



APR 17 2006

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Report Number A-01-04-00502

Mr. V. Matthew Marchese
Regional Director, Ethics and Compliance
American Medical Response of Massachusetts, Inc.
4 Tech Circle
Natick, Massachusetts 01760

Dear Mr. Marchese:

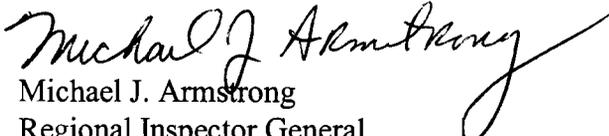
Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Ambulance Services Provided by American Medical Response of Massachusetts, Inc." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent that the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-01-04-00502 in all correspondence related to this report.

Sincerely,


Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Page 2 – Mr. V. Matthew Marchese

Direct Reply to HHS Action Official:

Charlotte S. Yeh, M.D.

Regional Administrator

Centers for Medicare & Medicaid Services – Region I

Department of Health and Human Services

Room 2325, J.F.K. Federal Building

Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF AMBULANCE
SERVICES PROVIDED BY
AMERICAN MEDICAL RESPONSE
OF MASSACHUSETTS, INC.**



Daniel R. Levinson
Inspector General

April 2006
A-01-04-00502

Office of Inspector General

<http://oig.hhs.gov>

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Medicare Part B covers a range of medical services, including medically necessary ambulance services. Section 1861(s)(7) of the Social Security Act provides for coverage of ambulance services where the use of other means of transportation is contraindicated by the individual's condition. Federal regulations (42 CFR § 410.40(d)) state that, for an ambulance transport to be considered medically necessary, the beneficiary's medical condition must require both the ambulance transportation itself and the level of service provided. Section 5246.4 of the "Medicare Carriers Manual" states that Medicare payments must be based on the lowest level of the service that would have met the patient's medical need. Further, section 2120.3 of this manual specifies that Medicare covers transportation only to the nearest hospital with the appropriate facilities for treating the illness or injury involved.

On June 3, 2002, American Medical Response of Massachusetts, Inc., (AMR) a subsidiary of American Medical Response, Inc., entered into a 3-year corporate integrity agreement with the Office of Inspector General. The agreement requires AMR to annually review its billing and coding practices for Federal health care programs.

Medicare paid AMR \$12,978,989 for 44,707 ambulance transports provided to 22,569 Massachusetts Medicare beneficiaries from July 1, 2002, through December 31, 2002. We contracted with a Program Safeguard Contractor (PSC) to review the medical records, patient care reports, and physician certifications of a random sample of 100 beneficiaries who received ambulance transports and services from AMR during this period.

OBJECTIVE

Our objective was to determine whether Medicare payments to AMR were for ambulance transports and services that met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Ambulance transports and other services that AMR provided to 57 of the 100 sampled beneficiaries met applicable requirements. However, 58 ambulance transports and other services provided to the remaining 43 sampled beneficiaries resulted in unallowable Medicare payments totaling \$11,690 (see Appendix B). Specifically:

- 37 ambulance transports valued at \$8,907 were not medically necessary, and
- 21 ambulance transports included services valued at \$2,783 that did not meet Medicare reimbursement requirements.

From the results of the sample review, we estimated that at least \$1,959,801 was improperly paid to AMR during this period for ambulance transports and services. We believe that AMR inappropriately billed for these transports and services because it did not have effective billing

controls to ensure that the ambulance services billed to Medicare met Medicare reimbursement requirements.

In November 2002, AMR self-disclosed that its compliance team had found questionable billing practices that had resulted in Medicare overpayments totaling \$275,288 during June, July, and August 2002. AMR refunded that amount to its carrier. Because the months of July and August overlapped with our review period, we have reduced our recommended disallowance by two-thirds of the amount self-disclosed, or \$181,690.

RECOMMENDATIONS

We recommend that AMR:

- develop controls for determining whether its claims submissions meet Medicare's reimbursement requirements and establish practices to ensure that these types of errors do not occur in the future, and
- work with the Massachusetts carrier to reimburse the Medicare program for the net estimated overpayment of \$1,778,111 (\$1,959,801 – \$181,690).

AMERICAN MEDICAL RESPONSE OF MASSACHUSETTS' COMMENTS

In its response to our draft report, AMR agreed with \$2,357 of the \$11,690 identified as overpayments in our sample. However, as a result of its own medical reviews, AMR believes that the remaining \$9,333 met Medicare reimbursement requirements.

AMR stated that it had adequate controls in place as a result of its compliance program and its compliance with the terms of the AMR of Massachusetts Corporate Integrity Agreement. In addition, AMR noted that it had self-disclosed to us “the medical necessity issues for the same time period that is the subject of this determination review” and that it has since implemented appropriate measures to ensure that it complies with Medicare's medical necessity requirements.

AMR's comments are included as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We will refer those findings with which AMR disagrees to the CMS action official responsible for resolving all disputed audit findings. We will provide CMS and the Medicare carrier with AMR's response, including the numerous attachments, for their review and consideration in the audit resolution process.

We acknowledge AMR's efforts to establish a compliance program to ensure that it complies with Medicare's medical necessity requirements. We also recognize that AMR refunded its carrier \$275,288 as a result of self-disclosed questionable billing practices during a 3-month period covering June, July, and August 2002. We have adjusted our recommendation accordingly.

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INTRODUCTION

BACKGROUND

The Medicare Ambulance Benefit

Medicare Part B (medical insurance) helps pay for physicians' services, outpatient hospital care, durable medical equipment, and some other medical services, including ambulance services. The Centers for Medicare & Medicaid Services (CMS) contracts with carriers, usually large insurance companies, to assist it in administering the Medicare Part B health benefits program.

Limitations for Coverage

Section 1861(s)(7) of the Social Security Act provides for coverage of ambulance services where the use of other means of transportation is contraindicated by the individual's condition. Federal regulations (42 CFR § 410.40(d)) state that, for ambulance transport to be considered medically necessary, the beneficiary's medical condition must require both the ambulance transportation itself and the level of service provided. Section 5246.4 of the "Medicare Carriers Manual" states that Medicare payments must be based on the lowest level of service that would have met the patient's medical need. Further, section 2120.3 of this manual specifies that Medicare covers transportation only to the nearest hospital with the appropriate facilities for treating the illness or injury involved.

Provider's Responsibility for Documenting Medical Need

Medicare requires service providers to document the medical need for transportation by ambulance. Local medical review policy designates the patient care report as the mechanism that service providers use to document the patient's condition and establish the medical necessity for ambulance services. Medical necessity must be documented in the patient care report and be consistent with other documentation. For nonemergency services, Medicare requires a physician certification statement, a written order that certifies the need for ambulance transportation. The patient care report and the physician certification statement, if required, should be legible, should include evidence to support medical necessity, and should be available to the carrier upon request.

American Medical Response of Massachusetts, Inc.

On June 3, 2002, American Medical Response of Massachusetts, Inc. (AMR), a subsidiary of American Medical Response, Inc., entered into a 3-year corporate integrity agreement with the Office of Inspector General. The agreement requires AMR to annually review its billing and coding practices for Federal health care programs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments to AMR were for ambulance transports and services that met Medicare reimbursement requirements.

Scope

Our review covered service dates from July 1 through December 31, 2002. During this period, Medicare paid AMR \$12,978,989 for 44,707 ambulance transports provided to 22,569 Massachusetts Medicare beneficiaries.

We did not review the overall internal control structure of AMR or the Medicare program. We did not test the internal controls because we achieved the objective of our review through substantive testing.

We conducted our fieldwork at CMS Audits in Baltimore, Maryland, from November 2003 through November 2004. Our review included visits to AMR's office in Natick, Massachusetts, and telephone contact with National Heritage Insurance Company (NHIC), the principal carrier for AMR.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and Medicare guidelines and the carrier's local medical review policies applicable to billing ambulance services provided to Medicare beneficiaries;
- extracted from the Massachusetts Medicare Part B ambulance file all ambulance services reimbursed to AMR for the period of our audit;
- selected a random sample of 100 beneficiaries and all of the ambulance services provided to them during the period of our audit (see Appendix A for our sampling methodology);
- obtained supporting dispatch, medical, billing, and payment records from AMR for each ambulance transport provided to each sampled beneficiary;
- obtained patient medical records for the time of each ambulance transport from institutional providers (hospitals, nursing homes, and other medical facilities) at the point of ambulance pick-up (origin) and point of ambulance drop-off (destination);
- obtained fee schedules, AMR's reasonable charge profiles, and carrier instructions to recalculate payments for our sample of 100 beneficiaries;

- contracted with a Program Safeguard Contractor (PSC) to review all documentation obtained to (i) determine whether the ambulance services that AMR provided met Medicare reimbursement requirements and (ii) reprice those services that the PSC's medical reviewers (a nurse and a physician) determined to be unallowable; and
- used an unrestricted variable appraisal program to determine the estimated overpayments to AMR.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Ambulance transports and other services that AMR provided to 57 of the 100 sampled beneficiaries met applicable requirements. However, 58 ambulance transports and other services provided to the remaining 43 sampled beneficiaries resulted in unallowable Medicare payments totaling \$11,690 (see Appendix B). Specifically:

- 37 ambulance transports valued at \$8,907 were not medically necessary, and
- 21 ambulance transports included services valued at \$2,783 that did not meet Medicare reimbursement requirements.

From the results of the sample review, we estimated that at least \$1,959,801 was improperly paid to AMR during this period for ambulance transports and services. We believe that AMR inappropriately billed for these transports and services because it did not have effective billing controls to ensure that the ambulance services billed to Medicare met Medicare reimbursement requirements.

MEDICAL NECESSITY FOR AMBULANCE TRANSPORTS

Federal Requirements

Section 1861(s)(7) of the Social Security Act provides for coverage of ambulance services where the use of other means of transportation is contraindicated by the individual's condition. Federal regulations (42 CFR § 410.40) state that, for ambulance transport to be considered medically necessary, the beneficiary's medical condition must require both the ambulance transportation itself and the level of service provided. NHIC's local medical review policy states that the ambulance service is a covered service when the patient's condition at the time of transport is such that the use of any other method of transportation would endanger the patient's health. The policy also states that Medicare payment for ambulance services is inappropriate for patients who are able to safely travel by other means of transportation and who do not require medical monitoring, medical supervision, or medical assistance.

Pursuant to Medicare requirements, medical necessity must be documented in the patient care report and be consistent with other documentation. For nonemergency services, Medicare requires a physician certification statement, a written order that certifies the need for ambulance

transportation. The patient care report and a physician certification statement, if required, should be legible, should include evidence to support medical necessity, and should be available to the carrier upon request.

Ambulance Transports That Were Not Medically Necessary

The PSC’s medical reviewers determined that 37 ambulance transports totaling \$8,907 were not medically necessary because alternative transportation would not have endangered the patient’s health (Table 1).

Table 1: Ambulance Transports That Were Not Medically Necessary

Reason	Number of Unallowable Transports	Amount Unallowable
Patient Able To Safely Travel By Wheelchair	30	\$7,049
Patient Not in Need of Medical Monitoring	4	1,189
Patient Not Emergently Ill	1	219
Patient Not in Need of Isolation Procedures	1	255
No Documented Rationale to Justify Ambulance Transport	1	195
Total	37	\$8,907

From their review of AMR’s ambulance patient care reports and the patient’s third-party medical records, the reviewers identified the following instances when ambulance transport was not medically necessary:

Patient Able to Safely Travel by Wheelchair

For 30 of the 37 medically unnecessary ambulance transports, AMR’s patient care reports presented the patients as bed-confined, nonambulatory, or unable to sit safely in a wheelchair. The medical reviewers determined that, at the time of transport, all of these patients were ambulatory, ambulatory with assistance, or able to sit in a wheelchair. As a result, the \$7,049 that Medicare paid for these transports was unallowable.

Patient Not in Need of Medical Monitoring, Supervision, or Assistance

For 4 of the 37 medically unnecessary ambulance transports, AMR’s patient care reports indicated that the patients required medical monitoring, supervision, or assistance. The medical reviewers found no evidence in third-party records that the clinical condition of these patients at the time of transport required medically trained personnel to provide such monitoring, supervision, or assistance. As a result, the \$1,189 paid for these transports was unallowable.

Patient Not Emergently Ill

For 1 of the 37 medically unnecessary ambulance transports, AMR's patient care reports indicated that emergency ambulance transport was not justified because that the patient was not emergently ill. This patient had a cough with phlegm that had persisted for 4 days. As a result, the \$219 paid for this transport was unallowable.

Patient Not in Need of Isolation Procedures

For 1 of the 37 medically unnecessary ambulance transports, AMR's patient care report indicated that the patient's condition required isolation procedures. The medical reviewers determined that this patient did not have specific conditions that would warrant isolation precautions either to protect the patient or to protect the public from exposure to communicable diseases. As a result, the \$255 paid for this transport was unallowable.

No Documented Rationale to Justify Ambulance Transport

For 1 of the 37 medically unnecessary ambulance transports, neither AMR records nor third-party medical records documented a rationale to justify Medicare reimbursement for ambulance transport. As a result, the \$195 paid for this transport was unallowable.

REIMBURSEMENT REQUIREMENTS FOR AMBULANCE SERVICES

Federal Requirements

The "Medicare Carriers Manual," section 5246.4, requires that Medicare payments be limited to the lowest level of service necessary to meet the patient's medical need. This section provides that, when a less expensive level of service would have met the patient's medical need, or was actually furnished, reimbursement must be based on the cost of the less expensive level of service. In addition, section 2120.3 of the "Medicare Carriers Manual" specifies that Medicare covers transportation only to the nearest hospital with the appropriate facilities for treating the patient's illness or injury.

Ambulance Services That Did Not Meet Medicare Reimbursement Requirements

The PSC's medical reviewers identified 21 ambulance transports that included ambulance services totaling \$2,783 that did not meet Medicare reimbursement requirements (Table 2).

Table 2: Ambulance Services That Did Not Meet Medicare Reimbursement Requirements

Reason	Number of Unallowable Transports	Amount Unallowable
Level of Service Billed Not Provided	12	\$727
Level of Service Provided Not Needed	4	381
Hospital Transfer Not Covered	4	1,478
Transport Not to the Nearest Facility	1	197
Total	21	\$2,783

From their review of AMR’s ambulance patient care reports and the patient’s third-party medical records, the reviewers determined the following:

Level of Service Billed Not Provided

For 12 ambulance transports, AMR’s patient care reports indicated that a less expensive level of care was provided than was billed. For 10 of these transports, the patients received the basic life support level of care and not the more expensive advanced life support as indicated on the claims. For two transports, the patients received the advanced life support level of care and not the more expensive specialty care transport as indicated on the claims. For one of these transports, no specialty care personnel qualified to provide the level of service billed was even on board. The difference between the level of service billed and the level of service provided was \$727.

Level of Service Provided Not Needed

For four ambulance transports, AMR’s ambulance crews administered medically unnecessary ancillary services that raised the level of service billed to a more expensive advanced life support category. The ancillary services included medically unnecessary cardiac monitoring, intravenous treatments, and application of oxygen. In each case, the medical reviewers determined that basic life support, a less expensive level of ambulance transport, would have met these patients’ medical needs. The difference between the level of service provided and the level of service that was reasonable and necessary was \$381.

Hospital Transfer Not Covered

For four ambulance transports, AMR billed Medicare for hospital transfers requested by patients even though the hospitals of origin had appropriate facilities for treating the illness or injury involved. As a result, the entire \$1,478 paid for these transports was unallowable.

Transport Not to the Nearest Facility

For one ambulance transport, the destination hospital requested by the patient was not the nearest hospital with appropriate facilities to treat the patient, as Medicare requires. The reviewers

disallowed \$197 for this transport to account for the cost associated with the difference in mileage from the nearest appropriate facility to the facility selected by the patient.

ESTIMATE OF UNALLOWABLE PAYMENTS

Based on the results of the PSC's sample review, we estimated that at least \$1,959,801 was improperly paid to AMR for ambulance transports and services that did not meet Medicare reimbursement requirements.

LACK OF EFFECTIVE ADMINISTRATIVE CONTROLS

AMR inappropriately billed for these services because it did not have effective controls to ensure that the ambulance transports and services billed met Medicare reimbursement requirements.

SELF-DISCLOSURE BY AMERICAN MEDICAL RESPONSE

In November 2002, AMR self-disclosed that its compliance team had found questionable billing practices that had resulted in Medicare overpayments totaling \$275,288 during June, July, and August 2002. AMR refunded that amount to its carrier. Because the months of July and August overlapped with our review period, we have reduced our recommended disallowance by two-thirds of the amount self-disclosed, or \$181,690.

RECOMMENDATIONS

We recommend that AMR:

- develop controls for determining whether its claims submissions meet Medicare's reimbursement requirements and establish practices to ensure that these types of errors do not occur in the future, and
- work with the Massachusetts carrier to reimburse the Medicare program for the net estimated overpayment of \$1,778,111 (\$1,959,801 – \$181,690).

AMERICAN MEDICAL RESPONSE OF MASSACHUSETTS' COMMENTS

In its response to our draft report, AMR agreed with \$2,357 of the \$11,690 identified as overpayments in our sample. However, as a result of its own medical reviews, AMR believes that the remaining \$9,333 met Medicare reimbursement requirements.

AMR stated that it had adequate controls in place as a result of its compliance program and its compliance with the terms of the AMR of Massachusetts Corporate Integrity Agreement. In addition, AMR noted that it had self-disclosed to us "the medical necessity issues for the same time period that is the subject of this determination review" and that it has since implemented appropriate measures to ensure that it complies with Medicare's medical necessity requirements.

AMR's comments are included as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We will refer those findings with which AMR disagrees to the CMS action official responsible for resolving all disputed audit findings. We will provide CMS and the Medicare carrier with AMR's response, including the numerous attachments, for their review and consideration in the audit resolution process.

We acknowledge AMR's efforts to establish a compliance program to ensure that it complies with Medicare's medical necessity requirements. We also recognize that AMR refunded its carrier \$275,288 as a result of self-disclosed questionable billing practices during a 3-month period covering June, July, and August 2002. We have adjusted our recommendation accordingly.

APPENDIXES

SAMPLING AND METHODOLOGY

OBJECTIVE:

The sample objective was to estimate overpayments for ambulance transports/services provided by American Medical Response of Massachusetts, Inc., (AMR) that did not meet Medicare medical necessity and reimbursement requirements. To achieve our objective, we selected an unrestricted random sample of 100 Medicare beneficiaries and all ambulance services that AMR provided to them from July 1 through December 31, 2002.

POPULATION:

The universe consisted of 22,569 beneficiaries who received 44,707 ambulance transports during the period July 1 through December 31, 2002. These transports included 109,011 line items of services totaling \$12,978,989 extracted from the Massachusetts Medicare Part B file for the period.

SAMPLING UNIT:

The sampling unit was a beneficiary and all of the ambulance services that he/she received from AMR for the period July 1 through December 31, 2002.

SAMPLING DESIGN:

A simple random sample of Massachusetts' beneficiaries furnished ambulance services by AMR from July 1 through December 31, 2002.

SAMPLE SIZE:

All of the ambulance services that AMR furnished to 100 Medicare beneficiaries from July 1 through December 31, 2002.

ESTIMATION METHODOLOGY:

Using a variable appraisal program, we estimated the overpayments for unallowable ambulance services from the sample to the universe.

APPENDIX B

STATISTICAL SAMPLE INFORMATION

<u>POPULATION</u>	<u>SAMPLE</u>	<u>ERRORS</u>
Items: 22,569 Beneficiaries Dollars: \$12,978,989	Items: 100 Beneficiaries Dollars: \$54,598	Items: 43 Beneficiaries Dollars: \$11,690

The sample projection was obtained using the RAT-STATS unrestricted variable appraisal program. We reported the lower limit of the 90 percent confidence interval. Details of our projection appear below:

Projection of Sample Results 90 Percent Confidence Interval

Point Estimate:	\$2,638,235
Lower Confidence Limit	\$1,959,801
Upper Confidence Limit:	\$3,316,669
Sample Precision:	+/-25.72%

Based on our statistical sample, we are 95 percent confident that the amount overpaid was at least \$1,959,801.



AMERICAN MEDICAL RESPONSE

August 24, 2005

Mr. David Duff
Office of Inspector General
Office of Audit Services
Region 1
JFK Federal Building
Boston, MA 02203

Re: Report # A-01-04-00502

Mr. Duff:

In response to the OIG Draft Determination Letter dated July 10, 2005 please find two spreadsheets (with two tabs on each spreadsheet) and individual review documentation to serve as AMR's response to the preliminary findings. After conducting a review of the patient files in question, AMR has come to the following conclusion:

Level of service (regulatory issues spreadsheet):

AMR agrees with the determination report – seven (7) times for \$889.03.

AMR disagrees with the determination report – twenty-three (23) times for \$1,893.80.

Medical Necessity (Medical Necessity spreadsheet):

AMR agrees with the determination report – eleven (11) times for \$1,468.29.

AMR disagrees with the determination report – sixty-six (66) times for \$7,438.52.

AMR believes it has adequate controls in place as a result of our Compliance program and our compliance under the terms of the AMR of Massachusetts Corporate Integrity Agreement. In addition, we have previously self disclosed to the OIG the medical necessity issues for the same time period that is the subject of this determination review. AMR has since implemented appropriate measures to ensure compliance with the medical necessity requirements.

As such, we are making a formal request for the opportunity of an in-person meeting with you to discuss all aspects of the review including the validity of the facts and reasonableness of the recommendations as outlined in the July 10, 2005 letter. I will contact you next week to schedule a time to meet. Until then, please contact me at (303) 495-1261 if you have additional questions or comments.

Best regards,

Matt Marchese
Chief Compliance Officer
American Medical Response

Enc.