambulance transportation.

Figure 2: Ambulance Revenue to City by Year

Year	Revenue Received by City
2013	\$856,736
2014	\$967,780
2015	\$989,520
Total	\$2,814,036

Figure 3: City of Santa Monica’s Ambulance Revenue to Contractor by Year

Year	Revenue Received by Contractor
2013	\$2,236,072
2014	\$2,626,190
2015	\$2,679,425
Total	\$7,541,687

Los Angeles (LA) County regulates rates and charges for ambulance transport as well as other services, treatments, and supplies used during the course of ambulance calls. As specified within the City of Santa Monica’s contract with the Contractor, charges shall be calculated and billed in accordance with the County’s regulations. The rate schedule used for preparing the bills in our sample is provided below. As of July 1, 2016, these rates and the list of charges have been updated.

Figure 4: Ambulance Rate Schedule

Rate Schedule	LA County FY 15-16 Maximum Rates
ALS: Response to call with equipment and personnel at an ALS level	\$1,561.00
BLS: Response to call with equipment and personnel at a BLS level	\$1,012.75
Code 3: Used during response or transport, per incident	\$126.75
Code 2: Used during response or transport, per incident	\$50.00
Mileage Rate: Each mile or fraction thereof	\$18.50
Special Charges	
Night Call: Request for service after 7:00 p.m. and before 7:00 a.m. of the next day will be subject to an additional maximum charge	\$82.25
Oxygen: Persons requiring oxygen shall be subject to an additional maximum charge per tank or fraction thereof	\$63.75
Backboard, splints, KED	\$49.75
Traction splints	\$90.00
Ice packs	\$26.50
Bandages, dressings	\$26.50
Oxygen cannula/mask	\$26.50
Cervical collar	\$44.75
Burn kit	\$48.75
Pulse oximeter	\$86.00
Automated external defibrillator (AED)	\$86.00
Continuous positive airway pressure (CPAP)	\$86.00

Note: This list does not include all of the special charges within LA County’s Rates. We omitted services that were not indicated as performed in any of the calls in our sample.

AmeriCare indicated that, if performed, they would not bill for certain excluded services. Excluded services include Waiting Time, Standby Time, Transport Non-Company Staff, Neonatal Transport, Respiratory Therapist, Nurse Critical Care Transport, Infusion Pump, Obstetrical Kit, and Volume Ventilator.

In addition to the fees for BLS and ALS transport, mileage, pulse oximeter, CPAP, and oxygen, there is a \$12 medical supply fee applied to all ambulance calls that the Contractor deposits into a City account.

B. METHODOLOGY

To evaluate ambulance billing and revenue collection, our methodology encompassed:

- Performing interviews with personnel from the City’s Fire Department and Finance Department, as well as the Contractor’s Chief Finance Officer.
- Reviewing a variety of documentation, including:
 - Current ambulance contract with modifications
 - LA County’s ambulance rates, effective July 1, 2015
 - LA County’s ambulance rates, effective July 1, 2016
 - Revenue collections information for July 1, 2015 to September 30, 2015 from the City and the Contractor
 - Activity reports from the City Fire Department’s EMBRS Fire Records Management System
 - Accounts Receivable (AR) aging information for July 1, 2015 to September 30, 2015 from AmeriCare
 - An example of the Contractor’s monthly activity summary, trip detail, aging AR summary, and collections activity
 - For selected calls, City patient care record (PCR) forms and the Contractor’s PCR forms
 - For selected ambulance calls, City invoices, billing records and billing narratives
 - For selected ambulance calls, Contractor’s invoices, billing records, and billing narratives
- Selecting a stratified random sample of ambulance calls that occurred between July 1, 2015 and September 30, 2015.
 - To ensure that we selected and reviewed a cross-section of all calls, we selected samples by different types of calls. Because ALS transports result in billing for the City, the majority of our sample is made up of these calls.

	Sample	Population
ALS Transport	60	789
BLS Transport	25	1,065
No Transport	15	479
No Transport Listed	5	142
Total	105	2,475¹

¹ From July 1, 2015 to September 30, 2015, there were a total of 2476 calls. This includes one call categorized as an “Intra Facility Transfer.”

- While we originally selected 15 calls that resulted in no transport, we discontinued our review of these calls because no billing is performed when no transport occurs, thereby limiting the testing we could perform. Of the five calls with no transport listed, we discontinued our review of two of these calls after determining that no transport resulted from these calls.
- Throughout this report, we used a total sample size of 88 calls (60 ALS Transports, 25 BLS Transports, 3 No Transport Listed). In certain cases, complete information was not available and we noted the number of calls used.
- Testing sampled selection to assess the timeliness, completeness, and accuracy of billings and collections performed by the Contractor.

C. SUMMARY OF RESULTS

From our review, we were able to identify a number of issues that are pertinent to the City and its management related to current ambulance billing practices, as well as opportunities for changes in the future. During the course of conducting this review, the ambulance rate schedule set forth by LA County changed and numerous itemized charges were eliminated. The application of these itemized charges related to a number of findings described within this report. While the elimination of these charges removed the risk of these issues occurring in the future, underlying issues related to recordkeeping, billing, and monitoring practices will continue to be relevant.

Many of the billing issues we identified are associated with a relatively low dollar value. However, the City has a responsibility to adequately manage its contract and associated legal risks, such as the appropriate billing for services. Additionally, we identified a variety of issues related to the accurate recording of gross fees. In particular, any time that gross fees are not recorded accurately, the Contractor's financial records no longer represent an accurate portrayal of the City's ambulance service and gross fees associated with it. Without this information accurately recorded, the City's ability to make projections is impaired.

The City is currently in the last year of its contract for ambulance services. As such, the City will soon have the opportunity to draft a new contract. With this new contract, the City can incorporate additional requirements for its Contractor, such as increased monitoring and additional performance requirements.

We identified a number of opportunities for improvement that can be addressed through actions by the City and/or its Contractor. The primary types of actions include:

- The City should incorporate additional language in future contracts to create clearer expectations for billing practices, revenue collection, reporting, and monitoring.
- The Contractor should implement process improvements regarding recordkeeping, billing, and revenue collection.
- The Contractor should provide enhanced reporting to the City's Fire and Finance Departments.
- The City should perform additional ongoing monitoring of billing practices and revenue collection.

- The City should consider reviewing past billings to identify inaccurate or inappropriately applied fees that would require refunds by the City or Contractor.

In total, we identified 28 findings (opportunities for improvement). Findings are listed below by area of focus, which include general recordkeeping, billing for core services, billing for special charges, and revenue collection.

General Recordkeeping
1. Inconsistencies exist in the basic recordkeeping related to ambulance calls.

Billing for Core Services
2. Not all fees charged for ambulance services were consistent with the applicable county rates as required by the City’s contract with the Contractor.
3. The County’s new ambulance rates, and current revenue sharing model, will yield less revenue for the City than in the prior FY.

Billing for Special Services
4. Billing for pulse oxygen service was inconsistent.
5. Inconsistencies were noted in the oxygen service recordkeeping.
6. The Contractor did not charge patients for all oxygen services delivered.
7. Not all charges for oxygen were consistent with the County’s maximum established rates.
8. There are inconsistencies in the records related to additional treatments.
9. The Contractor did not fully bill for all additional treatments, creating lost potential revenue for the Contractor and the City.
10. Not all fees charged for night service were accurate.
11. The Contractor’s practices regarding the billing of night calls are inconsistent.
12. The Contractor’s practices for charging fees for Code 3 responses may not be consistent with the intent of the County’s rate schedule.
13. Documentation regarding the type of transport provided, if any, was not complete for all calls.
14. Some calls were charged mileage rates in excess of those established by the County.

Billing for Special Services
15. There are inconsistencies in the number of miles recorded and the number of miles billed.
16. Problems with mileage recordkeeping and billing may have a compounding impact when coupled with errors in rates applied and discrepancies in addresses.

Revenue Collection
17. Lack of clarity about certain billing practices for the City creates uncertainty about the revenue due, thereby limiting accountability and full revenue collection from the Contractor.
18. Inconsistencies in the timing of billing activities may negatively impact revenue collection for the City.
19. Some of the Contractor's accounting practices may compromise the overall accuracy of the City's ambulance operations records.
20. Current practices do not provide maximum assurance that all revenue will be distributed appropriately to the City.
21. The Contractor's practices regarding referral to collections are inconsistent.
22. Limited reporting is provided to the City about collections activities.
23. Payments to the City are delayed longer than payments to the Contractor.
24. There is a lag time between the date the Contractor prepares its deposit slips and the date it makes the bank deposit.
25. The Contractor's current processes for processing check payments for the City results in revenue realization delays.
26. The current processes for processing credit card payments for the City results in revenue realization delays.
27. Although the Finance Department has recently developed a process for reconciling revenue collection, it has not yet been institutionalized.
28. Current billing practices may not maximize the City's ability to capture revenue for its ambulance services.

II. GENERAL RECORDKEEPING

A. METHODOLOGY

To assess the accuracy of recordkeeping for our selected sample of 88 ambulance calls, we compared a variety of data points, including identifying numbers, addresses, and transport method, to determine if they were recorded consistently between data sources. Specifically, we compared the following data points:

- Preprinted sequence number on the City's PCR form to the Contractor's PCR form (corresponding number should be handwritten)
- Incident address listed on the City's PCR, Contractor's PCR, and invoices issued
- Drop-off address listed on the City's PCR, Contractor's PCR, and invoices
- Transport method on the City's PCR, Contractor's PCR, and City's FireMedPro data

B. RESULTS, FINDINGS, AND RECOMMENDATIONS

1. **Finding: Inconsistencies exist in the basic recordkeeping related to ambulance calls.**

Based on our testing, we found discrepancies in some of the basic information recorded for ambulance calls. We found issues related to the sequence numbers or unique identifying number, incident address and drop-off address, and the transport method. Discrepancies with any of these data points can result in incorrect records, billings, and payments.

The sequence number is a unique number preprinted on the City's PCR form. It should be written on the Contractor's corresponding PCR form to ensure that incidents are identified appropriately. We compared the City's PCR form to the Contractor's PCR form. Of the 88 records we compared, we found 13 discrepancies. Of these 13 discrepancies, we found nine instances where a sequence number was not legible. However, these legibility issues may be related to scanning issues. The remaining four discrepancies included three instances where no sequence number was included and one instance where the sequence number written on the Contractor's PCR form was incorrect. Without the correct sequence number, it is more difficult to maintain complete records for both the City and the Contractor related to ambulance calls.

The location of incidents and where patients are dropped off are recorded on the City's PCR, Contractor's PCR, and the invoices issued. These addresses are used to calculate mileage charges that are included on invoices. We compared the incident address listed on the City's PCR, Contractor's PCR, and invoices. Of the 85 records we reviewed with complete information available, we found 10 discrepancies in the incident addresses.² In nine instances, the incident address did not

² While our complete sample size was 88 for this test, we only had complete information for 85 records including PCRs and bills for both the City and the Contractor. As a result, we used 85 records for this aspect of our review.

match between the City's PCR, Contractor's PCR, and invoice issued. In one instance, the City's PCR was missing an incident address. We also found differences in how the same location was noted. Specifically, we found three instances in which the same location was noted differently for the incident address. For example, we found that a facility's name may have been noted on the invoice, but the actual address was noted on the PCRs.

Similarly, we compared the drop-off address listed on the City's PCR, Contractor's PCR, and invoices issued. Of the 85 records we reviewed with complete information available, we found three discrepancies in the drop-off address. In these three instances, the invoice issued on behalf of the City showed the incident address as the drop-off address. Issues regarding addresses may lead to billing errors given their role in calculating mileage charges.

We noted inaccuracies in the transport method, which can have a variety of consequences. There are two types of ambulance transport: BLS and ALS. We compared the City's PCR to Contractor's PCR and the City's FireMedPro data. Of the 88 records we reviewed, we found 26 discrepancies related to the transport method. These discrepancies included transport type missing from the FireMedPro and/or PCR form and disagreement between transport type recorded on the PCR form and FireMedPro data. Without an accurate record of its transport activities in FireMedPro, the City does not have adequate information for ongoing billing and revenue monitoring. While the Contractor bills for both types of transport, in accordance with the City's contract the Contractor bills on the City's behalf for all ALS transports, but only some of the BLS transports, depending on the interventions performed. However, as we address in our billing analysis, BLS transports are also important for the City to monitor, particularly because some of these transports generate revenue as well. Therefore, discrepancies in the type of transport can hinder the City's ability to monitor its activities and associated revenue.

Upon inquiry, we determined that these discrepancies have a variety of causes. Beyond human error, we found that scanning issues also contributed to some of the issues we observed. For example, some sequence numbers were not legible due to issues with scanning the PCRs. Similarly, the City explained that FireMedPro may not have a transport method listed due to poor scanning quality. Additionally, we found inconsistencies in how addresses were listed. Some incident addresses were referenced by facility name on an invoice, while others were referenced by street address. This lack of standardization could lead to unnecessary confusion. The discrepancies in the City's PCR forms will likely be reduced with the City's recent implementation of electronic PCRs as of August 1, 2016. However, the Contractor continues to use paper PCR forms.

Recommendations:

- The City should continue with the implementation of electronic PCRs. As part of the implementation process, the City should evaluate how this technology can help address issues of legibility and completeness. In developing a new contract, the City should consider requiring Contractors to use electronic PCRs.

- As part of ongoing monitoring efforts, the Fire Department should implement an administrative quality assurance review of documentation. These reviews should assess completeness, legibility, and accuracy. For example, as part of other periodic tasks, review monthly ambulance calls to ensure that transport method is completed.
- The Fire Department should train the Contractor's field staff to ensure that ongoing improvements occur. The City should incorporate recordkeeping quality into future contract requirements.
- The City should establish address standardization requirements, such as requiring all incident addresses to be recorded as street addresses rather than facility names, and communicate these requirements to City and Contractor EMS staff.

III. BILLING: CORE SERVICES

A. BACKGROUND

The contract between the City and the Contractor addresses the collection of fees, billing responsibilities, and revenue distribution. Based on the contract, the rates in invoices are not to exceed the most current published LA County Public Ambulance Rates. The County publishes the maximum allowable rates that can be charged by ambulance operators for the fiscal year.

The Contractor bills charges using Contractor and City invoices. City invoices are sent out by the Contractor on the City’s behalf, and all associated revenue collected is remitted to the City. In the case of Medicare patients, the Contractor issues “bundled” bills—one bill that includes the services provided by both the Contractor and the City.

The applicable rates for the calls in our sample are LA County’s FY 2015-16. As shown in the table, there are some special charges set forth by the County that are typically not included on the Contractor or City invoice. For example, even if a burn kit is used, it would not appear on either invoice. As of July 1, 2016, these rates and the list of charges have changed.

Figure 5: Ambulance Rates and Associated Revenue Recipients

	LA County FY 15-16 Maximum Rates	Contractor Invoice	City Invoice
Rate Schedule			
ALS: Response to call with equipment and personnel at an ALS level	\$1561.00	No	Yes
BLS: Response to call with equipment and personnel at a BLS level	\$1012.75	Yes	No
Code 3: Used during response or transport, per incident	\$126.75	Yes ³	Yes ¹
Code 2: Used during response or transport, per incident	\$50.00	Yes	No
Mileage Rate: Each mile or fraction thereof	\$18.50	Yes	No
Special Charges			
Night Call: Request for service after 7:00 pm and before 7:00 am of the next day will be subject to an additional maximum charge	\$82.25	Yes	No
Oxygen: Persons requiring oxygen shall be subject to an additional maximum charge per tank or fraction thereof	\$63.75	Yes	No
Backboard, splints, KED	\$49.75	No	No

³ As discussed in Finding 12, the Code 3 charge should not be applied more than once per incident.

	LA County FY 15-16 Maximum Rates	Contractor Invoice	City Invoice
Traction Splints	\$90.00	No	No
Ice Packs	\$26.50	No	No
Bandages, dressings	\$26.50	Yes	No
Oxygen cannula/mask	\$26.50	Yes	No
Cervical collar	\$44.75	No	No
Burn Kit	\$48.75	No	No
Pulse Oximeter	\$86.00	No	Yes
Automated external defibrillator (AED)	\$86.00	No	No
Continuous positive airway pressure (CPAP)	\$86.00	No	Yes
<p>Note: This list does not include all of the special charges within LA County’s Rates. We omitted services that were not indicated as performed in any of the calls in our sample.</p> <p>AmeriCare indicated that, if performed, they would not bill for these excluded services. Excluded services include Waiting Time, Standby Time, Transport Non-Company Staff, Neonatal Transport, Respiratory Therapist, Nurse Critical Care Transport; Infusion Pump, Obstetrical Kit, and Volume Ventilator.</p>			

B. FEES PAYABLE TO THE CITY

In accordance with its contract with the City, the Contractor bills patients or their insurers, on behalf of the City, for the following services provided by the Fire Department: ALS, Pulse Oximeter, and Code 3, as well as the additional treatment of CPAP. The fee for ALS, which is also referred to as the ALSAF fee, represents the difference between the County’s fee for ALS service and BLS service.

The Contractor is responsible for collecting these payments and remitting them to the City. For FY 2015-16, the relevant rates for services reimbursable to the City are as follows:

Figure 6: City of Santa Monica – Services and Fees

Services and Fees Payable to the City	
ALS ⁴	\$548.25
Pulse Ox	\$86.00
Code 3	\$126.75
CPAP	\$86.00

In addition, there is a medical supplies reimbursement fee of \$12 per patient that is not billed to the patient. Instead, the Contractor pays the City directly based on the total number of ALS and BLS calls. Based on these rates and the possible combination of standard charges, the bills generated on behalf of the City for a standard ALS call could be one of the following:

Figure 7: City of Santa Monica – Standard Bill Amount

Standard Bill Amount – City Invoice			
ALSAF (ALS Only)	Code 3	Pulse Ox	Total
X			\$548.25
X		X	\$634.25
X	X		\$675.00
X	X	X	\$761.00

Note: The City does not frequently utilize the CPAP. If this were utilized on a patient, then the total charges for service would increase by \$86.00.

C. FEES PAYABLE TO THE CONTRACTOR

In accordance with its contract with the City, the Contractor bills patients or their insurers for the following services it provides: BLS, Code 2, Code 3, and Night Call. The Contractor is responsible for collecting these payments itself and retains all revenue collected. For FY 2015-16, the relevant rates for the Contractor’s services are the following:

⁴ This is referred to as the ALSAF Fee. It represents the difference between LA County’s FY 2015-16 rates for ALS and BLS levels of service.

Figure 8: Contractor – Services and Fees

Services and Fees Payable to the Contractor	
BLS	\$1,012.75
Code 2	\$86.00
Code 3	\$126.75
Night Call	\$82.25

Based on these rates and the possible combination of standard charges, the bills generated by the Contractor on its own behalf for a standard BLS call could be one of the following:

Figure 9: Contractor – Standard Bill Amount

Standard Bill Amount – Contractor Invoice				
BLS	Code 2	Code 3	Night Call	Total
X				\$1,012.75
X	X			\$1,062.75
X		X		\$1,139.50
X			X	\$1,095.00
X	X		X	\$1,145.00
X		X	X	\$1,221.75

Based on Medicare requirements, the Contractor only issues one invoice, or a bundled bill, for both its services and those of the City. The Contractor is responsible for remitting the City’s portion of payment to the City. In the case of Medicare, the City typically receives \$75.47 for providing ALS services to Medicare patients. This amount is based on the total Medicare benefits paid out for ambulance transports and an agreement between the City and Contractor for divvying up payments.

Figure 10: City and Contractor – Standard Combined Bill Amount

Standard Bill Amount – Combined Invoice				
BLS + ALSAF	Code 2	Code 3	Night Call	Total
X				\$1,561.00
X			X	\$1,643.25
X	X			\$1,611.00
X	X		X	\$1,693.25
X		X		\$1,687.75
X		X	X	\$1,770.00

D. METHODOLOGY

For the ambulance calls selected in our sample, we reviewed and compared the following information:

- City PCR forms, City invoices, City billing screens, and billing narratives
- Contractor PCR forms, Contractor invoices, Contractor billing screens, and billing narratives
- Additional patient information as available, including hospital face sheets and insurance eligibility of benefits letters

E. RESULTS, FINDINGS, AND RECOMMENDATIONS

We reviewed the billing for 85 ambulance calls, including 60 ALS calls and 25 BLS calls. We reviewed bills issued by the Contractor for: 1) the Contractor’s portion of ambulance services, and 2) the City’s portion of ambulance. Also, we reviewed instances when bundled billing was performed, with one bill prepared to show the cost for services performed by both the Contractor and the City followed by a revenue split after payment was received.

Based on our review, we found inconsistencies in the charges that were billed. Moreover, we found that the fees charged for ambulance services were not always consistent with LA County’s FY 2015-16 ambulance rates. A summary of the invoices we tested is provided in the two figures below.

Figure 11: Contractor's Invoices – Charges Billed

Description & Rate	Rate	Count
Consistent with FY 15-16 LA County Rates		
BLS + Code 2	\$1,062.75	21
BLS + Code 3	\$1,139.50	25
ALS + Code 2	\$1,611.00	32
Inconsistent with FY 15-16 LA County Rates		
SAMO BLS2, Night MCAL	\$1,461.00	2
SAMO BLS, Code 3	\$1,174.50	3
SAMO ALS1 M/M	\$1,660.50	2

Figure 12: City Invoices – Charges Billed

Description & Rate	Rate	Count
Consistent with FY 15-16 LA County Rates		
SAMO ALSAF	\$675	34
SAMO ALSAF+ Pulse Ox	\$761	43
Inconsistent with FY 15-16 LA County Rates		
SAMO ALSAF	\$696	1
SAMO ALSAF+ Pulse Ox	\$784.75	6
<No Billing>	\$0	1

2. Finding: Not all fees charged for ambulance services were consistent with the applicable County rates as required by the City’s contract with AmeriCare.

During our review of billing records for 85 ambulance calls, we found inaccuracies in the fees that were billed for services. These errors were found on the Contractor’s invoices, City invoices, and bundled invoices. We identified the different types of impacts of these errors: accounting, billing, and payment. The particular impact of these errors is multi-layered and varies by call.

- Accounting: All billing errors for both ALS and BLS calls have an accounting impact because they affect the accuracy of the Contractor’s overall accounting records. For instance, any time gross fees are not recorded accurately, the Contractor’s financial records no longer represent an accurate portrayal of the City’s ambulance service and the gross fees associated with it.

- **Billing:** The impact of billing errors on patients or their insurers differs depending on their coverage. In particular, because Medicare and Medi-Cal pay certain amounts for different types of services, billing a higher dollar amount had no actual impact on the amount of money paid out by Medicare or Medi-Cal. In contrast, private payers or other insurance companies may have overpaid as a result of these errors as they pay based on bill amount. For example, in one instance, the City did not receive any payment for its service because no bill was issued.
- **Payment:** For the billing errors where payment has not been received yet, errors can be corrected and invoices can be reissued. However, for instances where payment has already been received based on an incorrect bill, the Contractor and the City must issue refunds to correct overpayments. Additionally, incorrect billing caused incorrect amounts to be reported to the Collections agency.

Of the Contractor’s billing records, we noted seven exceptions in which charges included on the Contractor’s invoices were inconsistent with FY 2015-16 LA County billing rates as indicated below. A “No” in the Contractor Paid column indicates that fees were not collected.

Figure 13: Contractor’s Invoices – Exceptions Noted

Sample (#)	Charge	Accounting Impact (Gross Fees)	Billing Impact	Payment Impact: City	Payment Impact: Contractor
(11)	\$1,174.50	Yes	No (Medicare)	N/A	Yes
(18)	\$1,660.50	Yes	No (Medicare)	Yes	Yes
(20)	\$1,660.50	Yes	No (Medicare)	Yes	Yes
(26)	\$,1461.00	Yes	No (Medi-Cal)	N/A	Yes
(37)	\$1,174.50	Yes	Yes (Private Pay)	N/A	Yes – Credit Due
(46)	\$1,174.50	Yes	Yes (Insurance)	N/A	No
(72)	\$,1461.00	Yes	No (Medi-Cal)	N/A	Yes

Of the City’s billing records we reviewed for 85 ambulance calls, we noted seven exceptions in which charges included on City invoices were inconsistent with FY 15-16 LA County billing rates, as indicated below.

Figure 14: City of Santa Monica Invoices – Exceptions Noted

Sample (#)	Charge	Accounting Impact (Gross Fees)	Billing Impact	Payment Impact: City	Payment Impact: Contractor
(11)	\$784.75	Yes	No (Medicare)	Yes	Yes
(18)	\$784.75	Yes	No (Medicare)	Yes	Yes
(20)	\$784.75	Yes	No (Medicare)	Yes	Yes
(37)	\$784.75	Yes	Yes (Private Pay)	Yes – Credit Due	Yes – Credit Due
(46)	\$784.75	Yes	Yes (Insurance)	No	No
(72)	\$784.75	Yes	No (Medi-Cal)	No	Yes
(76)	\$696.00	Yes	Yes (Private Pay)	No – Collections	No – Collections
(79)	\$0.00	Yes	Yes (Medicare)	N/A	N/A

The majority of these errors were caused by the Contractor’s failure to update prior FY rates in a timely manner. Some invoices were prepared with the prior FY rates. However, each year the County published ambulance rates 30 days in advance of implementation. We also found some Medi-Cal specific rates that were not recently updated. The Contractor explained that because these charges will always be adjusted down through auto-contractual rates, these may receive less frequent attention. However, the overstatement of these charges still result in an overstatement of gross fees associated with ambulance services. Maintaining accurate records of gross fees is a critical element upon which the City will base projections such as the anticipated impact of changes in the payer mix.

Recommendations:

- The Contractor should immediately correct all inaccurate billings identified through this process, reissue invoices as necessary, correct balances reported to the Collections agency, and issue refunds.
- The Contractor should develop queries and reports to identify other similar billing issues. Once identified, these issues should be reported to both the City’s Fire and Finance Departments, and evidence of their timely resolutions should also be presented for review.
- The Contractor should update all fees in a timely manner to ensure that appropriate charges are in place at the beginning of each FY. The Contractor should disable all fees that are no longer applicable to avoid errors. The Contractor should run monitoring reports to ensure that fees are accurate.
- The Contractor should explore its ability to provide a report showing the line items charged for calls to support ongoing monitoring by the Contractor and City.

- The Fire Department should incorporate a review of these fees into its periodic administrative spot checks.

3. Finding: The County’s new ambulance rates and current revenue sharing model will yield less revenue for the City than in the prior FY.

During FY 2015-16, the City and the Contractor split revenue by establishing a fee, referred to as the ALSAF fee, which is the difference between the County’s fee for ALS service and BLS service. This fee was \$548.25 in FY 2015-16. As shown in Figure 11, the billing for the majority of the calls we reviewed, 84 of 85 calls, contained charges for more than the ALSAF fee alone. Of those, 34 contained charges for the ALSAF fee and Code 3 for a total of \$675, and 43 contained charges for the ALSAF fee, Code 3, and pulse ox for a total of \$761.

As of July 1, 2016, new ambulance rates became effective in the County. Besides changing the amounts, the new schedule eliminated numerous itemized charges. One of the eliminated charges is the pulse ox fee, which produced revenue for the City. Additionally, the itemized charges for Code 2 and Code 3 responses were eliminated. Instead, the County set forth four different rates based on ALS service or BLS service and two different response times.

Figure 15: New County Rate Schedule Components

Rate Schedule	Charge
(A1) Response to a <i>non-emergency call</i> with equipment and personnel at an ALS level	\$1,776
(A2) Response to an <i>emergency 9-1-1 call</i> with equipment and personnel at an ALS level	\$1,900
(B1) Response to a <i>non-emergency call</i> with equipment and personnel at a BLS level	\$1,183
(B2) Response to an <i>emergency 9-1-1 call</i> with equipment and personnel at a BLS level	\$1,268

Currently, the Fire Department and the Contractor have agreed upon a fee of \$632 for the City’s services. This fee represents the difference between the charges for a response to an emergency call and personnel at an ALS level and a response to an emergency call and personnel at a BLS level. While this fee is an increase from the previous year’s ALSAF fee, without the pulse ox fee and itemized Code 3 charge, the new revenue split will result in \$43 less per call for 34 of 85 calls in our sample and \$129 less per call for 43 of 85 calls in our sample.

In contrast, the rates charged by the Contractor's BLS services will increase from the previous FY rates. The current rate for non-emergency calls and personnel at a BLS level of service is now \$1,183, which is \$120.25 more than in the prior FY for BLS service with a Code 2 response. Similarly, the current rate for emergency calls and personnel at a BLS level of service is now \$1,268, which is \$128.50 more than in the prior FY for BLS service with a Code 3 response. Additionally, the new disposable medical supply fee of \$27 will be applied to all calls. This amount will be billed by the Contractor, who will retain this revenue.

The current revenue sharing split will result in an increase in fees for the Contractor, regardless of the BLS service selected, and a decrease in fees for the City. However, because the ambulance rate structure changed significantly since the development of this City's contract, neither the recent changes to the rate structure nor the current revenue sharing model are included in the current contract. Therefore, it appears that the City has an opportunity to work with the Contractor to negotiate a more equitable fee structure for their respective services.

Recommendations:

- Given the significant changes to the County's ambulance rate schedule, the City should explore adjustments to its revenue sharing structure with the Contractor for the remainder of the FY. For example, the City could propose receiving the difference between the emergency response and personnel at an ALS level to a non-emergency response and personnel at a BLS level, which would result in \$717 in fees. Moreover, the City should discuss with the Contractor how the medical supplies fees will be billed and revenue distributed.
- The City should modify the current contract and all future ambulance contracts to comprehensively address billing expectations and requirements. In particular, all services and charges published by the County should be addressed by the contract, including requirements for billing and revenue recipient. If the County modifies the services or charges, a contract amendment should be issued to update this agreement.
- The City should explore including additional language into the new contract to require the Contractor to maintain adequate and appropriate documentation for all services performed and billed.
- For the FY 2016-17, the City should create a table like the one shown below that includes all of the current year's rates and charges. This table should clearly define services or treatments and associated charges and revenue recipient. Areas of ambiguity or complexity, such as medical supplies fees, should be addressed in notes within the table. Once complete, this table should be added to the current contract and updated and included in future contracts.

Figure 16: City of Santa Monica Rates and Charges

	LA County FY 16-17 Maximum Rate	Billed	Contractor Invoice	City Invoice
Rate Schedule				
Response to a <i>non-emergency call</i> with equipment and personnel at an ALS level	\$1,776	Yes	No*	Yes
Response to an <i>emergency 9-1-1 call</i> with equipment and personnel at an ALS level	\$1,900	Yes	No*	Yes
Response to a <i>non-emergency call</i> with equipment and personnel at a BLS level	\$1,183	Yes	Yes	No
Response to an <i>emergency 9-1-1 call</i> with equipment and personnel at a BLS level	\$1,268	Yes	Yes	No
Mileage Rate: Each mile or fraction thereof	\$18	Yes	Yes	No
Waiting Time: For each 30-minute period or fraction thereof after the first 30 minutes of waiting time at the request of the person hiring the ambulance	\$100	No	N/A	N/A
Standby Time: The base rate for the prescribed level of service and, in addition, for each 30-minute period or fraction thereof after the first 30 minutes of standby time	\$96	No	N/A	N/A
*In the case of bundled billing, as required for Medicare, the Contractor shall issue a bill for ALS services and pass-through the following amount to the City <TBD:\$ amount passed through to City>				
Special Charges				
Night Call: Request for service after 7:00 pm and before 7:00 am of the next day will be subject to an additional maximum charge of	\$20.00	Yes	Yes	No
Oxygen: Persons requiring oxygen shall be subject to an additional maximum charge per tank or fraction thereof, and oxygen delivery equipment to include nasal cannula and/or oxygen mask, of	\$92.00	Yes	Yes	No
Neonatal Transport	\$190.00	No	N/A	N/A
Registered nurse <u>or</u> respiratory therapist specialty care transport with equipment and personnel for up to 3 hours of transportation time	\$2,137.00	No	N/A	N/A
Registered nurse <u>and</u> respiratory therapist specialty care transport with equipment and personnel for up to 3 hours of transportation time	\$2,416.00	No	N/A	N/A
Registered Nurse <u>and/or</u> Respiratory Therapist per hour after the first 3 hours	\$114.00	No	N/A	N/A

	LA County FY 16-17 Maximum Rate	Billed	Contractor Invoice	City Invoice
Volume Ventilator	\$176.00	<TBD>	<TBD>	<TBD>
Disposable Medical Supplies	\$27.00	Yes	<TBD>	<TBD>
Notes: The disposable medical supplies fees shall be applied to the <TBD: City/Contractor> invoices for all calls and the revenue shall be retained by the <TBD: City/Contractor>.				

IV. BILLING: SPECIAL CHARGES

A. BACKGROUND

There are a variety of individual services that may be performed by the City and/or the Contractor. According to the contract, AmeriCare can bill for additional services or fees as set forth within the LA County rates. The contract also specifies who receives the revenue generated by these additional fees, the Contractor or the City. Based on agreements between the Contractor and the City, not all of the fees set forth by the County are charged. For example, the City does not impose the fee for pickups at skilled nursing facilities. Similarly, the Contractor stated that it does not charge for waiting or standby time. (Refer to Figure 5 for ambulance rates and revenue recipients for FY 2015-16.) However, these agreements are not fully documented within the contract.

During the course of our review, LA County announced new ambulance rates for FY 2016-17. Besides changing the maximum rates for services, the new rates eliminated many of the additional service charges we examined in this section. Given these changes, our recommendations have been adjusted accordingly. While the elimination of these charges removes the risk of these issues from occurring in the future, underlying issues of related to recordkeeping, billing, and monitoring practices will continue to be relevant in the future.

Pulse Ox

Pulse ox is considered an important vital sign for emergency medical personnel to obtain. In recent years, pulse ox has come under debate as to whether it can be considered an ALS assessment or treatment or if it has become part of the standard of care. In July 2015, following the City's legal settlement related to ambulance billing, the City and Contractor sought clarification from legal counsel and it was determined that pulse ox can be charged, but it cannot be used to differentiate between ALS and BLS levels of assessment or interventions.

Oxygen

When oxygen is provided to a patient, additional fees can be charged. According to county ambulance rates, patients can be charged a maximum rate per tank or for fractions of a tank.

Additional Therapies

In addition to pulse ox and oxygen, there are a variety of other therapies that are employed by the Fire Department's paramedics and the Contractor's EMT's that have additional charges associated with them. In this section we review the following therapies for which there are associated fees:

- Backboard, splints, KED
- Traction splints
- Ice packs
- Bandages, dressings

- Cervical collar
- Burn kit
- Automated external defibrillator (AED)
- Continuous positive airway pressure (CPAP)

Night Calls

In accordance with the City's contract and County guidance, an additional charge can be applied to calls where the request for service is after 7:00 p.m. and before 7:00 a.m. of the next day. Based on FY 2015-16 County rates, a maximum charge of \$82.25 can be applied to these calls.

Code 3

Code 3, which used to be called "lights and sirens," refers to an emergency response. According to the County's published rates, the Code 3 charge can be "used during response or transport, per incident," and the charge during FY 2015-16 was \$126.75.

B. METHODOLOGY

For the ambulance calls selected in our sample, we reviewed the following:

- City's PCR forms, City's invoices, City's billing screens, and billing narratives
- Contractor's PCR forms, Contractor's invoices, Contractor's billing screens, and billing narratives

C. RESULTS, FINDINGS, AND RECOMMENDATIONS

Pulse Oxygen

To examine the use of pulse oxygen and its subsequent billing, we reviewed 85 calls and compared the City's PCR form, Contractor's PCR form, and invoices issued.

4. Finding: Billing for pulse oxygen service was inconsistent.

The applicable rates for calls in our sample are the County's FY 2015-16 ambulance rates which include an additional charge for the performance of pulse ox. We found that in 82 of the 85 calls, pulse ox was performed, based on the City's PCR records.

Figure 17: City Services Performed, Recorded, and Billed – Pulse Ox

Transport Type	Performed (City PCR Form)	Charges Recorded (Contractor PCR Form)	Billed (City Invoice)
ALS	Yes - 59	Yes - 56	Yes - 38
	No - 1	No - 4	No - 22
BLS	Yes - 23	Yes - 22	Yes - 10
	No - 2	No - 3	No - 15

Despite the overwhelming use of pulse ox, billing records did not reflect this widespread use. Specifically, for these same 85 records, we found that only 48 included charges for pulse ox. Conversely, in two of the three instances where pulse ox was not performed, we found that charges were assessed on the bill.

Given the frequency with which pulse ox service is provided, it could be a significant source of additional fees for the City. While charging this fee does not always mean that it will be paid, the failure to bill for pulse ox whenever performed understates the gross fees associated with ambulance services. We found that pulse ox charges were omitted for more than 40% of the calls in our sample where pulse ox was performed. These omissions from the City’s invoices in our sample represent a potential loss in revenue for the City of approximately \$2,924 with the actual amount depending on the exact payer mix. Based on the 85 records we reviewed, we found that these billing practices had the following potential financial impact:

Figure 18: Pulse Ox Billing Differences

Pulse Ox	ALS Transport	BLS Transport
Possible Gross Fees	\$86 x 59 = \$5,074	\$86 x 23 = \$1,978
Amount Billed	\$86 x 38 = \$3,268	\$86 x 10 = \$860
Difference: Revenue not Captured	\$1,806	\$1,118

Recommendations:

- The Contractor should immediately review the two calls already identified and refund pulse ox fees where appropriate.
- The Contractor should implement a more robust quality assurance process to ensure the completeness of all invoices and that gross fees are captured accurately in order to maximize revenue capture for the City.

- Since the itemized charge for pulse ox has been eliminated and would now be included in the ambulance transport fees, the City does not need to implement monitoring unless the County incorporates more itemized charges in the future. However, the City could consider performing a look back study comparing billing records to patient care records to determine if the City collected pulse ox fees for any patients without providing this service.

Oxygen

To examine the use of oxygen and its subsequent billing, we reviewed 22 calls where we found an indication that oxygen was used. For these calls, we compared the City’s PCR form, the Contractor’s PCR form, and invoices issued. As indicated in the figure below, we found discrepancies when comparing the City’s PCR form, Contractor’s PCR form, and invoices. The administration of oxygen was not recorded consistently for these calls across these types of documents.

Figure 19: Additional Services Performed, Recorded, and Billed – Oxygen

Oxygen Administered	Performed (City PCR Form)	Performed (Contractor PCR Form)	Charges Recorded (Contractor PCR Form)	Billed (Contractor Invoice)
Performed - Both PCR Forms (17)	Yes (17)	Yes (17)	Yes (16) No (1)	Yes (13) No (4)
Performed - City PCR Form Only (2)	Yes (2)	No (0)	Yes (2) No (0)	Yes (0) No (2)
Performed - Contractor PCR Form Only (5)	No (5)	Yes (5)	Yes (3) No (2)	Yes (4) No (1)
Total	22	22	22	22

5. Finding: Inconsistencies were noted in the oxygen service recordkeeping.

When comparing the City’s and Contractor’s PCR forms, we observed discrepancies in the records regarding the administration of oxygen. While it is possible that oxygen was administered by the Contractor during the course of a BLS transport without the knowledge of the City’s paramedic, without more information, these instances appear to be discrepancies in recordkeeping. There is no explanation for the two calls where oxygen was noted on the City’s PCR form only and not on the Contractor’s form. Additionally, one call had a charge for oxygen noted on the Contractor’s PCR form despite no record of it being administered by either the City or the Contractor. While no oxygen charge was actually applied, this type of discrepancy could result in billing errors.

Recommendations:

- The Contractor should work with its field staff to improve the completeness and accuracy of its recordkeeping.
- As part of the recommended periodic administrative spot checks, the Fire Department should compare the patient care forms maintained by the City and the Contractor, as well as the billing records.

6. Finding: The Contractor did not charge patients for all oxygen services delivered.

We found that 17 patients were billed for oxygen. However, both the City's and Contractor's records indicated that additional patients were given oxygen. Based on the recordkeeping discrepancies, we cannot determine the exact amount of revenue missed for oxygen administration (between two and five additional patients based on the sample, depending on whether the City's or Contractor's PCRs are used). Failure to bill oxygen charges not only results in revenue to the Contractor, but it also results in understated gross fees associated with the City's overall ambulance operation.

Recommendations:

- The Contractor should implement its own process to ensure that all applicable oxygen fees are being charged.
- Using the reports available with the implementation of electronic PCRs, the City should monitor the application of these fees as part of an ongoing quality control check.

7. Finding: Not all charges for oxygen were consistent with the County's maximum established rates.

Of the 17 instances in which patients were charged for oxygen, we found two instances in which patients were charged fees in excess of the County's rate. These billing errors were caused by a failure to change the prior FY pricing in a timely manner and, thus, these calls were billed at the prior year's rate.

Recommendations:

- The Contractor should analyze its billing data to examine whether or not other fees were charged inappropriately, particularly at the beginning of the new FY when County rates changed. Documentation of this analysis should be provided to the City for review and verification.
- Any charges in excess of LA County rates that are identified should be reported to the City and any overpayments should be returned to the appropriate parties. Documentation of these refunds should be provided to the City for review and verification.
- The Contractor should implement a quality control process to ensure that all rates are updated appropriately at the beginning of each FY or when new ambulance rates are implemented. This process and evidence of changes should be provided to the City for review and verification.

Additional Therapies

We reviewed 88 patient care records from our sample to analyze the performance of additional services, as well as their associated billing and application of charges. We compared the City’s PCR form, the Contractor’s PCR form, and invoices. On the City’s PCR form, we reviewed the Therapies section. On the Contractor’s PCR form, we reviewed the section regarding charges. Of the 88 records, we found that 63 records had no indication of other therapies with associated charges on the City’s PCR form, the Contractor’s PCR form, or invoices. For the remaining 25 records, we found that additional therapies or fees were noted on the City’s PCR form, the Contractor’s PCR form, and/or the invoices. As indicated in the figure below, we found discrepancies when comparing the City’s PCR form, Contractor’s PCR form, and invoices. Additional therapies were not recorded consistently for these calls across these types of documents. In particular, for these 25 calls, we found that 12 calls had additional therapies indicated on the City’s PCR form, 19 calls had charges recorded for additional therapies on the Contractor’s PCR form, and five calls had charges invoiced for additional therapies.

Upon further review of the 25 records with additional treatments or charges associated, we identified the discrepancies noted in the figure below. Because a given call can have more than one additional therapy indicated, this figure includes the count of therapies noted rather than a count of associated calls.

Figure 20: Additional Therapies Discrepancies

Additional Therapy	Performed (City PCR Form)	Charges Recorded (Contractor PCR Form)	Billed
CPAP	2	0	0
Splint	2	1	0
Ice Pack	4 ⁵	2	1
C-Collar	0	6	2
Bandage	0	4	1
C-Spine	6	4	0
Restraints	1	1	0
Special Handling	0	4	0
Monitor	0	2	0
Medical Records Fee	0	0	1
Total	15	24	5

⁵ In one instance, it was noted that two ice packs were used.

We found that for a given ambulance call, the additional therapy may be noted on the City’s PCR form as having been performed but not noted on the Contractor’s form to signal to the Contractor’s billing staff to bill for additional services, or vice versa. In particular, we found that these additional therapies only resulted in additional fees for five of these 25 calls. The Contractor uses the same form at the City of Santa Monica that it uses in other jurisdictions. Therefore, the Contractor’s form contains fields on its form for services that are not billed in Santa Monica such as special handling. Based on our review, we considered the potential financial impact of these additional treatments.

Figure 21: Potential Financial Impact of Discrepancies

Additional Therapy & Associated Charge	Performed (City PCR Form) <i>Count - Value</i>	Charges Recorded (Contractor PCR Form) <i>Count - Value</i>	Billed <i>Count - Value</i>
CPAP (\$86.00)	2 - \$172.00	0 - \$0.00	0 - \$0.00
Splint (\$49.75)	2 - \$99.50	1 - \$49.75	0 - \$0.00
Ice Pack (\$26.50)	4 - \$106.00	2 - \$53.00	1 - \$26.50
C-Collar (\$44.75)	0 - \$0.00	6 - \$268.50	2 - \$89.50
Bandage (\$26.50)	0 - \$0.00	4 - \$106.00	1 - \$26.50
C-Spine (\$44.75)	6 - \$268.50	4 - \$179.00	0 - \$0.00
Restraints ⁶ (\$49.75)	1 - \$49.75	1 - \$49.75	0 - \$0.00
Special Handling ⁷ (\$49.75)	0 - \$0.00	4 - \$199.00	0 - \$0.00
Monitoring (N/A)	0 - \$0.00	2 - \$0.00	0 - \$0.00
Medical Records Fee (\$15.00)	0 - \$0.00	0 - \$0.00	1 - \$15.00
Total	15 - \$696.75	24 - \$905.00	5 - \$142.50
City's Portion	\$172.00	\$0.00	\$0.00
Contractor's Portion	\$523.75	\$905.00	\$142.50

⁶ Restraints and special handling are on the list of additional charges indicated on the Contractor’s PCR Form. However, they could be used to mean a variety of different types of treatments or services. For example, “restraints” or “special handling” could be indicated on the Contractor’s PCR form when a backboard is required for the patient, and in Santa Monica the use of a backboard has an associated fee. However, restraints or special handling could alternately be indicated for a patient that needed to be restrained due to violence, which does not have an associated charge. For this analysis, we assumed that the terms “restraints” and “special handling” mean the use of a backboard with an associated charge.

The above figure shows that the discrepancies in recorded information relating to additional treatments result in variation in the potential financial impact of these discrepancies. The Contractor invoiced for five additional therapies that are associated with \$142.50 worth of charges. In contrast, the City's PCR forms noted 14 additional therapies with \$696.75 worth of charges and the Contractor's PCR form noted 24 additional therapies with \$905.00 worth of charges. Given the revenue sharing arrangement between the City and the Contractor, the recipient of this potential revenue would depend on the type of additional therapies. Specifically, the Contractor would retain the revenue for all additional therapies except for CPAP which would be retained by the City.

8. Finding: There are inconsistencies in the records related to additional treatments.

We found that additional treatments were recorded for 15 calls on the City's PCR forms and 24 calls on the Contractor's PCR forms. In some instances these differences are reasonable. For example, if an ice pack or bandage is administered in the course of a BLS transport by the Contractor's EMS staff, then it would be appropriate for this item to be omitted from the City's PCR form because the City's paramedics were not present during transport. Similarly, if the charges for special handling or restraints were used to provide treatments or services that have no associated charge in Santa Monica, then it is appropriate for these items to be omitted from the Contractor's PCR forms. However, there are numerous discrepancies that appear to be due to human error.

Recommendations:

- Due to the changes this year in County ambulance rates, which eliminated these individual special charges, the City does not need to implement monitoring to prevent issues related to this going forward unless the County incorporates more itemized charges in the future.
- If the County moves towards itemization of additional charges in the future, then the City should incorporate verification of additional services into its administrative quality assurance initiative.

9. Finding: The Contractor did not fully bill for all additional treatments, creating lost potential revenue for the Contractor and the City.

Based on the City's contract, the Contractor "shall bill and collect for all services as directed and regulated under applicable Federal, State or County guidelines." This language implies that complete billing should be pursued, but the contract does not state this directly. Additionally, the contract does not include language about certain services that the City has not decided to charge for, such as the skilled nursing facility fee.

Based on the results of our sample testing, our analysis revealed the potential financial impact of these inconsistencies. In particular, we found that the Contractor invoiced for \$142.50 worth of the additional treatments. All of the charges that were invoiced were for treatments or services for which the Contractor would receive the associated revenue. Using the City's records, a total of \$695.75 should have been invoiced for additional services, \$172 which would have been due to the City for CPAP services. Using the Contractor's records, a total of \$905 should have been invoiced for additional services.

Upon inquiry about the observed inconsistencies in billing for additional treatments, the Contractor stated that they do not bother to include these special charge line items, because they are so rarely covered by insurance or private payers. While most of the additional charges are revenue for the Contractor, certain charges represent revenue that is due to the City. The decision to not fully charge for additional services therefore represents potential lost revenue for the City and inconsistencies in billing practices. For example, in the two instances we identified where a CPAP was used, the Contractor failed to invoice for this treatment, resulting in a loss of \$172 in potential revenue for the City. Without more comprehensive language in the contract to guide billing expectations and requirements, there is an increased opportunity for inconsistent billing practices such as this.

While the decision to pick and choose which calls get additional charges may have seemed like a reasonable business decision for the Contractor itself given the limited likelihood of payment by certain payer types, its failure to fully invoice for these additional charges is problematic for the City. This leads not only to lost opportunities for revenue collection for both the Contractor and the City, but also an incomplete capture of gross fees.

Recommendations:

- The City should modify the current contract and all future ambulance contracts to comprehensively address billing expectations and requirements. In particular, all services and charges published by the County should be addressed by the contract, including requirements for billing and revenue recipient. If the County modifies the services or charges, a contract amendment should be issued to update the agreement.

For example, for the current FY 2016-17, the City should create a table that includes all of the current year's rates and charges. This table should clearly define what services or treatments will result in associated charges and who is the recipient of the revenue. Areas of ambiguity or complexity, such as medical supplies fees, should be addressed in notes within the table. Once complete, this table should be added to the current contract and updated and included in future contracts.

- The City should remove the skilled nursing facility fee from the current ambulance contract and all contracts going forward given that this fee is scheduled to be removed from the City's fee resolution in June 2017.

Night Calls

For each of the calls in our sample, we compared the incident time recorded within the Fire Department's system data to the Contractor's PCR form and the system's billing records. Of the 86 records reviewed, we found that the majority of the calls, 74 of 86, contained consistent information regarding after hours service or night calls. For the remaining 12 calls, we found that not all incidents that qualified as night calls had charges indicated on the Contractor's PCR form or were billed this additional fee.

Of the 12 calls that did not have consistent information about night service, three of these inconsistencies have a billing impact. In particular, we found that by failing to bill for these three after hours calls, the Contractor missed the opportunity to collect \$246.75. The remaining nine instances represent inconsistencies in recordkeeping, but they do not have a billing impact.

Figure 22: Night Calls Billing Impact

Night Calls Billing Impact	Call Count	Incident Qualifies	Charges Indicated	Billed
All Information Matches				
Incident qualifies, charges indicated, billed	18	Yes	Yes	Yes
Incident does not qualify, no charges indicated, not billed	56	No	No	No
Total	74			
Information Discrepancies: Billing Impact				
Incident qualifies, no charges indicated, not billed	1	Yes	No	No
Incident qualifies, charges indicated, not billed	2	Yes	Yes	No
Total	3			
Information Discrepancies: No Billing Impact				
Incident qualifies, charges not indicated, billed	8	Yes	No	Yes
Incident does not qualify, charges indicated, not billed	1	No	Yes	No
Total	9			

We reviewed the 26 calls that included billing for night calls. Of these 26 calls, we found that 23 were charged in a consistent manner, whereby patients were billed in a separate line item for “Night Call” at the maximum County rate of \$82.25. There were variations in how the remaining three patients were billed for this after-hours service. We found that the rate for “Night Call” exceeded the maximum County rate in two calls. Instead of \$82.25, patients were billed \$84.75. Also, the combined line item exceeded the maximum total for these services of \$1,145, which is the charge for BLS, Code 2, and the Night Call. In the case of one sample, the patient was charged twice for after-hours service, both as part of the BLS service charge and as a separate line item.

Figure 23: Night Calls Charge Amount

Sample	Separate "Night Call" Line Item (Wrong Rate Charged)	Combined Line Item (Wrong Rate Charged)	Excess Billed
(26)	No	Yes	\$316.00 = (\$1,461-\$1,145)
(37)	Yes	No	\$2.50 = (\$84.75-\$82.25)
(72)	Yes	Yes	\$318.50 = (\$1,461-\$1,145) + (\$84.75-\$82.25)
Total			\$637

10. Finding: Not all fees charged for night service were accurate.

Of the 26 instances where fees were charged for night calls, we found three instances where the fees charged were in excess of the County’s maximum rate. These billing errors were caused by a failure to change the prior FY pricing in a timely manner and, thus, these calls were billed at the prior year’s rate. In one of these instances, a patient was charged twice for the night call, and both of these charges were the incorrect amount. In these three instances, given the type of coverage, no actual excess payment was made.

Recommendations:

- The Contractor should analyze its billing data to examine whether or not other fees were charged inappropriately, particularly at the beginning of the new FY when County rates changed. Documentation of this analysis should be provided to the City for review and verification.
- Any charges in excess of LA County rates that are identified should be reported to the City and any overpayments should be returned to the appropriate parties. Documentation of these refunds should be provided to the City for review and verification.
- The Contractor should implement a quality control process to ensure that all rates are updated appropriately at the beginning of each FY or when new ambulance rates are implemented. This process and evidence of these changes should be provided to the City for review and verification.

11. Finding: The Contractor’s practices regarding the billing of night calls are inconsistent.

Based on our sample size, we found that 29 of 86 records, or roughly one third of calls qualified as night calls based on the incident time recorded within City’s system data. Of these calls we found inconsistencies in the Contractor’s recordkeeping relating to these calls. Specifically we found that sometimes the Contractor’s staff marked their patient care form to charge the night call fee and other times they did not.

Additionally, we found that three calls that did qualify for night call charges were not billed. This represents a missed opportunity for the Contractor to collect \$246.75. Not billing night call charges not only deprives the Contractor of this revenue, but also results in a failure to fully capture the gross fees associated with the City's overall ambulance operation.

Recommendations:

- The Contractor should implement its own process to ensure that all applicable night call fees are being charged.
- The City should monitor the application of these fees as part of an ongoing quality control check.

Code 3

12. Finding: The Contractor's practices for charging fees for Code 3 responses may not have been consistent with the intent of the County's rate schedule.

LA County's General Public ambulance rate schedule for FY 2015-16 states that "an ambulance operator shall charge no more than the following rates for one patient." According to these rates, Code 3, formerly known as "lights and sirens," is defined as "used during response or transport per incident."

Based on our review, we found that for many ALS calls, the Contractor billed patients for Code 3 on both the City and the Contractor's invoices, resulting in two charges for one patient. We also found that in many instances, the Contractor billed Code 3 on both the City and the Contractor's invoices for BLS. While the City does respond Code 3 to all medical calls it is dispatched to, this billing practice seems questionable considering the City's invoice on BLS calls is for its level of assessment rather than transport.

The County's new ambulance rate schedule does not include itemized charges for Code 3 responses. Therefore, this issue does not pose an ongoing issue for the City.

Recommendation:

- To identify if potential refunds are due, the City should consider seeking a formal opinion about the allowability of the practice of applying Code 3 twice for a single ambulance call. If this practice is not allowable, then the City should have the Contractor perform a billing analysis to examine the extent of fees charged in this manner.

13. Finding: Documentation regarding transportation is not complete.

The decision about whether or not the ambulance operator uses Code 3 in traveling to or from an incident is determined by the Fire Department. Upon traveling to the incident, the City's dispatch tells the ambulance whether to use Code 3. Similarly, at the incident, when it is time to transport the patient, the City's paramedics make the determination about whether or not Code 3 is necessary for transporting to the hospital. During our review of sample calls, we found that the Contractor almost always applied Code 3 charges despite the lack of documentation that the Contractor's field staff was

directed to use Code 3. Without documentation to corroborate that the Contractor was directed to use Code 3, it is difficult to determine whether or not these charges were appropriately applied.

The County’s new ambulance rates no longer include itemized charges for Code 3 responses. However, the new rates differ based on the type of response. If incomplete documentation about responses persists, then the inability to corroborate the appropriateness of charges will also persist.

Recommendations:

- The Contractor should develop policies and processes to consistently document response type and the City’s direction to transport Code 3, and bill accordingly.
- The City should monitor the application of fees based on response time as part of an ongoing administrative quality control check.

Mileage

14. Finding: Some calls were charged mileage rates in excess of those established by the County.

We reviewed the records related to mileage and mileage billing for 85 ambulance calls. All 85 records had mileage recorded on the Contractor’s PCR forms and charges on the Contractor’s invoices. For 79 of these 85 calls, the Contractor billed the mileage in accordance with the County’s FY 2015-16 maximum mileage rate of \$18.50. For the six remaining calls, we found that the Contractor billed in excess of this rate, at \$19.00 per mile. For these six calls, we examined the impact of this billing rate error. In total, the mileage billed for these calls was \$229.90, based on \$19.00 per mile, rather than \$223.85, at the approved maximum rate of \$18.50. This equates to a total overbilling of \$6.05 across these six calls.

Figure 24: Mileage Billing Differences

Sample	(A) Mileage Billed	(B) Amount Billed	(C) Correct Billing Rate	(D) Difference (B-C)
(18)	0.1	\$1.90	\$1.85	\$0.05
(20)	5.0	\$95.00	\$92.50	\$2.50
(37)	2.0	\$38.00	\$37.00	\$1.00
(46)	2.0	\$38.00	\$37.00	\$1.00
(72)	1.0	\$19.00	\$18.50	\$0.50
(76)	2.0	\$38.00	\$37.00	\$1.00
Total	12.1	\$229.90	\$223.85	\$6.05

Recommendations:

- The Contractor should analyze its billing data to examine whether other mileage fees were charged correctly, particularly at the beginning of the new FY when County rates changed. Documentation of this analysis should be provided to the City for review and verification.
- Any charges in excess of LA County rates that are identified should be reported to the City and any overpayments should be returned to the appropriate parties. Documentation of these refunds should be provided to the City for review and verification.
- The Contractor should implement a quality control process to ensure that all rates are updated appropriately at the beginning of each FY or when new ambulance rates are implemented. This process and evidence of these changes should be provided to the City for review and verification.

15. Finding: There are inconsistencies in the number of miles recorded and the number of miles billed.

We reviewed the records related to mileage and mileage billing for 85 ambulance calls. We compared the number of miles recorded on the Contractor’s patient care form to the number of miles billed by the Contractor for these calls. We found that the mileage recorded was equal to the mileage billed for 35 of these 85 calls. For the remaining 50 calls, we found that 47 calls billed mileage more than the mileage recorded, and three calls billed less mileage than the mileage records. In aggregate for these 85 calls, we found that the Contractor billed for 18.8 more miles than the number of miles recorded on the Contractor’s patient care forms. At the applicable County rate for mileage, this difference totals \$347.80.

Figure 25: Mileage Recordkeeping and Billing

	Call Count	Miles	Associated Charges with FY 15-16 Mileage Rate
Miles Billed: System report of Contractor’s billing record	85	179.4	\$3,318.90
Miles Recorded: Contractor’s PCR Form	85	160.6	\$2,971.10
Difference	0	18.8	\$347.80

Recommendations:

- The Contractor should develop policies and processes to ensure accurate billing of recorded mileage. These should be provided to the City for review.
- As part of the City’s ongoing administrative monitoring process, the City should compare the mileage billed by the Contractor to the mileage recorded.

16. Finding: Problems with mileage recordkeeping and billing may have a compounding impact.

We considered the issue of mileage accuracy coupled with this use of incorrect rates. For example, we found that four of the six calls that were billed with incorrect rates may have also had inaccurate mileage amounts recorded. If the miles recorded on the Contractor’s forms were used for billing, coupled with the accurate mileage rate, the mileage charges for these four calls would have been \$36.80 in total. In one instance, the mileage charge would have changed from \$19.00 to \$5.55, a difference of \$13.45.

Figure 26: Mileage Billing Difference, Rate Issues

Sample	(A) Mileage Billed	(B) Amount Billed	(C) Correct Billing Rate	(D) Difference (B-C)	(E) Mileage Recorded	(F) Correct Billing Rate x Mileage Recorded	(G) Difference (B-F)
(37)	2	\$38.00	\$37.00	\$1.00	1.8	\$33.30	\$4.70
(46)	2	\$38.00	\$37.00	\$1.00	1.7	\$31.45	\$6.55
(72)	1	\$19.00	\$18.50	\$0.50	0.3	\$5.55	\$13.45
(76)	2	\$38.00	\$37.00	\$1.00	1.4	\$25.90	\$12.10
Total	7	\$133.00	\$129.50	\$3.50	5.2	\$96.20	\$36.80

The Contractor does not record the actual odometer readings at the beginning and end of each trip. Instead, the Contractor appears to reset the trip odometer to zero at the beginning of each trip and record the final mileage at the end of the trip. This is not consistent with the instruction on the Contractor’s own PCR form. Additionally, without written actual odometer readings, there is less reliability about the mileage reported and increased risk that miles are not being recorded or reported accurately. Moreover, weaknesses in complete and consistent reporting of incident addresses and drop-off addresses create additional uncertainty about the mileage billing.

Recommendations:

- The Contractor should report actual odometer readings at the beginning and end of each trip. Alternatively, the Contractor should propose additional controls for ensuring the accuracy of trip odometer readings under the current recording method.
- The City should collaborate with the Contractor’s field staff to ensure that ongoing improvements occur in recordkeeping. Incorporate recordkeeping quality into future contract requirements.
- In future contracts the City should consider requiring Contractors to use commonly available GPS programs to calculate mileage based upon reasonable travel routes and traffic conditions.

V. REVENUE COLLECTION

A. METHODOLOGY

We interviewed personnel involved in billing and revenue collection from the Fire Department, Finance Department, and the Contractor.

We reviewed the following documentation:

- Invoices, billing screenshots, and billing narratives for sample selected
- Deposit information received from the City
- Deposit information received from the Contractor
- Memo prepared by the Finance Department regarding a billing and revenue reconciliation process
- Outside collection agency's report
- Aging reports
- General ledger information from the City for ambulance revenue accounts

B. RESULTS, FINDINGS, AND RECOMMENDATIONS

17. Finding: Lack of clarity about certain billing practices for the City creates uncertainty about the revenue due, thereby limiting accountability and full revenue collection.

Ambulance calls can result in no transport, BLS transport, or ALS transport. Within the City's system, calls are referred to by transport type. However, the type of transport does not necessarily dictate the level of service provided and resulting billing. According to the Contractor, they perform all billing in accordance with Medicare guidelines.

For all ALS transports, the Contractor bills for ALS services because this transport type indicates that a City paramedic was involved in the transport which makes it a qualifying ALS intervention. For BLS transports, the Contractor bills for ALS services if the paramedics performed a qualifying ALS level of intervention. These types of intervention have changed over time. The Contractor reported that prior to January 2016, these qualifying interventions were the performance of a pulse ox, EKG, or blood glucose test. In January 2016, qualifying interventions no longer include pulse ox and are limited to the EKG and blood glucose test.⁸ Although the City's own PCR forms contain information about whether paramedics performed these interventions, they are not routinely monitored for the purpose of billing monitoring.

⁸ In Santa Monica, 12-lead EKGs are considered qualifying interventions. The City no longer administers "regular" or 3-lead EKGs.

Additionally, the Contractor does not currently provide detailed reporting about how BLS transports are initially billed for BLS services only or for ALS services that result in revenue receivable by the City. Without this information, it is difficult for the City to accurately determine the ambulance calls for which it is due revenue and effectively monitor billing and revenue collection. Without monitoring of all calls that are associated with City revenue, the City faces an increased risk of failure to fully capture this revenue.

Because of the inherent complexities in determining ALS billing for BLS transports, we found some inconsistencies in these billings. Within our sample of 25 BLS transports, the Contractor billed 24 of these calls for ALS services. However, not all of these 24 calls were ultimately recorded as billable ALS services, thereby overstating gross fees. For example, of those 24 calls, seven calls were later written off because they were only BLS services and qualifying ALS interventions were not performed. Similarly, seven other calls were for Medi-Cal patients, which do not generate revenue for the City, whether or not ALS interventions are provided. These fees will be adjusted down automatically, because of the patient's coverage rather than because of the services provided. The Contractor's current practices to initially bill most BLS transports for ALS services overstates the gross fees associated with the City's ambulance operations. These overstatements may lead to overstated valuations of the City's ambulance operations, as well as inaccurate revenue projections.

Recommendations:

- Following the City's recent implementation of electronic patient care forms, the City should work with its software vendor to develop mechanisms for reporting the administration of qualifying interventions for which ALS services can be billed.
- The Contractor should develop policies and a process to ensure the integrity of its initial patient billing, particularly of BLS transports. The Contractor should consider the following:
 - Discontinue the practice of creating initial billing for ALS services for all BLS transports and then writing off charges if qualifying interventions were not performed.
 - Establish a process to report account adjustments to the City.

18. Finding: Inconsistencies in the timing of billing activities may negatively impact revenue collection.

Through our examination of bills for sampled calls, we observed some instances of inconsistent timing of billing activities for the Contractor's invoice and the City's invoice. For example, we reviewed five calls from our sample that were private pay patients and, therefore, would have received separate invoices from the Contractor and the City. For all five calls, we found that the City's billing was performed anywhere from one to six days after the Contractor's billing. Given the importance of timing in successful accounts receivable collection, any delays could have a negative impact. Additionally, if invoices are not presented at the same time, then there is a risk that the first invoice will be paid but not the second. Moreover, while reviewing deposit information, we found as part of remittance information that a customer had to call to request their bill for an ambulance call three months earlier.

Additionally, we noted other instances for which the Contractor had received payment from a private payer but the City still had not. Within our sample, there were 31 calls with private payers. Of these calls, we identified four calls for which the Contractor received payment from the private payer but the City had not. Our review of these instances revealed inconsistencies in the actions taken by the Contractor on their own behalf and on the City's behalf. In one instance, we found that the Contractor sent an electronic claim to insurance for its invoice and four days later the Contractor sent a paper claim to insurance for the City's invoice. After the Contractor's claim was denied, the patient paid the Contractor's invoice, yet there is no indication that attempts were made at the same time to collect the City's outstanding bill. Reviewing the City's billing record indicated there was no follow-up action after the initial claim was sent to insurance for processing.

In another instance, the Contractor submitted an electronic claim for its invoice and submitted the City's invoice to insurance eight days later. After receiving updated insurance information from the patient, the Contractor resubmitted its invoice and received payment for most of their services. Twelve days later, payment of the City's invoice was denied because it was not a benefit of the subscriber's health plan. After receiving this denial, the Contractor submitted an invoice directly to the patient five days later and three more invoices over the next several weeks. During that same time, the Contractor noted calls with the patient's family to collect credit card payment for the outstanding balance on the Contractor's invoice, as well as the full amount for the City's invoice. After the credit card payment was denied, the Contractor's follow-up action resulted in full pay-off of their outstanding balance but no payment towards the City's bill. After the Contractor issued the fourth and final invoice for the City's services, no action was taken for five months, at which point the account was sent to collections. Examples such as these suggest that the Contractor is neither performing the initial billing activities consistently for its own invoices or the City's invoices, nor is it pursuing payments consistently for itself and the City.

Recommendations:

- In the long-term, the City should consider pursuing bundled billing.
- In the short-term and in collaboration with the City, the Contractor should develop measures to show that billing activities are being performed in the same timeframe. These measures should include reports showing the revenue collection activities and results.
- As part of the recommended billing spot audits, the City should review the Contractor's billing activities for both the Contractor and for the City to ensure that these are performed within the same timeframe and that the City's outstanding balances are being pursued appropriately.

19. Finding: Some of the Contractor’s accounting practices may compromise the overall accuracy of records of the City’s ambulance operations.

For each ambulance call within the City, the Contractor creates two billing records in its records management system. For calls where patients are private payers, the Contractor issues two separate invoices, one for the Contractor’s portion of the services provided and one for the City’s portion of the services provided. However, due to Medicare requirements, the Contractor has to submit one bundled bill for all services for patients with Medicare. Therefore, both ALS and BLS services are bundled together on one billing record for the Contractor. The Contractor also records the ALS service on the City’s billing record. Looking at the data in aggregate may be misleading because there are duplicative gross fees for one call (i.e., records would show one ALS service by the City as well as ALS and BLS services by the Contractor).

Once a Medicare payment is received, the Contractor records this payment in the Contractor’s billing record for the call. The Contractor then records adjustments, both debit and credit, to reflect the portion of the payment that is due to the City. The City’s portion of the Medicare payment, typically \$75.47 per call, is paid to the City through a transfer from the Contractor to the City and recorded on the City’s billing record as a payment. In aggregate, these internal accounting practices do not provide an accurate picture of the revenue collected. Because the Contractor records both a debit and credit adjustment in their records for the City’s portion of the payment, the current practices have the effect of double counting the City’s portion of the Medicare payment. Therefore, total revenue collected by both the Contractor and the City for ambulance services would be overstated.

We found that the Contractor was not consistent in applying the adjustment of the ALSAF fee to all Medicare ALS calls within our sample. Specifically, of the 32 calls for Medicare patients billed for ALS service, we found 10 instances where this adjustment was not applied to the Contractor’s billing record. Similarly, we found that of the 32 calls, the City’s billing records for five of these calls recorded Medi-Cal contractual adjustments, rather than Medicare adjustments.⁹ Not only were these adjustments not calculated accurately for Medi-Cal, but reports or analysis of contractual adjustments were also inaccurate. Moreover, the City receives revenue from Medicare calls but not Medi-Cal calls. These inaccurate contractual adjustments could compromise the accuracy of revenue due to the City.

Recommendations:

- The Contractor should modify its current accounting practices for Medicare payments to accurately capture the distribution of Medicare payments between the Contractor and the City. For example, the Contractor should consider how to apply only one adjustment rather than two adjustments that cancel each other out.
- The Contractor should establish processes and policies regarding the application of the ALSAF fee adjustment to all Medicare calls.

⁹ Medi-Cal pays limited reimbursement for ambulance benefits. The Contractor retains all of the revenue for Medi-Cal ambulance calls – which was on average \$115 in 2015.

- The Contractor should establish processes and policies to ensure the consistent and accurate application of contractual adjustments. In particular, the Contractor should explore how to address the apparent inaccuracies in the Medi-Cal contractual adjustments identified.

20. Finding: Current practices do not provide maximum assurance that all revenue will be distributed appropriately to the City.

According to the Contractor, the application of the ALSAF fee adjustment to the Contractor's billing record prompts the Contractor to transfer payment to City. Specifically, it is this adjustment that creates a signal to the Contractor to transfer payment to the City. Therefore, without consistent application of this adjustment, the City may not receive revenue it is due in a timely manner or at all.

Within our sample, we found 10 instances of Medicare patients billed for ALS services where this adjustment was not applied. Within these 10 calls, we found three instances where revenue was due to the City. While all three of these instances have since been resolved, and the City has received the appropriate revenue, this raises concerns about the consistency with which Medicare revenue is being transferred to the City. For example, one of these instances was not corrected until it was brought to the attention of the Contractor during the course of our fieldwork. Moreover, we observed Medicare payments received by the City even though adjustments were not applied, which creates questions about the ALSAF fee adjustment as the mechanism for triggering payment to the City.

Without additional billing information from the Contractor, the City does not know the level of services that the Contractor billed for and therefore lacks complete information about the revenue it is due. In particular, for BLS transports, the City does not receive information from the Contractor regarding whether ALS services are billed and revenue is due to the City. For the sample we selected of 25 BLS transports, the Contractor billed ALS services for 24 of these calls. However, seven of these calls were later written off as BLS service only, and another seven were adjusted down for Medi-Cal. Thus, of the 24 calls with ALS services billed, revenue would only be due to the City for 10 calls.

Without reporting at the time of billing, the City does not have adequate information to know how much revenue should be collected on its behalf. For example, in one instance we found within the narrative of the City's billing record that the Contractor noted the account should have been billed as bundled billing and that if insurance denies the claim, the account should be closed due to billing error. In this instance, the City received full revenue for its services. However, this example demonstrates current gaps within billing practices and the City's monitoring. Without additional controls in place, there is an opportunity for the Contractor to inappropriately write off ALS charges and state that only BLS service was provided for calls in any instances where revenue cannot be collected due to billing errors or other weaknesses in billing practices.

Recommendations:

- The Contractor should review how it prompts itself within the records management system when payment to the City is due. For example, the Contractor could explore making the Contractor itself a payer.

- In collaboration with the City, the Contractor should develop a report to provide adequate information to the City to facilitate accurate monitoring of billing and revenue collection on behalf of the City.

21. Finding: The Contractor’s practices regarding referral to collections are inconsistent.

In order to maximize the chances of collection, it is critical to have frequent communication after charges are incurred. For example, as defined by the City’s contract, the Contractor must send a first collection notice within ten days of the date services are rendered to a patient and a minimum of four collection notices within fifty days. If no payment is received after issuing multiple invoices, then the Contractor performs its own skip tracing to locate the patient and increase the chances of payment. For example, staff perform skip tracing to find new addresses to send invoices or other relevant information that may result in payment. If these efforts to gather additional information are unsuccessful, then the Contractor refers these outstanding balances to an outside collections agency.

While the Contractor’s course of action following non-payment is appropriate, the Contractor lacks policies or formal guidance to ensure consistent practices. In particular, the Contractor does not have a firm timeline for performing skip tracing activities or a deadline for referring accounts to the outside collections agency. The rate of successful collection of outstanding accounts receivables decreases significantly the longer accounts age. During our review, we found that accounts were recommended for referral to collections, but they were not sent to the collections agency for another month or more following referral. According to the Contractor, it currently sends accounts for collection every four to six weeks. Thus, without a firm deadline for referral to collections agencies, the Contractor may be decreasing the chances of payment with any delays.

During our review of selected ambulance calls, we noted that the Contractor did not always pursue collections at the same time for the City’s outstanding balances as it did for its own. For example, one of the calls in our sample had outstanding balances for both the Contractor’s invoice (\$150) and the City’s invoice (\$761). These balances were recommended for referral to the collections agency on the same date, but were not sent on the same date. Instead, the City’s outstanding balance was sent to the collections agency four months after the Contractor’s outstanding balance was sent.

Recommendations:

- To improve the consistency and efficiency of the collections process, the Contractor should develop and implement a policy that includes:
 - Definitive timelines to guide its collections activities, including timing that maximizes the potential for payment collection
 - Requirements to treat outstanding balances equally, regardless of whether they are related to the Contractor’s invoices or the City’s invoices
- The Contractor should increase the frequency at which it refers accounts to collections agency in order to minimize delays and increase the possibility of collection.

- The Contractor should develop reports and regularly provide these to the City to demonstrate ongoing adherence to these timelines. For example, reports should show the timing when each invoice is issued, internal collections activities such as skip tracing are performed, and referrals are made to collections.
- Using the reports provided, the City should perform ongoing monitoring to ensure that the City is performing billing and collections activities in a timely manner.

22. Finding: Limited reporting is provided to the City about collections activities.

Within the Contractor's records management system, staff record outstanding balances referred to the collections agency as write-offs. While this practice is reasonable for the Contractor's own accounting purposes, there is currently limited information being provided to the City to facilitate ongoing monitoring of these collections activities. For example, the Contractor does not regularly provide the City with detailed information showing the accounts that have been referred to collections, the status of those collections, and the overall success rate of these collections. Without this information, the City cannot adequately monitor the collections activities or associated revenue collected.

Recommendations:

- The Contractor and the collections agency should regularly provide the City with required information to facilitate oversight of collections referrals and revenue collected.
- The City's Finance Department should work with the Contractor to obtain, analyze, and monitor the collections agency's collection rate information. Following the implementation of more prompt and consistent collections practices, the Finance Department should monitor the collections rate to ensure that it is within the industry's expected range.

23. Finding: Payments to the City are delayed longer than payments to the Contractor.

We reviewed the total payments received by the Contractor and the City for the sample calls selected. We found that the Contractor received \$31,750 and the City received \$9,972. We compared the timing lag between the payment receipt and the ambulance call date. We found that on average the Contractor collected payment roughly 61 days after the ambulance call date. In contrast, we found that the City received payments roughly 96 days after the ambulance call date.

Similarly, we found that when comparing the receipt of the same payment type that there were delays between when the Contractor received payment and when the City received payment. For example, on average, the check payments for the Contractor were received and recorded almost 30 days before the City received check payments. Similarly, within our sampled calls, we found that the Contractor received credit card payments in an average of 92 days and EFT payments in an average of 47 days. In comparison, the City received payment from these sources on average within 101 days.

The Contractor's current recordkeeping for payment types may make monitoring of payment methods and speed cumbersome. Based on the Contractor's payment records to the City between January 2013 and December 2015, we found that there were 19 different payment codes recorded. Many of these payment types were duplicative and have since been consolidated. In mid-2015, the Contractor modified its payment remittance methods by increasing the transfer of funds to the City through ACH. Although these changes are improvements, additional changes are likely necessary to facilitate full accountability and effective oversight by the City.

Recommendation:

- In collaboration with the City, the Contractor should develop mechanisms to demonstrate the speed with which payments are being received, processed, and deposited to the City's account.

24. Finding: There is lag time between the date the Contractor is preparing its deposit slips and the date it is making the bank deposit.

We reviewed the deposit records for the payments the Contractor made to the City. We analyzed the records for 68 deposits that occurred between January 1, 2015 and December 31, 2015. We found that, on average, deposits were made to the bank almost five days after the deposit slip was prepared. In particular, we found that in 26 instances, six days or more elapsed between deposit slip preparation and bank deposit. We found that in three instances 15 days elapsed between deposit slip preparation and deposit. While the Contractor reports storing all payments securely, any delays in depositing funds increases the risk of misappropriated assets and reduces cash flow for the City.

Recommendations:

- The Contractor should consider possible improvements to increase the speed with which payments are deposited.

25. Finding: The Contractor's current processes for processing check payments for the City results in revenue realization delays for the City.

In addition to the lag time we observed between deposit preparation and deposits, we observed an apparent lag time between when checks are received by the Contractor and when they are deposited into the City's account. To review the time between payment dates and deposit dates, we reviewed the dates of checks from the collections agency. We found that for the 12 checks deposited during calendar year 2015, there was an average of more than 18 days between the check date and deposit date. Currently, the Contractor receives checks on behalf of the City, but it waits to deposit these until a full-time employee is available to take these to the bank. Although limiting bank deposit transports to full-time employees rather than part-time employees is a responsible practice, this practice delays the deposits and increases the chance of check payments being returned for insufficient funds. Based on our review of deposits into the City's account, the deposits are composed largely of checks, on average 20 per deposit. Given the inherent challenges in collections for ambulance services, it is critical that payments are processed as quickly as possible and that checks are not allowed to age.

Recommendations:

- To increase the speed with which checks are deposited, the Contractor should obtain and implement the use of a remote check scanner.

26. Finding: The current processes for processing credit card payments for the City results in revenue realization delays for the City.

The City has a web-based system for processing credit card payments. However, the Contractor does not have access to the City's credit card system and, therefore, cannot directly process credit card payments for the City. Instead, the Contractor has to process credit card payments for the City on its own credit card system and transfer this money to the City through the ACH process. Not only does this create confusion for customers because their credit card receipt says the name of the Contractor instead of the City, but it also delays the speed with which the City receives revenue.

Recommendations:

- In collaboration with the City's Finance Department, the Contractor should explore options to use the City's web-based credit card processing system, such as providing the Contractor with a login to directly process credit card payments.

27. Finding: Although the Finance Department has recently developed a process for reconciling revenue collection, the process has not been institutionalized yet.

In 2015, Moss Adams performed a citywide Internal Controls Review and noted weaknesses in the reconciliation of ambulance billing and revenue collection. The audit report included a recommendation for the Fire Department to perform monthly reconciliations between the reports received from the Contractor and the City's own records. Following this recommendation, the City assigned Finance Department staff to help the Fire Department develop an effective and efficient reconciliation process. In April 2016, staff issued an internal memo reporting the results of this project.

Many of the issues and challenges noted within the City's memo were issues we encountered through our own fieldwork for this engagement. For example, the Finance staff noted challenges in the manual process for comparing information from the Fire Department's systems to the Contractor's system reports. Similarly, the Finance staff noted the lack of detail or supporting documentation currently provided by the Contractor.

Based on our review of this memo, the Finance staff has developed a solid process to begin reconciling ambulance services provided, billing, and revenue collection. Overall, we agree with the actions recommended by the Finance Department. As noted within this report, there are additional improvements we recommend to maximize the integrity and accuracy of the reconciliation process. Given the significant lag time involved in medical billing and payment, it is important for the City to develop a process to monitor non-payment from month-to-month.

Recommendations:

- As indicated in the April 2016 memo, the City should begin monitoring the services provided to BLS transports in order to determine whether ALS billing should be performed and revenue collected by the City.
- To improve the accuracy of gross fees charged, the City should work with the Contractor to explore opportunities to revise billing practices for BLS transports not provided ALS services. For example, the City could propose that no City billing is generated for BLS transports without ALS services.
- The Finance Department should consider how to incorporate the following additional monitoring efforts into the proposed monthly processed:
 - Referral to collections agency including timing and success rate
 - Rate of revenue collection by the City versus the Contractor
 - Speed of revenue collection by the City versus the Contractor
- In collaboration with the Finance Department, the Contractor should develop and provide reporting information to the City for assurance of initial billing activities (explanation why no billing) and any account adjustments that occur after initial billing, such as “BLS Service Only.”
- In collaboration with the Finance Department, the Contractor should develop and provide reporting information to the City with reliable patient coverage information.
- In collaboration with the Finance Department, the Contractor should modify its aging reports to provide adequate detail to the City to allow ongoing monitoring of revenue collection.
- The City should monitor medical supplies fees for all transports.

28. Finding: Current billing practices may not maximize the City’s ability to capture revenue for its ambulance services.

With the exception of Medicare, which requires bundled billing, the Contractor currently issues separate invoices for its own ambulance services and the City’s ambulance services. This practice is in accordance with the City’s contract and allows the Contractor to clearly account for its own billing versus the City’s billing. However, the submission of two invoices for a single ambulance call creates some challenges. In particular, instead of creating and submitting one invoice for one ambulance call, which includes both ALS and BLS services, the Contractor has to create two separate invoices for these services. Therefore, instead of using the billing codes for ALS transport, the Contractor must use separate billing codes on each of the invoices for the BLS transport service and the additional ALS services provided. The codes used to bill these additional ALS services are less commonly used and are therefore more likely to result in the denial of payment by insurance companies. Within the ambulance billing industry, there is a shift towards bundling bills for all calls, not just Medicare calls.

Additionally, when two invoices are submitted to an insurance company for payment, the insurance company may approve and submit payment for one invoice and deny the claim for the other. This is more likely to occur when the invoices are not submitted at the same time, which is an issue that was observed in some of the calls within our sample. Similarly, the receipt of two invoices for a single ambulance call can also create confusion for patients who directly receive bills.

The practice of separate billing versus bundled billing for calls creates additional challenges for the Contractor to perform its billing and collection duties, as well as additional work for the City to monitor these bills and associated revenue. To ensure revenue collection, the Contractor has to monitor and follow up on collections for accounts on its own behalf as well as the City's. As discussed earlier, we observed instances where collections activities were not always performed in a coordinated manner, a challenge that is created by separate billing. Moreover, to ensure that billing is being performed appropriately, the City must review both the invoice issued on behalf of the City as well as the Contractor's own invoice. For example, if the City reviews only the invoices billed on its behalf, then it will not know if the billings included on the Contractor's invoices are also appropriate. Similarly, with revenue collection performed separately for each type of invoice, the City must review the records of revenue collection and remit to the City, as well as revenue collected and retained by the Contractor in order to have a full picture of revenue collection activities.

Recommendations:

- When developing its next ambulance billing contract, the City should explore the option of bundled billing. The City should develop methods to monitor billing practices and revenue collection activities in an efficient and effective manner. Where appropriate, the City should consider incorporating monitoring and reporting requirements into the City's next ambulance billing contract.
- The City should work with its current Contractor to discuss the ability to shift to bundled billing.



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October 11, 2016

Sent via e-mail to: Gigi.Decavalles-Hughes@smsgov.net

Gigi Decavalles-Hughes
Director of Finance
City of Santa Monica
1717 Fourth Street, Suite 250
Santa Monica CA 90401

Re: City of Santa Monica Ambulance Contract Billing Audit

Dear Ms. Decavalles-Hughes:

Thank you for providing AmeriCare this opportunity for our firm to submit a response to the audit of the City's Ambulance Contract Billing recently performed by Moss Adams. Scilla Outcault, from Moss Adams worked with our staff and we appreciated the opportunity to participate in this review.

We have reviewed the draft report issued by Moss Adams providing their findings and recommendations and are pleased to offer our comments related to the report for your review and consideration.

1. Record keeping accuracy.

AmeriCare agrees with the findings for this item:

- However, the sequence numbers are not used by AmeriCare anywhere in the billing process. AmeriCare uses incident numbers as our internal tracking due to the fact that the incident numbers come to us on the daily reports.
- AmeriCare will add an audit qualifier of the pick-up address into their QA process. Often the address that we get initially upon dispatch is just a cross street or incomplete address and later the proper address is identified. It may be the case where the City or AmeriCare does not update to the most current address available. AmeriCare's billing system recognizes addresses and gives the choice of adding that to the information in the billing system.
- The City of Santa Monica checks ALS and BLS on their PCR based on actual transport with paramedic on board or not. AmeriCare determines if an ALS intervention was performed, and chooses the correct level of service based on the intervention and/or transport with paramedics. If the patient is transported with paramedics on board, ALS is always billed. If the paramedics did not transport with the patient, then AmeriCare's billers determine if an ALS intervention was performed. The County of Los Angeles, nor Medicare (the guidelines that are followed for billing), do not specify what the criteria for an ALS intervention is. AmeriCare adopted the intervention billing practices as set forth by the County of Orange which is if one of three procedures are performed: a pulse ox (no longer used as a qualifier in late 2016 as it is now a BLS intervention), EKG, or blood glucose. If one of those tests were performed, then ALS may still be billed, but that would be different from what is seen on either PCR.
- BLS only transports are documented in the patient's account; however they are not billable per the contract and County guidelines.

2. Rates not always at proper county rates.

AmeriCare agrees with the finding for this item:

- The LA County rates that were effective on 7/1/15 were not entered into the system until mid-July which resulted in some transports in early July that were billed immediately to be sent to payors at the previous rates. This was an error by AmeriCare. AmeriCare will review billings that were affected by the delay in entering the LA County rates and reimburse any entities due a refund for overpayment.

3. County's new rates will yield less revenue.

AmeriCare disagrees with the findings for this item.

- Pursuant to 5.1.2 of the agreement, the ALSAF fee continues to be calculated as the difference between the ALS and BLS County rates which currently represents \$632. Additionally pursuant to 5.1.3 of the agreement, AmeriCare recommends that the City of Santa Monica continue to bill, on City invoices, an emergency response fee (lights and sirens) of \$126.75 for the fire department's responding apparatus as approved by the City Council. This rate is unaffected and not governed by the County of Los Angeles but set by the City Council as it is not applicable to the contractor's ambulance vehicle.

4. Billing for pulse ox was inconsistent.

AmeriCare agrees with the findings for this item.

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed consistently and appropriately based on County and CMS guidelines.

5. O2 inconsistencies in record keeping

AmeriCare partially disagrees with the findings for this item.

- Santa Monica fire department documents all treatments/interventions that were rendered by the fire department on their PCRs. AmeriCare documents AmeriCare's treatments/interventions on the AmeriCare PCR. If the patient was transported BLS, without Fire on board, and oxygen was administered by AmeriCare, then AmeriCare would have been the one to document the administration of oxygen. It appears there may be an assumption that oxygen was provided by both SMFD personnel and AmeriCare personnel. In some cases, AmeriCare staff may have administered on scene and during transport. AmeriCare billing staff look to documentation on both SMFD PCRs and AmeriCare PCRs to determine appropriateness of specific charges for specific interventions, supplies and services provided by both SMFD and AmeriCare personnel.

6. O2 not always charges when performed.

AmeriCare agrees with the findings for this item.

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed consistently and appropriately based on County and CMS guidelines.

7. O2 charges not always consistent with county rates.

AmeriCare agrees with the findings for this item.

- The LA County rates that were effective on 7/1/15 were not entered into the system until mid-July which resulted in some transports in early July that were billed immediately to be sent to payors at the

previous rates. This was an error by AmeriCare. AmeriCare will review billings that were affected by the delay in entering the LA County rates and reimburse any entities due a refund for overpayment.

8. Inconsistencies in records related to additional treatments.

AmeriCare partially agrees with the findings of this item:

- The employees of AmeriCare and Santa Monica Fire only document treatments/interventions that each entity actually performed.

9. Lost potential revenue due to not billing additional treatments.

AmeriCare partially agrees with the findings of this item:

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed consistently and appropriately based on County and CMS guidelines.

10. Not all night service fees were correct.

AmeriCare agrees with the findings for this item.

- The LA County rates that were effective on 7/1/15 were not entered into the system until mid-July which resulted in some transports in early July that were billed immediately to be sent to payors at the previous rates. This was an error by AmeriCare. AmeriCare will review billings that were affected by the delay in entering the LA County rates and reimburse any entities due a refund for overpayment.

11. Billing of night calls are inconsistent.

AmeriCare agrees with the findings for this item.

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed consistently and appropriately based on County and CMS guidelines.

12. Code 3 charges not consistent with County's intentions.

AmeriCare disagrees with the findings for this item.

- Pursuant to 5.1 in the contract, AmeriCare bills an emergency response fee for the City's response as a separate vehicle apparatus response for each patient transported. This fee is not governed by the County of Los Angeles and is set by the City Council. AmeriCare also bills for its emergency response as an ambulance response pursuant to the county code and established fees for ambulance responses and/or transports.

13. Documentation regarding transportation not complete.

AmeriCare partially disagrees with the findings for this item.

- AmeriCare bills for the code 3 charge of lights and sirens on the AmeriCare bills based on the EMTs documentation on the PCR. However, AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls

as well as the SMFD portion are billed consistently and appropriately based on County and CMS guidelines.

14. Calls charges mileage in excess of County established rates.

AmeriCare agrees with the findings for this item.

- The LA County rates that were effective on 7/1/15 were not entered into the system until mid-July which resulted in some transports in early July that were billed immediately to be sent to payors at the previous rates. This was an error by AmeriCare. AmeriCare will review billings that were affected by the delay in entering the LA County rates and reimburse any entities due a refund for overpayment.

15. Inconsistencies in miles recorded and billed.

AmeriCare agrees with the findings for this item.

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed consistently and appropriately based on County and CMS guidelines.

16. Mileage record keeping and billing may have compounding impact.

AmeriCare agrees with the findings for this item.

- The LA County rates that were effective on 7/1/15 were not entered into the system until mid-July which resulted in some transports in early July that were billed immediately to be sent to payors at the previous rates. This was an error by AmeriCare. AmeriCare will review billings that were affected by the delay in entering the LA County rates and reimburse any entities due a refund for overpayment. All County rates are entered into the billing system prior to any new billings for the covered time periods, therefore no compounding impact of the mileage rates.

17. Lack of clarity about billing practices creates uncertainty.

AmeriCare agrees with the findings for this item.

18. Inconsistencies in the timeliness of billing.

AmeriCare disagrees with the findings for this item.

- AmeriCare bills both the AmeriCare portion of the transport as well as the SMFD portion of the transport simultaneously. AmeriCare is able to submit claims for AmeriCare transports electronically which speeds up the process on submittal and collections. The City claims are sent on paper claims and have a slightly longer turnaround based on the mode of delivery. There are several other factors that create discrepancies in the billing processes between the two entities. AmeriCare has a clearly defined hardship policy in which AmeriCare can accept payments, discounts, etc on the AmeriCare portion of the billing. The City of Santa Monica has not adopted such a policy, therefore calls are sent to collections or may sit unpaid without the ability to accept payments or discount based on hardship needs. The ALSAF fee is not a recognized charge by the majority of insurances, however the ambulance transport is. This often results in prompt payment of the ambulance transport and can result in a denial as a non-covered service for the ALSAF portion.

19. Accounting practices could compromise the accuracy City's records.

AmeriCare agrees with the findings for this item.

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed and reimbursed consistently and appropriately based on County and CMS guidelines. AmeriCare will supply the City of Santa Monica any necessary records to help in the reconciliation process for fees owed to the city.

20. Current practices do not assure revenue distributed properly.

AmeriCare agrees with the findings for this item.

- AmeriCare will add in additional QA to identify and correct inconsistencies in the billing process. Training and written documentation will be issued in order to ensure to the best of our ability that the billing for both the AmeriCare portion of Santa Monica 911 calls as well as the Santa Monica portion are billed and reimbursed consistently and appropriately based on County and CMS guidelines. AmeriCare will supply the City of Santa Monica any necessary records to help in the reconciliation process for fees owed to the city.

21. Referral to collections are inconsistent.

AmeriCare partially agrees with the findings for this item.

- AmeriCare sends accounts to collections monthly, but can increase the submittals at the City's request.

22. Limited reporting is provided to the City about collections activity.

AmeriCare agrees with the findings for this item.

- AmeriCare will work with the outside collection agency used for both portions of the Santa Monica fire billing in order to obtain the necessary information to reconcile the revenue as well as ensure the proper actions taken on all accounts.

23. Payments to the City delayed longer than to the contractor.

AmeriCare partially disagrees with the findings for this item.

- AmeriCare bills both the AmeriCare portion of the transport as well as the Santa Monica portion of the transport simultaneously. AmeriCare is able to submit claims for AmeriCare transports electronically which speeds up the process on submittal and collections. The City claims are sent on paper claims and have a slightly longer turnaround based on the mode of delivery. There are several other factors that create discrepancies in the billing processes between the two entities.
- AmeriCare has a clearly defined hardship policy in which AmeriCare can accept payments, discounts, etc. on the AmeriCare portion of the billing. The City of Santa Monica has not adopted such a policy, therefore calls are sent to collections or may sit unpaid without the ability to accept payments or discount based on hardship needs. The ALSAF fee is not a recognized charge by the majority of insurances, however the ambulance transport is. This often results in prompt payment of the ambulance transport and can result in a denial as a non-covered service for the ALSAF portion. Upon an appeal, many of these denied services are paid, however the timeframe that they are paid is greater than the AmeriCare portion that is readily reimbursed.

24. Lag time between deposit preparation and actual deposit.

AmeriCare agrees with the findings for this item.

- AmeriCare is working with the City to obtain a check scanner in order to make daily deposits into the Santa Monica Fire account. At this time, deposits are made weekly on behalf of Santa Monica.

25. Check payment process creates delays

AmeriCare agrees with the findings for this item.

- AmeriCare is working with the City to obtain a check scanner in order to make daily deposits into the Santa Monica Fire account. At this time, deposits are made weekly on behalf of Santa Monica.

26. Credit card payment process creates delays.

AmeriCare agrees with the findings for this item.

- AmeriCare has requested the ability to use the City's credit card system to process credit card payments which would ensure quick funding into the Santa Monica account.

27. The Finance Department has developed a process for reconciling revenue.

AmeriCare agrees with the findings for this item.

- AmeriCare is happy to help with this process in any way possible.

28. Current practices may not maximize revenue realization.

AmeriCare partially agrees with the findings for this item.

- AmeriCare agrees that exploring bundled billing for all SMFD transports would streamline the process and ensure more timely reimbursement based on the fact that emergency ambulance transportation is a readily covered service by insurers for most of the services provided by SMFD. However, some line items may require the continuance of separate invoice billing on SMFD invoices.

In closing, please know AmeriCare values its contractual relationship with the City of Santa Monica and is committed to working with City staff to implement the recommended operational enhancements set forth in the auditor's report as directed by the City.

If we can assist with any questions or additional information, either Stephanie Carlson or I am available as needed.

Sincerely,



Mike Summers
President/CEO

Cc: Jeff Furrows (via e-mail: jeff.furrows@smgov.net)
Bill Walker (via e-mail: bill.walker@smgov.net)
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