UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

UNITED STATES OF AMERICA
ex rel. Shawn Pelletier,

Plaintiff,

v. Case No. 3:11-cv-00587-TJC-MCR

Liberty Ambulance Service, Inc.

Defendant.
_________________________________/

UNITED STATES' COMPLAINT IN INTERVENTION

Having been defrauded by millions of dollars in medically unnecessary ambulance transports and transports obtained by virtue of illegal kickbacks by Defendant Liberty Ambulance Service, Inc. ("Liberty Ambulance"), the United States of America ("United States" or "Government") brings this action pursuant to the False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq,* and the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b). As explained below, the Defendant had a practice and policy of submitting false claims to the government for ambulance transports that were either medically unnecessary or were upcoded to a higher level of reimbursement. Moreover, Liberty Ambulance routinely submitted false statements in the form of ambulance run reports to support these claims. These statements were false because they did not accurately reflect the patient's condition. To be sure, these statements were not mere negligence. Instead, Liberty Ambulance coached its employees to only include key words that would justify reimbursement and to omit words that would make reimbursement less likely.

Further, as explained below, Liberty Ambulance induced considerable business through the offering of illegal kickbacks. This remuneration – discounts offered to private payors, but not the federal government – caused the federal government to pay out millions in claims that were tainted by kickbacks. Because the Defendant caused the submission of false claims in violation of the FCA and the Anti-Kickback Statute and because the Defendant was unjustly enriched, the United States brings forth the current suit.

I. NATURE OF ACTION

1. The United States brings this action to recover treble damages and civil penalties under the FCA and the Anti-Kickback Statute to recover damages and other monetary relief under the common law or equitable theories of unjust enrichment and payment by mistake.

2. The United States bases its claims on Defendant submitting and causing to be submitted false or fraudulent claims to federal health care programs in violation of 31 U.S.C. §§ 3729(a)(1), 3729(a)(1)(A), and 3729(a)(1)(B) and in violation of 42 U.S.C. § 1320a-7b(b).

3. Within the time frames detailed below (namely from approximately September 1, 2005 until present), Defendant knowingly submitted, or caused to be submitted, thousands of false claims to Medicare and TRICARE for reimbursement which resulted in millions of dollars of reimbursement that would not have been paid but for Defendant's misconduct.

II. JURISDICTION AND VENUE

4. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §§ 1331, 1345.

5. This Court may exercise personal jurisdiction over Defendant pursuant to 31 U.S.C. § 3732(a) and because Defendant resides and transacts business in the Middle District of Florida.

6. Venue is proper in the Middle District of Florida under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) and (c) because Defendant resides and transacts business in this District.

III. PARTIES

7. The United States brings this action on behalf of: 1) the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS"), which administers the Medicare program; 2) the Department of Defense's TRICARE Management Activity ("TRICARE") and 3) the Office of Personnel Management's Federal Employee Health Benefit Program ("FEHBP").

8. Shawn Pelletier ("Relator") is a resident of Jacksonville, Florida. He was employed by Liberty Ambulance as an Emergency Medical Technician ("EMT") from approximately 2006 until 2008. In September 2011, Relator filed an action alleging violations of the FCA on behalf of himself and the United States pursuant to the *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)(1).

9. Defendant Liberty Ambulance Service, Inc. is a Jacksonville-based company that provides emergency and non-emergency medical transport service. It has been a Florida corporation since February 20, 1981. Since 2009, Liberty Ambulance has submitted more than 136,000 claims to the Medicare program alone and has received almost $15 million in reimbursement.

IV. MEDICAL BACKGROUDND REGARDING AMBULANCE TRANSPORTS

10. Medicare pays for emergency and nonemergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation, such as taxi, private car, wheelchair van, or other type of vehicle, is contraindicated (i.e., would endanger the beneficiary's medical condition). Medicare does not cover means of transport other than ambulance.

11. An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to: (a) Place the patient's health in serious jeopardy, (b) Result in serious impairment of bodily functions, or (c) Result in serious dysfunction of any bodily organ.

12. Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to: severe pain or hemorrhage; unconsciousness or shock; injuries requiring immobilization of the patient; patient needs to be restrained to keep from hurting himself or others; patient requires oxygen or other skilled medical treatment during transportation; and suspicion that the patient is experiencing a stroke or myocardial infarction.

13. Nonemergency transportation by ambulance is appropriate when a patient is bed-confined AND his/her condition is such that other methods of transportation are contraindicated; OR if the patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (e.g., the patient is combative and a danger to himself or others).

14. While bed-confinement is an important factor to determine the appropriateness of nonemergency ambulance transports, bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare's ambulance benefits.

15. To be considered bed-confined, the patient must meet all three of the following criteria: (a) Be unable to get up from bed without assistance, (b) Be unable to ambulate, and (c) Be unable to sit in a chair or wheelchair.

16. While program requirements determine whether Medicare will pay for an ambulance transport, the level of service required by the patient's condition determines the amount paid for a transport. As discussed below, Medicare only pays for the level of service deemed medically necessary.

17. Medicare pays for different levels of ambulance services. These service levels include Basic Life Support (BLS), Advanced Life Support (ALS), and Specialty Care Transport (SCT), among others.

18. These levels of service are differentiated by the qualifications and training of the crew and the equipment and supplies available on a vehicle that allows for treatment of more complex medical conditions.

19. For example, to provide an ALS-level service, an ambulance must be equipped with specialized equipment, such as defibrillators and pulmonary/cardiac monitors and certain medications. Another distinction between ALS and BLS is the personnel that staff the ambulance.

20. Providers of ambulance services submit claims for payment to carriers or fiscal intermediaries. Independent ambulance suppliers bill carriers on the uniform Medicare billing form, the Centers for Medicare & Medicaid Services (CMS) 1500.

21. Ambulance suppliers are not required to submit additional documentation for billing purposes. However, Medicare rules require ambulance suppliers to retain appropriate documentation that contains information about the personnel involved in the transport and the patient's condition, and to obtain a PCS for nonemergency transports. These documents must be kept on file and made available for contractor review if requested.

V. THE LAW

A. The False Claims Act

22. The False Claims Act provides for the award of treble damages and civil penalties for, *inter alia*, knowingly causing the submission of false or fraudulent claims for payment to the United States Government. 31 U.S.C. § 3729(a)(1).

23. The FCA provides, in pertinent part, that:

> (a)(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (a)(1)(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (a)(1)(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; . . ;
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> * * *
>
> is liable to the United States Government for a civil penalty of not less than $[5,500] and not more than $[11,000], . . . plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .

31 U.S.C. § 3729.[1] For purposes of the False Claims Act,

> the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information,
>
> and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(b) (1986).

VI. THE MEDICARE PROGRAM

24. In 1965, Congress enacted Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., known as the Medicare program. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A. Medicare is administered by CMS, which is part of HHS. At all times relevant to this complaint, CMS contracted with private contractors referred to as "fiscal intermediaries," "carriers," and "Medicare Administrative Contractors," to act as agents in reviewing and paying claims submitted by healthcare providers. *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.3, 421.100.

25. To participate in the Medicare program, health care providers enter into agreements with HHS-CMS in which the provider agrees to conform to all applicable statutory and regulatory requirements for reimbursement from Medicare, including the provisions of Section 1862 of the Social Security Act and Title 42 of the Code of Federal Regulations. Among the legal obligations of participating providers is the requirement not

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[1] The False Claims Act was amended pursuant to Public Law 111-21, the Fraud Enforcement and Recovery Act of 2009 ("FERA"), enacted May 20, 2009. Given the nature of the claims at issue, Section 3279(a)(1) of the statute prior to FERA, and as amended in 1986, and Section 3729(a)(1)(A) are both applicable here. Section 3729(a)(1) applies to conduct before FERA was enacted, and section 3729(a)(1)(A) applies to conduct after FERA was enacted. Section 3729(a)(1)(B) was formerly Section 3729(a)(2), and is applicable to all claims in this case by virtue of Section 4(f) of FERA.

to make false statements or misrepresentations of material facts concerning payment requests. *See* 42 C.F.R. §§ 1320a-7b(a)(1)-(2), 413.24(f)(4)(iv), 1001.101(a)(1); 42 U.S.C. § 1320a-7b(a)(1)-(2).

A. Submitting Claims for Reimbursement

26. For outpatient treatment, all Medicare reimbursement is subject to Part B. *See* 42 U.S.C. §§ 1395j-1395w-4. Ambulance transports are included in the definition of "medical and other health services" for purposes of Medicare Part B coverage. *See* 42 C.F.R. § 410.10(e).

27. To obtain Medicare reimbursement pursuant to Part B, providers submit claims using forms known as CMS 1500s. Among the information the provider includes on a CMS 1500 form are certain five-digit codes, known as Current Procedural Terminology, or CPT codes, that identify the services rendered and for which reimbursement is sought.

28. Services are excluded from coverage under Medicare Part B if they are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member[.]" 42 U.S.C. § 1395y(a)(1)(A).

29. Any provider seeking Medicare reimbursement through Part B must certify on a CMS Form 1500 that "the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision."

30. Medicare further prescribes certain basic record-keeping requirements. 42 § C.F.R. 410.32(d). Specifically, the supervising physician or the organization billing Medicare must maintain documents showing "accurate processing" of the medical services

billed. *Id.* If the physician or organization does not have adequate documentation showing the procedure at issue, Medicare deems that service to be non-medically necessary and per se unreasonable. *See* 42 § C.F.R. 410.32(d)(3)(ii).

B. Anti-Kickback Statute Compliance

31. Through the passage of the Anti-Kickback Statute, Congress has prohibited the knowing inducement of referrals through any remuneration. 42 U.S.C. § 1320a-7b(b).

32. Health and Human Services (HHS) has previously opined that a company runs afoul of the Anti-Kickback Statute when a company both offers a discount to one payor but that same discount is not offered to Medicare or Medicaid and when that discount is used as an inducement to receive access to a provider's Medicare or Medicaid population. *See* Exhibit A, Health and Human Services Advisory Opinion 99-13.

33. Advisory Opinion 99-13 generally stands for the proposition that, while discounts are potentially permissible under an Anti-Kickback Statute safe harbor, the safe harbor provision will not be triggered if the price reduction is offered to one payor but not offered to Medicare or Medicaid. *See generally id.*

34. The Advisory Opinion noted that the size or structure of the discount was not "determinative of an AKS violation." *Id.* Rather, "the appropriate question to ask is whether the discount – regardless of its size or structure – is tied or linked directly or indirectly to referrals of other Federal health care program business."

35. Companies that offer a discount to one payor – but not to Medicare or Medicaid – and do so with the intent of generating additional business from the Medicare or Medicaid programs run afoul of the Anti-Kickback Statute.

VII. THE TRICARE PROGRAM

36. TRICARE is a managed health care program established by the Department of Defense. 10 U.S.C. §§ 1071-1110. TRICARE provides health care benefits to eligible beneficiaries, which include, among others, active duty service members, retired service members, and their dependents.

37. For purposes of the TRICARE program, Liberty Ambulance is considered a "corporate services provider." *See* 32 C.F.R. § 199.6(f)(1)(i).

38. The regulatory authority establishing the TRICARE program delegated to its director or designee the authority to develop additional regulatory requirements for program participants. *See* 32 C.F.R. § 199.6(f)(1)(iv)(A).

39. TRICARE does not cover services performed at a "corporate services provider" if the provider does not meet the Medicare conditions of participation or conditions of coverage for substantially comparable services. *See id*., at (II)(C)(7).

VIII. FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM

40. In contrast to Medicare and TRICARE, the Federal Employees' Health Benefit (FEHB) Program contracts with private health plans to deliver health benefits to federal employees. 5 U.S.C. §§ 8902-8903. Providers submit claims to these private health plans, most of which then seek and receive reimbursement dollar for dollar from the trust fund maintained for the FEHB Program as part of the U.S. Treasury. 5 U.S.C. § 8906.

41. Each of the various private FEHB Program plans will reject claims for services that are not medically necessary or not required to meet accepted standards of

care. For example, the 2011 Blue Cross and Blue Shield Service Benefit Plan cautioned that claims were "payable only when we determine they are medically necessary."

VIII. DEFENDANT'S FRAUDULENT CONDUCT

A. Defendant Knowingly Submitted False Claims to the Government

42. Beginning in September 2005 – and continuing to the present – the Defendant has either knowingly, reckless, or as a product of deliberate ignorance, submitted false claims to the federal government for payment.

43. Despite the program requirement that patients be transported by ambulance only when ***every other*** means of transport is contraindicated, Liberty Ambulance routinely transported patients that could travel by other means.

44. To this end, Relator Pelletier has provided sworn testimony that he routinely transported patients that could ambulate, travel by private vehicle, or travel by wheelchair. *See* Exhibit B, Sworn Statement of Shawn Pelletier. Relator Pelletier bases these statements based on his own personal observation.

45. According to Relator Pelletier's sworn testimony, "nine times out of ten" Liberty Ambulance patients would lack the need to be transported by ambulance. *See id*. at 7.

46. Relator Pelletier was also instructed, on his first day on the job, that if Liberty Ambulance did not "get paid, you don't get paid." *Id*.

47. Relator Pelletier also indicated that his training was different than his read of the Center for Medicare and Medicaid Services (CMS) regulations for ambulance transports. *Id*. at 8.

48. Relator Pelletier further indicated that the majority of patients that he transported could walk, talk, were coherent, and were alert and oriented. *Id*. He indicated that he transported "hundreds" of patients that did indeed ambulate to the ambulance. *Id*. at 9.

49. These directions to transport ambulatory patients – and then bill Medicare – came from the top of Liberty Ambulance's chain of command. Captain Barefoot would not allow employees to pick up their paychecks until they had altered their run report to make sure it was eligible for reimbursement. *Id*. at 10.

50. Despite these patients' condition, Mr. Pelletier – on behalf of Liberty Ambulance – transported these patients. In turn, Liberty Ambulance submitted claims for reimbursement for these patients.

51. Relator Pelletier has stated that the primary source of abuse was transporting patients to dialysis facilities as these twice or three times a week trips would be high-revenue generating tools for the ambulance company. These patients often lacked any need for ambulance transport.

52. Another former employee – Andrew Ratliff – has provided sworn testimony that, while he was told never to lie on his run reports, he was also instructed to "write the report so [Liberty] get[s] paid." *See* Exhibit C, Sworn Statement of Andrew Ratliff at 6.

53. Mr. Ratliff also testified that he was "instructed to write the report [so that] no patient ever walks" and that "[n]ever write ambulatory in your report." *Id*. at 6-7.

54. Another employee – Robert Brian Brown – has provided sworn testimony that he was instructed to document patient's conditions, but those reports would be alerted

if they were phrased in such a manner so that they could not get reimbursed. *See* Exhibit D, Sworn Statement of Robert Brown at 4.

55. Mr. Brown also corroborated the statements that paychecks were withheld until run reports were alerted so as to justify reimbursement. *See id*. at 6-7.

56. Moreover, former dispatcher Amanda Strickland testified that she regularly instructed crews to alter their run reports so as to justify Medicare reimbursement. *See* Exhibit E, Sworn Statement of Amanda Strickland at 10-12.

57. For example, if a crew called and said a patient was ambulatory, Ms. Strickland testified that she would tell the crew to "[j]ust put that you found the patient laying there and that you just transferred the patient over to the stretcher. Don't put all the other information." *Id*. at 11-12. She learned to instruct crews this way due to direction from her bosses.

B. Defendant Knew of These Falsely Submitted Claims

58. Defendant was not only acutely aware that false claims were being submitted, but also directed that these false claims be submitted so as to maximize reimbursement.

59. Beginning sometime before 2008 and continuing to present, Liberty Ambulance trained its employees to falsify ambulance run reports so as to guarantee reimbursement – even when these transports were medically unnecessary.

60. As part of this training, Liberty Ambulance created a fifteen page "Run Report Training Course" manual. *See* Exhibit F, Liberty Ambulance Run Report Training Course Manual.

61. The manual begins by discussing the tension between the operations staff (the ambulances) and the billing office. The manual starts on page 2 with an axiomatic maxim that "[o]perations cannot upgrade their equipment and get new ambulances if the billing office can't collect on the transports. The billing office can't get the carriers to reimburse the claim if they don't have the necessary information. Neither side can justify pay raises without income from the service." *Id.* at 2.

62. Pages 3 through 8 of this manual provide an instruction to all new staff on phrases to avoid, phrases to use, and concepts to watch out for, so as to maximize the likelihood of reimbursement.

63. On page 8, Liberty Ambulance "strongly suggest[s] that [crews] use these wordings when writing your run reports." Liberty Ambulance then states words and combinations of words that "have, in the past, proven successful in aiding claims successfully through the payment process." *Id.* at 8.

64. Employees of Liberty Ambulance saw these types of words and phrases as directives and understood that these phrases were to be used, regardless of the patient's true condition.

65. Continuing in the manual, Liberty Ambulance instructed its employees to "**<u>NEVER write 'patient ambulated to stretcher' or 'patient was sitting in wheelchair.'</u>**" *Id.* at 12 (emphasis in original). Continuing, the manual notes that "while this information may be pertinent information on scene before a trip to the ER, it is immaterial information on other types of transports." *Id.*

66. This type of directive – to leave out relevant information because it might undermine the likelihood of reimbursement – resulted in a culture of Liberty knowingly submitting false statements to justify medically unnecessary ambulance transports.

67. In addition to a training manual, Liberty had other specific guidance that instructed employees to not include information that would undermine their efforts to receive reimbursement.

68. For example, an undated memo from Captain Barefoot to all staff instructed employees that Liberty was having trouble with reimbursement. To cure this problem, Captain Barefoot instructed crews to "OMIT ALL POSITIVE FINDINGS (Just don't write them.)" *See* Exhibit G, Memo from Captain Barefoot to All Staff.

69. Captain Barefoot further suggested that the reason to justify ambulance reimbursement was often found in the patient's past history, if not in the patient's current condition.

70. This directive resulted in Liberty Ambulance staff omitting relevant information, submitting claims that were not medically necessary, and using past – and not current – medical history to justify reimbursement.

C. Defendant's Run Reports Constitute False Statements

71. Plaintiff has examined 400 randomly selected patient run reports from Liberty Ambulance. A review of these run reports reveals that these reports constitute false statements and that false claims were, in turn, submitted to the government for payment.

72. Many of the run reports lacked even basic indicia of medical necessity. Furthermore, the majority of these run reports all had the same "buzz words" and same

generic descriptions of ambulance transport. These reports largely omitted issues of ambulatory status but did almost uniformly state that "patient was sheeted to stretcher."

73. For example, Liberty Ambulance transported patient S.L. on November 24, 2010. L.P. was transported by Liberty Ambulance from Memorial Hospital to Life Care Jacksonville, a long-term care facility.

74. Despite the fact that S.L. was a "walk-in" patient at Memorial Hospital, and despite the fact that he was healthy enough to be discharged, Liberty Ambulance transported this patient – and billed the government – via ambulance.

75. In its record documenting the need for ambulance transport, Liberty noted that the patient "has foot wounds," "was transferred to stretched and secured with all belts and side bars." The record also noted that the patient was "transported and monitored en route."

76. This record is a false statement as it is inconsistent with S.L.'s underlying medical records and it inaccurately describes the patient's condition.

77. As another example, Liberty Ambulance transported patient G.F. on March 13, 2007. The stated need for such a transport was apparently because the patient was "bed confined." Liberty Ambulance justified this transport by noting that the patient was "transferred to transport where vitals were taken and maintained."

78. Despite suggesting that the patient was bed confined and needed to be sheeted via stretcher, Liberty Ambulance conceded in its own run report that the "patient was found sitting upright in chair" – a phrase that directly contradicts the bed-bound status and the need for the patient to be transported by ambulance.

79. These examples are but two of a much more systematic scheme to defraud the government by transporting patients unnecessarily.

80. Apart from these "buzz words," a medical expert has reviewed these 400 run reports. He has noted that many of these files are false and suggest that Liberty had a policy of deliberately submitting false claims to the government.

81. Many of the run reports were unnecessarily coded at the Advanced Life Support level, rather than Basic Life Support level. Based on his review of the run reports submitted by Liberty, he has concluded that 29% of the ALS Non-Emergency runs lacked a necessary ALS assessment or intervention and 27% of the ALS Emergency runs lacked a necessary ALS assessment or intervention. These transports should, accordingly, have been billed as BLS transports.

82. Further, apart from upcoding from BLS to ALS, the Plaintiff's medical expert has reviewed Liberty's ambulance run reports and has determined that, based on Liberty's own representations, many (29%) of the run reports lack the basic indicia of medical necessity.

83. For example, on December 7, 2011, Liberty Ambulance transported patient B.P. from Orange Park Medical Center to Consulate Health Care – a transport of 1.4 miles. In all, the actual travel time was 5 minutes.

84. Based on this transport, Liberty identified that Orange Park Medical Center dispatched Liberty to pick up a "sick person" who had a "fever." When the crew arrived, B.P. was found to be fully alert/oriented, times three, had a full 15 on the Glasgow Coma Scale, and her vital signs were well within limits.

85. When Liberty employees arrived at OPMC, B.P. was lying in a bed at the hospital. Liberty's employees reportedly had the patient "walk[] to the stretcher with crew assistance" and secured her to the stretcher with "all safety restraints." After making the five minute transport, Liberty's employees assisted B.P. in "walk[ing] to hospital type bed."

86. Given these circumstances, there is no reason for ambulance transport. Yet, Liberty billed Medicare $500 for this transport and received $168 in reimbursement.

87. Similarly, on March 18, 2006, Liberty transported patient M.P. to and from his assisted living facility to receive dialysis at the Mayo Clinic. The transport was less than 1 mile and apparently took two minutes.

88. M.P. apparently suffered from end stage renal disease and needed dialysis treatment multiple times per week.

89. When Liberty's EMT arrived to transport M.P. they found him to be "verbal, responsive, not confused . . . and well kept." M.P. was apparently sitting in a wheelchair at the time of transport, as the run report indicates that the patient was transferred from his wheelchair to a stretcher.

90. According to the run report, at no point did the patient express any "pain, difficulty breathing or discomfort." Again, there is no medical necessity for this transport.

D. Defendant Intentionally Violated Anti-Kickback Statute

91. Apart from submitting false claims to the government, Liberty Ambulance has engaged in a systematic kickback scheme to further maximize its reimbursement from the federal government.

92. Liberty Ambulance has a policy and practice of offering commercially unreasonable rates to private payors – such as hospitals, nursing homes, and the like – but

not offering these same discounts and rates to the government. Liberty Ambulance offers these discounts to private payors so that these payors will then provide Liberty Ambulance with exclusive access to the payors' federal government subsidized patient population.

93. By way of one example, Liberty Ambulance offered extremely discounted rates to a local Jacksonville hospital – Memorial Hospital – in 2009 in order to gain that hospital's business. *See* Exhibit H, 2009 Fee Schedule to Memorial Hospital.

94. This fee schedule, among other things, offered Memorial Hospital a "flat rate" for transports between Memorial Hospital and Specialty Hospital. Further, Liberty Ambulance offered to not bill any "indigent discharges" to Memorial Hospital – or any of its sister companies. *See id.*

95. Liberty Ambulance never offered the federal government any of these flat rates nor write-offs for indigent patients.

96. The rationale for offering these discounted rates to Memorial Hospital was to create an exclusive arrangement wherein Liberty Ambulance would transport all patients from Memorial Hospital – both private pay patients and patients whose bill was being paid by the federal government.

97. Liberty Ambulance's peers could not offer these rates as these rates were below the fair market value and were commercially unreasonable. *See generally* Exhibit I, Century Letter to Memorial Hospital; *see also* Exhibit J, Declaration of Marsha Morrell..

98. As further testament to the commercial unreasonableness of these rates, Liberty Ambulance itself conceded that it was losing money – almost $1,000 ***per day*** – from these rates and this loss could only be "offset" by obtaining transports for other patients;

e.g., other Medicare patients. *See* Exhibit K, October 24, 2013 Email from Dwayne Perkins to Eleanor Lynch.

99. Memorial Hospital was not unique in receiving these benefits that were not available to federal payors. Liberty offered similar discounts to other non-federal payors.

100. By offering these commercially unreasonable discounts to private payors, and not to the federally subsidized healthcare programs, Liberty Ambulance intentionally offered a kickback – a commercially unreasonable discount – in order to maximize its referral of federal beneficiaries. This conduct violates the Anti-Kickback Statute.

101. In all, through the efforts of Liberty Ambulance, more than $28 million in claims were submitted to the federal healthcare programs. The vast majority of these claims were medically unnecessary, predicated on false statements, and should not have been reimbursable.

FIRST CAUSE OF ACTION

(False Claims Act: Presentation of False Claims)
(31 U.S.C. § 3729(a)(1) and (a)(1)(A))

102. The United States repeats and realleges the preceding paragraphs as if fully set forth herein.

103. Defendant Liberty Ambulance knowingly presented and caused to be presented false or fraudulent claims for payment or approval to the United States by submitting claims for ambulance transports that were ineligible for payment.

104. By virtue of the false or fraudulent claims that defendant made and/or caused to be made, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus civil penalties of not less than $5,500 and up to $11,000 for each violation.

SECOND CAUSE OF ACTION

(False Claims Act: Presentation of False Statements to Get False Claims Paid)
(31 U.S.C. § 3729(a)(1)(B))

105. The United States repeats and realleges the preceding paragraphs as if fully set forth herein.

106. Defendant Liberty Ambulance knowingly made, used, or caused to be made or used false records or statements to get false or fraudulent claims paid by the United States for ambulance transports that were ineligible for payment.

107. By virtue of the false or fraudulent claims that Defendant made and/or caused to be made, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus civil penalties of not less than $5,500 and up to $11,000 for each violation.

THIRD CAUSE OF ACTION

(Unjust Enrichment)

108. The United States repeats and realleges the preceding paragraphs as if fully set forth herein.

109. The United States claims the recovery of all monies by which Defendant has been unjustly enriched.

110. As a consequence of the acts set forth above, Defendant was unjustly enriched at the expense of the United States in an amount to be determined which, under the circumstances, in equity and good conscience should be returned to the United States.

FOURTH CAUSE OF ACTION

(Payment by Mistake)

111. The United States repeats and realleges the preceding paragraphs as if fully set forth herein.

112. The United States claims the recovery of all monies by which Liberty Ambulance has been paid by mistake.

113. As a consequence of the acts set forth above, Liberty Ambulance was paid by mistake at the expense of the United States in an amount to be determined which, under the circumstances, in equity and good conscience, should be returned to the United States.

FIFTH CAUSE OF ACTION

(Violation of Anti-Kickback Statute)
(42 U.S.C. § 1320a-7b(b))

114. The United States repeats and realleges paragraphs 90 through 100 as if fully set forth herein.

115. As a consequence of the acts set forth above, Liberty Ambulance violated the Anti-Kickback Statute by intentionally offering discounts to certain payors but not offering the same discounts to the federal government subsidized healthcare programs.

116. The United States claims the recovery of all monies by which Liberty Ambulance has been paid by virtue of this inappropriate kickback scheme, as well as treble damages and civil penalties of not less than $5,500 and up to $11,000 for each violation..

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in its favor against Defendant as follows:

I. On the First Count under the False Claims Act, for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

II. On the Second Count under the False Claims Act, for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

III. On the Third Count for unjust enrichment, for the damages sustained and/or amounts by which Defendant were unjustly enriched or by which Defendant retained illegally obtained monies, plus interest, costs, and expenses, and for all such further relief as may be just and proper.

V. On the Fourth Count for payment by mistake, for the damages sustained and/or amounts by which Defendant was paid by mistake or by which Defendant retained illegally obtained monies, plus interest, costs, and expenses, and for all such further relief as may be just and proper.

VI. On the Fifth Count for violations of the Anti-Kickback Statute, for the damages sustained and/or amounts by which Defendant was paid by virtue of improper remuneration (e.g., commercially unreasonable discounts) or by which Defendant retained illegally obtained monies, plus interest, costs, and expenses, and for all such further relief as may be just and proper.

DEMAND FOR JURY TRIAL

The United States demands a jury trial in this case.

Respectfully submitted,

A. LEE BENTLEY
United States Attorney

/s/ Jason Mehta
JASON PAUL MEHTA
Assistant United States Attorney
USA Number #142
300 North Hogan Street, Suite 700
Jacksonville, Florida 32202
Telephone: (904) 301-6300
Facsimile: (904) 301-6310
Jason.Mehta@usdoj.gov

CERTIFICATE OF SERVICE

I hereby certify that on June 12, 2015, I caused a true and accurate copy of the foregoing to be filed using the Court's CM/ECF system. As well, a copy of this complaint will be served on the defendant Liberty Ambulance Service.

/s/ Jason Mehta
JASON PAUL MEHTA
Assistant United States Attorney

EXHIBIT A

[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requester.*]

Issued: November 30, 1999
Posted: December 7, 1999

[name and address redacted]

Re: OIG Advisory Opinion No. 99-13

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding certain arrangements for discounted pathology services provided to physicians (the "Proposed Arrangement"). You have asked whether the Proposed Arrangement would result in prohibited remuneration under the anti-kickback statute, section 1128B(b) of the Social Security Act (the "Act") or would constitute grounds for the imposition of sanctions under the anti-kickback statute, section 1128B(b) of the Act, the exclusion authority related to kickbacks, section 1128(b)(7) of the Act, or the civil monetary penalty provision for kickbacks, section 1128A(a)(7) of the Act. In addition, you have asked whether the Proposed Arrangement would constitute grounds for a permissive exclusion for charging Medicare or Medicaid substantially in excess of the usual charges, section 1128(b)(6)(A) of the Act.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion, we conclude that the Proposed Arrangement might constitute prohibited remuneration under the anti-kickback statute if the requisite intent to induce referrals of Federal health care program business were present and might be subject to sanctions arising under sections 1128B(b), 1128(b)(7), and 1128A(a)(7) of the Act, as well as grounds for a permissive exclusion under section 1128(b)(6)(A) of the Act.

This opinion may not be relied on by any person other than the addressee and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

A. [Company A]

Company A is a State X professional corporation with three shareholders, all of whom are specialists in pathology and are licensed to practice medicine in State X. Company A employs five pathologists and fourteen technicians. It provides pathology services (including clinical and anatomic pathology services) (1) to five hospitals, as well as to the patients of physicians in private practice.

B. Billing Procedures

Company A has several billing methodologies depending upon the payor. For Federal health care program patients, Company A bills its charges to the government payor and bills the patients for any

applicable copayments or deductibles.

For non-Federal health care program patients, referring physicians have two payment options. One option is for Company A to bill its charges directly to the applicable third-party payor, and bill the patients for any copayments or deductibles. The alternative is for Company A to bill the physicians for the pathology services and accept that payment as payment in full. The physicians then bill the third-party payors and patients for the purchased pathology services. This option is commonly referred to as "account billing".

Under its account billing arrangements, Company A has traditionally offered physicians a discount off its usual charges which reflects the cost savings it realizes. Company A generates a single monthly statement to the referring physician who is required to pay on a prompt basis. Company A has represented that an account billing arrangement saves time and expense because: (i) claims are not submitted to a wide range of payors; (ii) Company A need not consider the claims submission criteria of the various payors; and (iii) Company A is not responsible for determining and collecting applicable copayments and deductibles owed by the patients. In addition, Company A realizes a better collection rate under account billing. Most physicians who have an account billing arrangement with Company A refer virtually all of their patients to Company A, whether the patients' specimens are covered under the account billing arrangement or are directly billed to the Federal health care programs.[(2)]

C. The Proposed Arrangement

Under the Proposed Arrangement, Company A will offer its account billing customers discounts that are greater than its cost savings, in order to match the prices of its competitors. Some of the discounted charges will be below the actual cost of providing the pathology services. In addition, Company A's profit margin for the non-Federal health care program business under the Proposed Arrangement would be less than the profit margin on the services that it bills directly to Federal health care programs. The discount will not be conditioned upon the physicians sending Company A its Federal health care program business. However, Company A has assumed that the physicians receiving discounts under the Proposed Arrangement will send virtually all of their patients to Company A. If Company A does not match the discounts of its competitors, Company A has represented that it will lose both the account billing business and the Federal health care program business of those clients.

II. LEGAL ANALYSIS

A. The Anti-Kickback Statute

The anti-kickback statute makes it a criminal offense knowingly and wilfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce referrals of items or services paid for by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. This Office may also initiate administrative proceedings to

exclude persons from Federal health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.[(3)]

1. Special Fraud Alert Relating to Arrangements for the Provision of Clinical Laboratory Services

In 1994, we issued a Special Fraud Alert describing certain laboratory practices that implicated the anti-kickback statute. The Special Fraud Alert set forth our analysis that when a laboratory offers or gives to a referral source anything of value for less than fair market value, an inference may be made that the thing of value is offered to induce the referral of business. Specifically, we gave the example of laboratories waiving charges for laboratory tests to physicians for managed care patients, in order to retain the high-paying non-managed care business. In that example, the free laboratory services for managed care patients could be a kickback between the laboratory and the physician for the fee-for-service patients.

2. The Discount Exception and Safe Harbor

The anti-kickback statute contains a statutory exception for "a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program." Section 1128B(b)(3)(A) of the Act. This discount exception reflects the intent of Congress to encourage price competition that benefits the Medicare and Medicaid programs. The Department of Health and Human Services has published regulations implementing this discount "safe harbor" exception. See 42 C.F.R. § 1001.952(h).

To determine whether Company A's proposed discount practice implicates the anti-kickback statute, we must determine whether the Proposed Arrangement fits within the discount safe harbor. We conclude that the Proposed Arrangement does not fit within the safe harbor. The statutory exception for discounts, as implemented by the regulatory safe harbor, does not protect price reductions -- like those at issue here -- offered to one payor but not offered to Medicare or Medicaid. See 42 C.F.R. § 1001.952(h)(3)(iii).

Specifically, the preamble to the discount safe harbor illustrated the potential problem with laboratory price reductions:

> [W]e are aware of cases where laboratories offer a discount to physicians who then bill the patient, but do not offer the same discount to the Medicare program. In some of these cases, the discount offered to the physician is explicitly conditioned on the physician's referral of all of his or her laboratory business. Such a "discount" does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts to be reported to the programs with costs and charges reduced appropriately to reflect the discounts. 56 Fed. Reg. 35977 (July 29, 1991).

Such price reductions create a risk that a laboratory may be offering remuneration in the form of discounts on business for which the purchaser pays the laboratory, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the laboratory. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payor's discounted rates. Moreover, laboratories may have an incentive to engage in abusive billing practices to recoup losses on the discounted business. Accordingly, the Proposed Arrangement does not fit in the discount safe harbor.

Having concluded that the Proposed Arrangement does not fit in the safe harbor, we must consider whether the discount arrangement between Company A and physicians utilizing account billing under the Proposed Arrangement may involve illegal remuneration to the physicians for their referrals of Federal health care program business not covered by the account billing arrangement and not subject to the discount. We conclude that it may.

The circumstances surrounding the Proposed Arrangement suggest that a nexus may exist between the discount to the physicians for non-Federal health care program business and referrals of Federal health care program business. First, the physicians are in a position to direct a significant amount of Federal health care program business to Company A that is not covered by the account billing component of the Proposed Arrangement. Second, both parties have obvious motives for agreeing to trade business: the physicians have the opportunity to make a larger profit on the non-Federal health care program business, and Company A is able to secure profitable Federal health care program business in a highly competitive market. Third, Company A has represented that it is likely that physicians who have account billing arrangements with Company A will refer Federal health care program business to Company A as a matter of practical convenience.

In evaluating whether an improper nexus exists between a discount and referrals of Federal business in a particular arrangement, neither the size nor structure of the discount is determinative of an anti-kickback violation. Rather, the appropriate question to ask is whether the discount -- regardless of its size or structure -- is tied or linked directly or indirectly to referrals of other Federal health care program business. Evidence that the discount is not commercially reasonable in the absence of other, non-discounted business is highly probative. In this regard, discounts on account billing business that are particularly suspect include, but are not limited to:

- discounted prices that are below the laboratory's cost,[(4)] and
- discounted prices that are lower than the prices that the laboratory offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of account billing business generated by the physician, but (ii) does not have any potentially available Federal health care program business.

This is an illustrative, not exhaustive, list of suspect discounts; other arrangements may be equally suspect. Each of the above pricing arrangements independently gives rise to an inference that the laboratory and the physicians may be "swapping" discounts on account billing business in exchange for profitable non-discounted Federal health care program business.

Based on the facts presented here, we are unable to exclude the possibility that Company A may be offering improper discounts under the Proposed Arrangement with the intent to induce referrals of more lucrative Federal health care program business. Nor are we able to exclude the possibility that the physicians may be soliciting improper discounts on business for which they have the opportunity to earn money in exchange for referrals of business for which they have no opportunity, but for which the laboratories can receive additional revenue. Indeed, the Proposed Arrangement poses a significant risk of such improper "swapping" of business, especially in light of Company A's representation that many of its competitors are agreeing to such discounts. These competitor discount arrangements may similarly run afoul of the anti-kickback statute. The risk of improper "swapping" is compounded by the likelihood that physicians will refer Federal health care program business to their account billing laboratory as a matter of practical convenience.

B. Permissive Exclusion for Billing Medicare Substantially in Excess of Usual Charges

Price reductions offered to physicians that are not offered to Medicare or Medicaid raise additional

issues under section 1128(b)(6)(A) of the Act, which provides for permissive exclusion from the Federal health care programs of individuals or entities that submit or cause to be submitted bills or requests for payment (based on charges or costs) under Medicare or Medicaid that are substantially in excess of such individual's or entity's usual charges or costs, unless the Secretary finds good cause for such bills or requests. In determining an individual's or entity's "usual" charges, we will look at the amounts charged to non-Federal payors, including physicians. If the charge to Medicare or Medicaid substantially exceeds the amount the laboratory most frequently charges or has contractually agreed to accept from non-Federal payors, the laboratory may be subject to exclusion under section 1128(b)(6)(A) of the Act.

The limited information submitted by Company A is insufficient to make a determination as to whether the Proposed Arrangement may run afoul of section 1128(b)(6)(A).[(5)]

III. CONCLUSION

Based on the facts certified in the request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement might constitute prohibited remuneration under the anti-kickback statute, if the requisite intent to induce referrals of Federal health care program business were present, and might be subject to sanctions arising under the anti-kickback statute pursuant to sections 1128(b)(7), 1128A(a)(7), or 1128B(b) of the Act, and the permissive exclusion provision under section 1128(b)(6)(A).

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Company A, the requester of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.
- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requester to this opinion.
- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is herein expressed or implied with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed Arrangement.
- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.
- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those that appear similar in nature or scope.
- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The Office of Inspector General reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, rescind, modify, or terminate this opinion.

Sincerely,
/s/
D. McCarty Thornton
Chief Counsel to the Inspector General

1. Throughout this opinion, the term pathology services is synonymous with laboratory services.

2. We express no opinion regarding the legality of their existing account billing arrangement under the anti-kickback statute, permissive exclusion, or any other legal authority.

3. Because both the criminal and administrative sanctions related to the Proposed Arrangement are based on violations of the anti-kickback statute, the analysis for purposes of this advisory opinion is the same for both.

4. In determining whether a discount is below cost, we look, for example, at the total of all costs (including labor, overhead, equipment, etc.) divided by the total number of laboratory tests.

5. We express no opinion regarding the legality of the current account billing arrangement under the permissive exclusion or any other legal authority.

EXHIBIT B

1
2
3
4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
6
7
8
9 SWORN STATEMENT OF
10 SHAWN J. PELLETIER
11
12 DATE TAKEN: January 16, 2011
13 TIME: 10:52 a.m.
14 PLACE: 6817 Southpoint Parkway
Suite 1804
15 Jacksonville, FL 32216
16
PRESENT: George K. Brew, Esquire
17
REPORTED BY: Marianne Branson, RPR
18
19
– – –
20
21
22
23
24
25

1 SHAWN J. PELLETIER,
2 having been produced and first duly sworn as a
3 witness, testified as follows:
4 EXAMINATION
5 BY MR. BREW:
6 Q Sir, would you please tell us your full
7 name?
8 A Shawn J. Pelletier.
9 Q Mr. Pelletier, where are you currently
10 residing?
11 A
12 Q And when is your date of birth?
13 A
14 Q Mr. Pelletier, are you currently employed?
15 A No.
16 Q When was your last employment?
17 A Last ambulance employment was Liberty.
18 Q Liberty?
19 A I'm self-employed now.
20 Q Okay, you're self-employed now. What is
21 your current company?
22 A Rapid Patient Mobilization.
23 Q And what is it that you do?
24 A Nonemergency medical transport.
25 Q And how long have you been engaged in

1 transporting patients?
2 A I've been licensed for two years.
3 Q And what is your past profession?
4 A Paramedic, firefighter.
5 Q Have you worked for other ambulance
6 companies?
7 A Yes.
8 Q What was the last ambulance company you
9 worked for?
10 A Liberty Ambulance.
11 Q What period of time did you work for them?
12 A Almost two years. I believe the last day
13 was August of 2008. No. I don't remember the last
14 day.
15 Q Well, the last date is not material. What
16 was the approximate period of time you worked for
17 them?
18 A Almost two years.
19 Q And what was that period of time, 2008 to
20 2006?
21 A Yes.
22 Q Who were your supervisors?
23 A Direct supervisors were the lieutenants
24 and captains, which was Jimmy Barefoot, David Hicks,
25 Dwayne Taylor, Clint Randolph. And upper management

1 is Jim Timmer, Michael Assaf.
2 Q Describe for me, if you would, your duties
3 there as a transporter.
4 A All aspects of advanced life support and
5 basic life support, patient transportation.
6 Q What types of patient transportation would
7 you do, all types?
8 A All types. Everything from emergency to
9 nonemergency, dialysis transports, emergency to the
10 emergency room, from patients' homes, from nursing
11 homes, interfacility transports, discharges from
12 hospitals.
13 Q Would you have to fill out paperwork when
14 you performed these runs?
15 A Do it every transport.
16 Q What type of paperwork would you fill out?
17 A You have to fill out a company transport
18 sheet, which has the patient demographics and the
19 patient care record on it. You had to take the
20 patient's corresponding information from the
21 hospital, which was all their medical information,
22 their history, their current reason for transport,
23 their certificate of medical necessity, which is an
24 absolute -- if you left with nothing else, you had
25 to leave with that.

1 Q What is that certificate?
2 A The certificate of medical necessity
3 ensures that the patient has a reason to go by
4 ambulance.
5 Q What are reasons for the patient to go by
6 ambulance?
7 A You have to have a combination of
8 reasons. The patient has to be bed bound, and bed
9 bound is completely bed bound. Patient cannot sit,
10 patient cannot walk with assistance, patient cannot
11 stand, patient cannot transfer. The patient has to
12 be completely incapacitated.
13 Q Who fills out the certificate of
14 necessity?
15 A Usually either the nurse or the doctor at
16 the facility. Usually the nurse fills it out by
17 verbal order of Dr. So-and-so. And the doc is
18 usually supposed to sign it.
19 Q Why is it that you would need a
20 certificate to transport a patient?
21 A To be able to bill the insurance company.
22 It has to be certified that there's a reason they
23 have to go by ambulance and they can't be
24 transported by any other means, and any other means
25 would be detrimental to their health.

1 Q In essence, you can transport any patient
2 you so choose, though; correct?
3 A Yes.
4 Q So the certificate of necessity is simply
5 something that you need to get paid?
6 A Correct.
7 Q All right. What other elements -- I'm
8 sorry. What other pieces of paperwork, if any, do
9 you need to get paid for the transportation?
10 A You need specific writing in your patient
11 run report; you have to be specific. You have to
12 get -- other pieces of paperwork, I don't
13 understand. What do you mean?
14 Q All right. Let me back up for a moment.
15 You mentioned you need the certificate of necessity
16 that's provided to you by whoever discharges the
17 patient; correct?
18 A Yes.
19 Q Okay. Do you need any other pieces of
20 paperwork that you have to submit that you create --
21 A Yes, run report.
22 Q -- in order to get paid?
23 A Your run report.
24 Q What goes on the run report, again?
25 A The run report is a complete rundown on

1 the patient, what they're experiencing, all their
2 health information, what they're currently --
3 supposed to be what they're currently experiencing,
4 not at all what's in their history.
5 And nine times out of ten, they don't have
6 a reason to go by ambulance.
7 Q When you say it has to be what they're
8 currently experiencing, who told you that or how do
9 you know that?
10 A The training materials at the ambulance
11 company. Very first day of training they teach you
12 that if we don't get paid, you don't get paid. It's
13 in the training material. It's in memos. It's in
14 verbal reprimand.
15 Q Let me pause you for a moment. The
16 current status of the patient on the run report you
17 say is something that should go on the run report;
18 correct?
19 A Correct.
20 Q Is that a federal or state requirement?
21 A Medicare and Medicaid require that,
22 require that you don't exaggerate any conditions to
23 make it more payable, that you don't elaborate on
24 past history.
25 Q Have you yourself read any of these

1 regulations?
2 A Yes. I read them front to back.
3 Q Where did you obtain them?
4 A CMS, Medicare. Initially when I started
5 doing this kind of research was back in 2002.
6 Q Okay. Have you been told to do anything
7 differently than what the CMS guidelines require you
8 to do by anyone at Liberty Ambulance?
9 A Almost every single day. At Liberty and
10 previously at Century.
11 Q For instance, tell me about types of
12 patient runs that would not be covered by CMS, in
13 your understanding.
14 A A discharge from a facility where the --
15 Q Let me pause you. When I say CMS,
16 obviously I mean Medicare and Medicaid.
17 A One of the absolute -- the worst is
18 discharges. Discharges and interfacility transports
19 are routinely done in an illegal form. They're
20 always -- I can't say always.
21 They're -- the majority of them patients
22 are -- they don't meet any criteria. They are able
23 to walk, they talk, they're completely coherent.
24 They're alert and oriented to person, time, and
25 place. And these are some -- they're the strictest

1 criteria that you are not supposed to take those
2 patients.
3 Q Well, is there anything to prohibit you
4 from taking these patients? For instance, there's
5 nothing illegal to transport somebody who can walk
6 to the ambulance; correct?
7 A Correct. If you -- you are required to
8 take the patient by the contract, and --
9 Q What contract are you referring to?
10 A The contract that the ambulance company
11 has with the transferring facility.
12 Q Have you yourself gone on a run and picked
13 up a patient who ambulated to the ambulance, and
14 then you placed that information on the run report
15 and turned it in to the company at Liberty?
16 A Hundreds.
17 Q All right. What happens when you turn in
18 a run report which indicates that the patient is
19 able to ambulate to the ambulance?
20 A On your -- the following week -- usually
21 when you turn your run report in, they're reviewed
22 by Captain Barefoot, which is Jimmy Barefoot. He
23 reviews the run reports, and he'll highlight the run
24 report to death.
25 And on the following week when you're

1 supposed to get your paycheck, if your name is on a
2 sheet, you will not get your paycheck unless you
3 alter your run report and fix it, because they tried
4 to send it up for billing, it did not get paid.
5 So they tell you you don't get your check
6 until you amend your run report, whatever -- and
7 usually there's -- there were times when they were
8 10, 15, 20 at a time for each person. I've seen
9 stacks of runs reports.
10 (Exhibit A was marked for identification.)
11 BY MR. BREW:
12 Q All right. Let me show you a document
13 which I'll refer to as Exhibit A to this deposition
14 and ask you if you can identify that document?
15 A I have seen this.
16 Q Did you see -- when did you see this
17 document first?
18 A I saw this when a friend of mine who is
19 still a current employee called and asked me about
20 it and asked me if this was okay, before he would
21 sign the signature sheet.
22 Q All right. Who provided this document to
23 you?
24 A This was from Brian Brown, a current
25 employee at Liberty. This report is -- this memo is

1 no longer part of the memo book. This has been
2 purged.
3 Q When do you think this memo was a part of
4 the memo book or the training book?
5 A Approximately seven months ago this memo
6 came out.
7 Q Okay. In this memorandum which I've
8 referred to as Exhibit A, do you see Item 5?
9 A Yes.
10 Q What does Item 5 state?
11 A On discharges, omit all positive
12 findings. Just don't write them.
13 Q Was that a policy that was in place during
14 your tenure at Liberty?
15 A Yes.
16 Q What's the purpose of omitting all
17 positive findings, in your understanding?
18 A A positive finding is a reason -- is a
19 disqualifying reason for payment. Hence, the
20 patient walked, the patient was fine, the patient
21 didn't require any help.
22 Anything positive on the patient you were
23 not allowed to write. You had to dig into their
24 history and write negative things that may have
25 happened 20 years ago.

1 Q All right. What does Item 2 state?
2 A 2 states: Elaborate on their PMHX, past
3 medical history.
4 Q What would be the purpose of elaborating
5 on their past medical history?
6 A We were routinely told and trained that
7 their past medical history, therein lies a reason,
8 so in their history, the more you write the less
9 they get kickback. So if you write a book in your
10 narrative, they tend to just pay the -- pay the
11 billing.
12 Q Do you have an understanding or knowledge
13 as to whether or not past medical history is a
14 factor you should be considering in transporting a
15 patient?
16 A Absolutely not, unless it's -- unless the
17 patient has qualifying reasons for that transport,
18 such as the patient had a CVA, stroke, back in 2006,
19 which is why they're contracted, or which is why
20 they're incoherent, which is why they're all those
21 reasons.
22 If their history relates to the current
23 condition you would put something. You would just
24 establish that the patient is incoherent due to a
25 CVA in 2006. You wouldn't write basically what --

1 what Liberty tries to teach you is by finding a
2 reason, you are saying that the patient is status
3 post CVA, but don't put the date.
4 Q I note in Exhibit A in the first large
5 paragraph that there's a statement: We've seen that
6 all the proper lines and spaces have been addressed,
7 but there is no "reason for transport" or "medical
8 necessity." Remember, we must have a reason why
9 each patient needs our services, and this reason
10 usually lies within their past medical history.
11 What is your understanding of that
12 statement?
13 A My understanding is that it's clear as a
14 bell. There is no reason for transport or medical
15 necessity for the bulk of these patients, and
16 they're telling you to find in their past medical
17 history, and elaborate on the past medical history,
18 a reason for transport.
19 MR. BREW: Let's take a break for a
20 minute, if we could.
21 (Brief recess from 11:06 a.m. through
22 11:08 a.m.)
23 BY MR. BREW:
24 Q Do you know who the owners of Liberty are?
25 A The on-the-records owner -- the on-the-

1 record owners are Robert Assaf and his wife. The
2 reason they're still on there as the owner is
3 because you can't transfer the COCPN. Their son
4 Michael is actually the new owner, Michael Assaf.
5 Q What is a COCPN?
6 A Certificate of public convenience and
7 necessity. You have to have so many population to
8 have an ambulance service, a hospital, things like
9 that.
10 Q And what is the current -- the son's full
11 name, do you know?
12 A Michael Assaf.
13 Q Does Michael Assaf have any role in
14 supervising or running the company?
15 A He is almost always there. His right-hand
16 man, Jim Timmer, is a very big reason things are the
17 way they are.
18 Q Why do you say that?
19 A Jim is very aggressive. Jim has been
20 physically abusive towards staff, and he -- I know
21 personally I've seen him put his hands on staff
22 members.
23 He will tell people: You're going to do
24 what I tell you. You're going to be fired.
25 He has tried to have people's licenses

1 revoked for not doing what he says. And he tells
2 dispatchers and people who disagree with him, we
3 can't do this transport like this: Shut up and do
4 what you're told. It's bad.
5 Q Does he direct them to falsify reports so
6 that they can get paid?
7 A Yes.
8 Q In what manner?
9 A Fix the run report so it gets paid. I
10 know that run reports get amended and then they
11 get -- the original report would get shredded
12 sometimes.
13 Q How do you know that?
14 A Through Amanda.
15 Q What is Amanda's last name?
16 A Amanda Strickland.
17 Q What has Amanda Strickland told you about
18 shredding or destroying original reports and
19 amending reports?
20 A That usually once a report is written and
21 it's amended, the original report gets shredded.
22 Q Who would do the shredding of the reports?
23 A The billing department, which would have
24 been Amanda.
25 Q And who would have done the amending of

1 the reports?

2 A The staff members. Us. The medics and

3 EMTs.

4 Q The individuals who were actually driving

5 and performing the runs?

6 A Yes.

7 Q What other individuals, in your knowledge,

8 have the type of knowledge which you're relating to

9 us?

10 A Every single current and former staff

11 member.

12 (Exhibit B was marked for identification.)

13 BY MR. BREW:

14 Q Let me show you a second document. It's

15 actually a composite document, which I'll refer to

16 as Exhibit B to this statement, and ask you if

17 you're familiar with that document?

18 A Yes. That's the Liberty Run Report

19 Training Course.

20 Q Was that in effect during your tenure at

21 Liberty?

22 A Yes.

23 Q Okay. Did you have to sign for this

24 document?

25 A I believe we signed an orientation

1 signature sheet.
2 Q Okay. Let me have you turn to Item Number
3 12.
4 A The burden is now on you?
5 Q One second. It would be Item Number 12
6 under Hospital Discharges and Non-Emergency
7 Transports.
8 A Number 12. On non-emergencies and
9 hospital discharge, never --
10 Q Can you read that for us?
11 A Never write patient ambulated to stretcher
12 or patient was sitting in the wheelchair. While
13 this may be pertinent information on scene before a
14 trip to the ER it is immaterial information on other
15 types of transports.
16 Q What does that mean?
17 A It means don't write what you see. It
18 means don't write that the patient walked to the
19 stretcher. Don't write that the patient was sitting
20 in a wheelchair. Those are disqualifying
21 statements.
22 Q Have you yourself routinely seen patients
23 ambulate to the vehicle?
24 A Time and time again. Every single day.
25 Q Approximately how many times a day while

1 you worked at Liberty?
2 A Probably 60 percent of my patients could
3 walk.
4 Q And you --
5 A Almost 90 percent of discharge patients
6 could walk.
7 Q And of those run reports, were you
8 instructed by the management of Liberty not to
9 describe that type of behavior -- I'm sorry,
10 ambulating and what have you by a patient?
11 A Yes.
12 Q If you were to write that on a run report,
13 that the patient ambulated to ambulance, what would
14 occur?
15 A It would not be paid by Medicare, period.
16 It's a disqualifying statement.
17 Q Have you yourself written that on run
18 reports and then had those run reports amended by
19 the management of Liberty?
20 A Time and time again.
21 Q What would the amendment be?
22 A The amendment would be: You either
23 rewrite the whole run report or you write -- you
24 alter the run report. You put a one line, and then
25 you would, below it, amendment, patient -- patient

1 was sheeted, basically, the patient did not walk, my
2 mistake. Usually they made you write a whole run
3 report.
4 Q Would your -- how would your compensation
5 be calculated by Liberty when you worked there?
6 A Hourly.
7 Q Did you ever have your compensation
8 withheld because the run reports were not paid?
9 A Yes.
10 Q And how would they calculate what to
11 withhold?
12 A No, they just wouldn't give you your whole
13 check. They would keep your entire check until you
14 fixed it so that it would be able to be billable.
15 Q And by "fix it" do you mean falsify it?
16 A Yes. On the second page this actually --
17 this matches the memo from Jimmy where --
18 Q One moment. You're talking about the
19 second page of the training memo, Exhibit B?
20 A Yes.
21 Q Matches Exhibit A in what respect?
22 A Run reports, what needs to be included.
23 The burden is now on you to meet the medical
24 necessity requirements.
25 It's not up to the paramedic and the EMT

1 to establish medical necessity. Medical necessity
2 should be established before we even respond. The
3 hospital determines that medical necessity.
4 Q Is it your understanding that you were
5 instructed by management or were you -- let me
6 strike that.
7 Were you instructed by management, then,
8 to create medical necessity?
9 A Yes. Within their medical history.
10 Q And describe how you did that.
11 A You would have to dig into the medical
12 history and find something, even if it was their
13 admitting issue. If their admitting issue was they
14 had a trip-and-fall and they had a bruise, you would
15 use that, but you would document it on your report
16 that it's at discharge. You wouldn't -- you would
17 make it seem as if this was an acute condition in
18 some way, by not putting the date, status post
19 stroke, status post open-heart surgery, but it was
20 five years ago and the patient is fine.
21 Patient can walk; patient wants to walk.
22 Sometimes you have to force the patient to get on
23 the stretcher.
24 Q Let me make certain I have this correct.
25 In other words, you would go into their past medical

1 history and find a past diagnosis or condition that
2 would basically justify transportation and billing
3 under Medicare so that they would get paid?
4 A Correct.
5 Q Even though that current condition wasn't
6 apparent or obvious in the patient when you picked
7 them up?
8 A Correct.
9 Q So if the patient did, in fact, walk to
10 the ambulance, you were told to omit the fact that
11 they walked to the ambulance and utilize a past
12 medical reason for justifying the transportation and
13 billing it under Medicare?
14 A Correct.
15 Q In the training manual it says: The
16 burden is now on you to meet medical necessity
17 requirements. What does that mean to you?
18 What did that mean to you?
19 A To me it means that I have to help Liberty
20 find a reason to get this paid. I have to find a
21 reason. I have to look at the patient and establish
22 a dilapidating reason for the patient to need an
23 ambulance, and they can't transport by any other
24 means possible because it would be detrimental to
25 their health.

1 Q What, if any, supervisors at Liberty
2 instructed you to do those very things?
3 A Clint Randolph, the director of training;
4 Jimmy Barefoot, the captain who reviews run reports;
5 Dwayne Perkins, the chief; and all the dispatchers.
6 Q Can you name some of the dispatchers?
7 A Christine, Amanda. There was one other
8 one; I don't remember her name.
9 The ones that were in charge, usually, the
10 ones that were the supervisors would review your run
11 report. And it came to the point where they started
12 reviewing the run report when you turned in, and
13 they would look for the CMN and have you fix it.
14 If you didn't have EKG strips with
15 patients, without an EKG strip you didn't get paid.
16 The run report didn't get paid. So there were times
17 that staff members were told to go out in the unit
18 and hook up the EKG machine to themself and put an
19 EKG strip on the run report.
20 Q And did you ever witness that being done?
21 A Yes.
22 Q By whom was it done?
23 A I was one of them. I was told to go do
24 it.
25 Q And who told you to go do it?

1 A That was Amanda at the time.
2 Q What is Amanda's last name?
3 A Strickland.
4 Q The certificate of medical necessity that
5 you'd receive from the facility, what hospitals
6 provided those during your run reports?
7 A Every single hospital has to provide it.
8 Q Did you ever receive a certificate of
9 medical necessity from a facility that you believed
10 was false?
11 A Yes.
12 Q Describe that.
13 A I would go into an emergency room, for
14 example, and in the emergency room for a discharge
15 you have to have a CMN, certificate of medical
16 necessity to get them out, or to transport them back
17 to the nursing home, or home.
18 And the certificate of medical necessity
19 would say that the patient is bed bound, but you'd
20 walk in the room and the patient is not there.
21 You'd walk out of the room and the patient is
22 walking down the hall towards you because they were
23 in the bathroom.
24 You're not allowed to argue with the
25 staff. If you argue with the staff, the company

1 will lose their contract. You can't say: Fix this
2 run report. You can't say: There is no reason for
3 me to take this patient.
4 What happens is you have to take that
5 patient on their CMN, and in the unit you have to
6 establish your own reason.
7 Q Is there a reason why the hospital or the
8 facility would create an incorrect certificate of
9 medical necessity?
10 A To get the patient out. If the CMN -- the
11 only purpose of the CMN is so that the payer,
12 Medicare, Medicare, insurance companies, will pay
13 for the discharge. They don't pay to get the
14 patient out if the patient doesn't need an
15 ambulance. So they won't pay for a stretcher
16 chair. They won't pay for a wheelchair transport.
17 So by falsifying a CMN, you get the
18 patient out. It doesn't cost the patient, it
19 doesn't cost the hospital, and it doesn't cost the
20 transport company.
21 Q Is it your understanding that various
22 hospitals in town are falsifying certificates of
23 medical necessity?
24 A Every day.
25 Q Have you ever asked any one of their staff

1 to correct a certificate of medical necessity that
2 was, for instance, incorrect with regard to the
3 patient's ability to ambulate?
4 A Yes.
5 Q When and where did that take place?
6 A It has happened at Baptist Beaches; it has
7 happened at Shands; it has happened at Baptist
8 Downtown; it has happened at Memorial.
9 Q Where you've asked them about the --
10 A You question -- by questioning the CMN,
11 yes. I questioned the nurse on the CMN. This
12 doesn't match the patient. And within minutes you
13 get a phone call from the office that you argued
14 with a staff.
15 Q And what are you instructed to do?
16 A Take the patient and do what they say.
17 Q Have you ever had any conversations with
18 any of the staff in any of these medical hospitals
19 or facilities in which you've asked them are they
20 falsifying the CMNs, or what is the purpose of
21 writing ambulatory on it or not ambulatory?
22 A I've never asked them what the -- what the
23 purpose is. I've asked them -- I've confronted
24 staff that the CMN does not match the patient.
25 Q And what has the staff done in response?

1 A Don't worry about it. Take the patient.
2 And they call the office, and you usually get in
3 trouble.
4 Q For contesting a description on the
5 certificate of medical necessity you get in trouble?
6 A Yes.
7 MR. BREW: All right. Let's take a break,
8 if we could.
9 (Brief recess from 11:24 a.m. through
10 11:29 a.m.)
11 BY MR. BREW:
12 Q Mr. Pelletier, have you yourself been
13 involved in transporting any dialysis patients on
14 behalf of Liberty?
15 A Yes. Numerous.
16 Q Are the dialysis -- tell me the
17 circumstances under which the dialysis patients
18 would be transported by ambulance.
19 A A dialysis patient is supposed to meet the
20 same criteria as every other patient. They have to
21 be unable to sit in a wheelchair, unable to go by
22 stretcher, or they have to have some reason why they
23 have to have medical -- advanced medical supervision
24 to be transported to dialysis.
25 Most of the patients that we take to and

1 from dialysis can walk, they can sit. They want to
2 walk, they want to sit. They require -- many of
3 them require almost no assistance.
4 Q Why are they being transported by
5 ambulance, then?
6 A Because you make more by ambulance than
7 you do by wheelchair or stretcher. And wheelchair
8 or stretcher doesn't get paid by Medicare. You rely
9 on -- the patient -- you're basically a taxi
10 service.
11 Q Would you -- as an ambulance driver for
12 Liberty, can you transport -- for instance, load a
13 wheelchair patient and transport them without --
14 without any further medical care involved?
15 A Absolutely. Many of them.
16 Q Are there other services which will pick
17 up wheelchair-bound patients and transport them that
18 are not ambulances?
19 A Yes. Many. And Liberty has those units.
20 They're wheelchair and stretcher units.
21 Q So there is a difference between an
22 ambulance and a wheelchair and a stretcher unit?
23 A Yes. There's not an EMT or a paramedic on
24 the wheelchair or stretcher unit.
25 Q Are you testifying that they would send an

1 ambulance and bill Medicare for a nonambulatory
2 patient who would require medical assistance during
3 transport even though the patient being transported
4 is ambulatory and does not require medical
5 assistance?
6 A Yes. And we would transport them further
7 than we're supposed to based on Medicare
8 guidelines. In other words, for example, there's
9 one patient that we took three times a week to
10 dialysis and back from dialysis. He sat in a
11 wheelchair, he stood and pivoted on his own, had
12 very minimal, minimal assistance required.
13 En route to dialysis, he would ask us to
14 stop and get his lottery numbers and get him
15 something to eat. On the way home we would stop at
16 the store and get him whatever he needed at the
17 store.
18 And he was -- dialysis is supposed to --
19 Medicare pays for you to go to the closest
20 appropriate facility, and Liberty would transport
21 this guy across town and bill Medicare all that
22 mileage.
23 Q Is it your testimony that they would do so
24 in order to increase the bill?
25 A Yes.

1 Q Would you yourself turn in reports that
2 accurately reflected the patient being transported
3 in such circumstances as you've described and then
4 have Liberty demand that you alter or falsify the
5 report?
6 A Yes. Same thing at Century. I would
7 always write patient ambulated, patient walked,
8 patient required minimal assistance, patient did not
9 meet criteria. And those reports would get kicked
10 back, and I would not get my check unless I fixed
11 those reports.
12 Q And by fixing the reports, is it your
13 testimony that you mean falsifying the reports?
14 A Yes.
15 Q Did you work at Century Ambulance as well?
16 A Yes. Before Liberty.
17 Q And what period of time did you work at
18 Century?
19 A 2004 to 2006.
20 Q Who were your supervisors at that period
21 of time at Century?
22 A My direct supervisor was Gary Daley
23 (phonetic). He was actually my partner. He was my
24 station captain. Above him was Robert Allen, Ray
25 Bailey, Marsha Morrell.

1 I don't remember the guy that did the
2 billing, but the billing guy would usually send you
3 the kickback. And then before they started doing
4 the electronic I used to get kickbacks all the time.
5 Q What do you mean by kickback?
6 A An unpayable -- an unbillable run report.
7 Q So by kickback you don't mean money, you
8 mean you were being given back your run reports that
9 were not billable?
10 A Correct.
11 Q And were you told what to do with those
12 run reports?
13 A The exact same thing. Amend them so that
14 they get paid. Find a -- look in their medicals,
15 find a reason they need our transport.
16 Q Would these be valid and justified reasons
17 or false reasons?
18 A They were almost all false reasons.
19 I did what I was trained to do, what I was
20 taught to do. You write what you see, what you do,
21 what the patient tells you and what -- the outcome
22 of what we've done, what the outcome of what we had
23 done was, which is called your SOAT, subjective,
24 objective, actions taken, and treatment rendered.
25 When -- I started being told that you

1 don't write your subjective anymore, you don't write
2 what you see. You write what you're told to write.
3 That's when I started to question. That's when I
4 started writing deliberately on my run report so
5 they wouldn't get paid.
6 And there are guys that I know of that
7 don't -- they were in a training class at Liberty
8 and they started to question and they were released
9 from orientation. They were fired there for
10 questioning in training.
11 Q And who are -- what are the names of those
12 individuals?
13 A There were two -- I don't know their name,
14 but they're two St. Johns -- St. Johns Fire and
15 Rescue guys. They were coming to Liberty for part-
16 time work.
17 MR. BREW: Mr. Pelletier, at this time I
18 don't have any further questions. I appreciate
19 your cooperation.
20 (Off-the-record discussion)
21 BY MR. BREW:
22 Q Mr. Pelletier, I have just a few more
23 questions. Do you have your driver's license on
24 you?
25 A Yes, I do.

1 Q May I take a look at it, please?
2 A Yes.
3 Q What I'd like to do is make a copy of your
4 driver's license and attach it to the statement as
5 Exhibit C.
6 And as a final question, do you hold any
7 professional licenses or certifications?
8 A Yes.
9 Q What are they?
10 A I'm a critical care licensed paramedic.
11 I'm a tactical medic for SWAT teams and things like
12 that. I am a Florida state firefighter. Numerous
13 other certifications and licenses.
14 Q All right. Can you tell us what they are,
15 generally?
16 A I'm a dive medic. I'm a -- I'm a licensed
17 repossession agent. I'm licensed to bill Medicare
18 and Medicaid.
19 Q All right. We'll make a copy of your
20 driver's license and attach it to the deposition,
21 and we can give you your license back.
22 A Sure.
23 (Exhibit C was marked for identification.)
24 (The statement was concluded at
25 11:38 a.m.)

1
2 CERTIFICATE OF OATH
3
4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
6 I, the undersigned authority, certify that
7 SHAWN J. PELLETIER personally appeared before me and
8 was duly sworn.
9
10 WITNESS my hand and official seal this 2nd day
11 of February 2011.
12
13 Marianne Branson
14
15 MARIANNE BRANSON
Commission # DD 948085
Expires January 25, 2014
Bonded Thru Troy Fain Insurance 800-385-7019
16
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1
2 C E R T I F I C A T E
3
4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
6 I, Marianne Branson, RPR-CP, certify that I was
7 authorized to and did stenographically report the
8 statement of SHAWN J. PELLETIER and that the
9 transcript is a true and complete record of my
10 stenographic notes.
11 I further certify that I am not a relative,
12 employee, attorney, or counsel of any of the
13 parties, nor am I a relative or employee of any of
14 the parties' attorney or counsel connected with
15 the action, nor am I financially interested in the
16 action.
17 Dated this 2nd day of February 2011.
18
19
20
21 Marianne Branson, RPR-CP
22 Court Reporter
23
24
25

EXHIBIT C

1
2
3
4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
6
7
8
9 SWORN STATEMENT OF
10 ANDREW B. RATLIFF
11
12 DATE TAKEN: January 16, 2011
13 TIME: 11:59 a.m.
14 PLACE: 6817 Southpoint Parkway
15 Suite 1804
Jacksonville, FL 32216
16
17 PRESENT: George K. Brew, Esquire
18 REPORTED BY: Marianne Branson, RPR
19
— — —
20
21
22
23
24
25

1 ANDREW B. RATLIFF,
2 having been produced and first duly sworn as a
3 witness, testified as follows:
4 EXAMINATION
5 BY MR. BREW:
6 Q Mr. Ratliff, would you please tell us your
7 full name?
8 A Andrew Barrett Ratliff.
9 Q Mr. Ratliff, where do you currently
10 reside?
11 A
12
13 Q Let me show you a document which I will
14 mark as Exhibit A to this statement and ask you if
15 that's a true and correct copy of your driver's
16 license?
17 A Yes, sir, it is.
18 MR. BREW: Thank you.
19 (Exhibit A was marked for identification.)
20 BY MR. BREW:
21 Q Mr. Ratliff, are you currently employed?
22 A Yes, sir.
23 Q With whom are you employed?
24 A Liberty Ambulance Service.
25 Q And how long have you worked for Liberty?

1 A Three years to the day yesterday.
2 Q What is your job at Liberty?
3 A I am an EMT, and my job is to respond to
4 emergency and nonemergency calls. And we also do
5 discharges from hospitals and nursing homes and
6 transfer patients to and from doctors'
7 appointments.
8 Q All right. Do you currently hold any
9 certifications and licenses?
10 A Yes, sir.
11 Q What are they?
12 A I'm certified in CPR, First Aid, AED, and
13 certified State of Florida EMT.
14 Q Has your job at Liberty been the same for
15 the past three years, approximately?
16 A Yes, sir.
17 Q Okay. Tell us how you go about
18 transporting a patient.
19 A Whenever dispatched on the call, the
20 dispatcher gives us the appropriate information,
21 where we're going, to what room, and the receiving
22 facility that we're taking the patient to and the
23 room number, also what time a call is dispatched and
24 the run number.
25 When we arrive to pick up the patient, we

1 first meet the nurse, who has paperwork for us
2 stating patient's condition, their mental status
3 usually, and whether or not they have any infectious
4 diseases. Also there's a certificate of medical
5 need filled out by the hospital stating why the
6 patient needs to go by ambulance.
7 We check all this paperwork out, and then
8 we load our patient to the stretcher, and we
9 document all this to the process.
10 Once the patient is on the stretcher, we
11 secure them with the seat belts and take them to the
12 ambulance where we do our physical assessment, check
13 them out from head to toe, assess their mental
14 status and their vital signs.
15 Then we transport the patient to the
16 receiving facility and make contact with a nurse
17 where the patient is going to be dropped off. And
18 we give her our report of the patient's condition
19 and what to expect, and we also turn over the
20 paperwork to the nurse.
21 Q Is there any concern on your behalf
22 transmitted to you by supervisors at Liberty about
23 how they're compensated for transporting a patient
24 like that?
25 A Yes, sir. We are told the patient --

1 every patient we transport has to meet certain
2 criteria making it payable at Medicare, such as the
3 patient is either bed bound or they have some type
4 of deficit requiring -- there's a list of certain
5 requirements that they've provided to us at one
6 point in time stating the patient has to meet one of
7 these criteria to be transported by Liberty so we
8 can get paid for the call.
9 We have been told before to write our run
10 reports such that we get paid for them, because if
11 the company doesn't get paid, we don't get paid.
12 Q Who would have been your supervisors at
13 Liberty, or management at Liberty, that would have
14 told you that?
15 A One is Captain Jimmy, or James, Barefoot;
16 he sends out memos from time to time. And if
17 there's a problem with the run reports, the patient
18 care reports, sometimes you have to report to him to
19 clarify any errors they find in the report.
20 Q What do you mean by report to him to
21 clarify errors?
22 A Sometimes when you clock into work, if he
23 is in the area they'll say: I need to see Ratliff.
24 And we will go over to him away from everybody so he
25 can show me the reports and any issue he had. I'll

1 go report to him -- I'll sit down and talk to him
2 about any issues he found in the reports I wrote.
3 Q Have you ever been instructed to falsify a
4 report?
5 A Yes and no. They tell us: Write the
6 report so we get paid, but don't lie.
7 But they'll reprimand me for not writing
8 the report -- saying why was this patient walking to
9 the stretcher. They'll tell me: Write the report
10 so we get paid or else you don't get paid.
11 So pretty much every patient has to be
12 either not able to walk or have some other type of
13 deficit as in they're confused from a stroke or
14 other mental condition. They will tell us to write
15 the report so they get paid, but they'll also back
16 up that sentence with: But don't falsify
17 documentation.
18 Q So how would you go about writing a
19 report, then, say for a patient who was able to
20 walk?
21 A The way we're instructed to write the
22 report is no patient ever walks. You find the
23 patient in whatever position, sitting, or on the
24 bed, and you place them on the stretcher, is how
25 we're told. You place the patient on the

1 stretcher.
2 Personally, I've started writing my
3 reports, because I didn't want to get in trouble for
4 my documentation, as I found the patient like this,
5 they were standing, I assisted them to the
6 stretcher, if they walked to it, and then I placed
7 them on the stretcher with the seat belts and
8 secured them.
9 They told us to write it one way, but I've
10 taken the initiative to protect myself because I
11 don't want to get in trouble for fraudulently
12 writing reports. But they will tell you in
13 orientation and training that no one walks and no
14 one is ambulatory. Never write ambulatory in your
15 report.
16 Q Have you any knowledge as to whether or
17 not your reports have been altered from how you've
18 written them in order for Liberty to get paid or
19 reimbursed through Medicare?
20 A They've had me rewrite reports before
21 saying that this report wasn't written correctly so
22 we get paid. I don't have the knowledge of run
23 numbers. I've been there for three years. But I
24 have been told before to write the report so it
25 better explains why Medicare is paying for this

1 ride.
2 Q All right. Let me show you a document
3 which I'll mark as Exhibit B to your statement and
4 ask you if you're familiar with that document?
5 A Yes, sir. This document was placed where
6 we -- where our dispatchers are, where we clock in
7 and out and work, and we distribute our gear from
8 our truck back to them. And I actually made a copy
9 of this document because I thought there was
10 something wrong with it.
11 Q What do you think is wrong with Exhibit B?
12 A It's been several months since I read
13 this. Do you mind if I take a second?
14 Q Yeah. Please take your time.
15 A The Hospice runs lacking in substance,
16 that's why I made a copy of this. And the
17 elaborating on their past medical history.
18 Omit all positive findings, that's also
19 another reason why I made a copy of this. There's
20 no reason they should have us do that.
21 Also I remember something that's missing
22 from this document. It was written in highlighter
23 on the bottom of this so you couldn't make a copy of
24 this. It says every crew member must read this
25 statement, this note, and sign the back of it.

1 Behind it there was two or three pages of crew
2 members' names, and you were supposed to sign beside
3 your name.
4 Yes, sir, I remember this one. This one's
5 several months old.
6 Q All right. Who is James Barefoot?
7 A He is our captain of -- as far as our
8 structure of supervisors go, he's the head
9 supervisor supposedly. He's a paramedic who has
10 been there, oh, 12 plus years. He is responsible
11 for reading the reports and making sure they're
12 legible and that all the content's supposed to be
13 there so we get paid for the ride.
14 Q When you say you would not get paid, would
15 your entire paycheck be withheld?
16 A They never went too in-depth about that.
17 They made it seem like for us to have business and
18 to get paid, you would have a job, they're trying to
19 word it as, just remember, if there's no business
20 for us, there's no business for you, and then I
21 could be relieved of my duties or fired.
22 Q Let me ask you, first, about Item Number 5
23 on Exhibit B, which indicates that on discharges,
24 omit all positive findings, parenthesis, just don't
25 write them, closed parenthesis.

1 What was your understanding of that
2 instruction by Liberty?
3 A That was if the patient was at the
4 hospital and now they're doing better, they're
5 progressing. Maybe previously when they came in
6 they weren't walking for whatever reason they were
7 at the hospital, and if they're making improvements
8 and they're able to stand, they're gaining strength,
9 their mental capacity is improved from when they
10 were there, don't show any improvement.
11 This reminds me of when we were in
12 training, they told us to paint a picture when we
13 write our reports and to make it look dark and
14 ominous, so they're saying. They don't want it to
15 look like this patient is happy and doing well.
16 They want it to look like this patient's bowed off,
17 so the report looks bad so -- apparently so we can
18 get paid for doing the call.
19 Q When you say get paid, do you mean so that
20 Liberty would be reimbursed by Medicare?
21 A Yes, sir.
22 Q And were you -- is it your knowledge and
23 understanding that getting paid for Liberty means
24 getting reimbursed through Medicare?
25 A Yes, sir.

1 Q In omitting all positive findings, were
2 you instructed by Mr. Barefoot to, for instance,
3 omit that a patient was able to walk to the
4 ambulance?
5 A Yes, sir. They established that in
6 training, which is before this memo came out. We
7 have orientation training for new employees. They
8 told us to never write that patients can walk,
9 because we don't -- Medicare doesn't pay for those
10 types of patients.
11 Q And would you routinely have patients that
12 you transported who could walk to the ambulance?
13 A Yes, sir. Every day.
14 Q And was it your instruction and did you,
15 in fact, omit those findings on your run reports?
16 A No, sir. I -- I put how I found the
17 patients on my own terms. I would say if I found
18 them standing, and I would put patient assisted to
19 stretcher, because we were told the patient never
20 walked to the stretcher. We were told to write you
21 assist the patient to stretcher because they need
22 the assistance, even though they could perfectly
23 walk by themselves.
24 I followed the instructions of writing
25 "patient was assisted to stretcher" if they were

1 standing up when we found them.
2 For instance, if we're late to pick them
3 up and the patient is standing in the hall tapping
4 their foot because they're ready to go, the patient
5 never walked to the stretcher under their own
6 accord. They have to be assisted by us, which is to
7 help document why they need a stretcher and they
8 can't go by wheelchair.
9 Q In many of those instances was it
10 necessary to assist the patient to the stretcher?
11 A No, sir, not at all. They could do it
12 themselves. We were told the only reason why they
13 were there is because Medicare doesn't pay for taxis
14 or wheelchair calls, and the patient had to get out
15 of the hospital somehow.
16 Q Would the hospital be complicit in
17 discharging this patient under those guidelines even
18 though the patient didn't meet those guidelines?
19 A Yes, sir, frequently. Especially at
20 Memorial Hospital we would receive a certificate of
21 medical necessity with the patient's name, birth
22 date, Social Security number, and then there's
23 criteria boxes that must be filled in by the nurse
24 or the staff, and then a physician or a nurse has to
25 sign the bottom of it.

1 Frequently they'll either be blank in the
2 section of why they needed a stretcher, or she
3 said: I just made something up and put in there so
4 it's not blank. That happens frequently.
5 Q And can you identify any of these
6 individuals at Memorial who would have done so?
7 A Not at this time. It's been a while since
8 I've had one of those instances. They might have
9 had some type of training where they're supposed to
10 write something in general. I can't remember the
11 nurses' names at this time.
12 Q Would the hospital certificate of
13 necessity frequently not match the description of
14 the patient you're retrieving from the hospital?
15 A Yes, sir, frequently. That happens
16 daily. It'll say -- I have one patient I wrote down
17 the run number and the date it happened, where the
18 hospital certificate of need stated total
19 assistance, total help required written in the
20 nurse's handwriting, and that patient walked under
21 her own power to the stretcher.
22 Q Do you have any knowledge as to why the
23 hospital would do that?
24 A We're told that they have to get rid of
25 the patients, and this is the only way to make empty

1 beds for the patients coming in. They told us they
2 just need this patient out of there because there's
3 too many people there. They need to get rid of --
4 they need an empty bed, and this is the only way to
5 do it.
6 Q Why wouldn't they simply call a taxi for
7 the patient?
8 A Oh, because insurance and Medicare doesn't
9 pay for taxis, and the patient is certainly not
10 going to pay for that, and neither is the nurse.
11 That's what they told us.
12 Q Who told you that?
13 A It's various staffs from all the floors.
14 It's common knowledge that if you need a ride, just
15 call Liberty and they'll take you no matter what.
16 Q Which hospitals are you referring to that
17 it would be common practice at?
18 A Most specifically at Memorial since
19 Liberty has a recent contract with them, year old.
20 We frequent that hospital numerous times daily,
21 anywhere from 30 to 40 at least. And they send out
22 patients, and the nurses are too busy. They're
23 overworked and understaffed, and they have to get
24 rid of these patients. This is the only way to do
25 it.

1 Q Does this take place at any other
2 hospitals in town that you're personally aware of?
3 A I've taken some from Orange Park Medical
4 Center as well where the criteria isn't met; the
5 paperwork is just filled out. And sometimes from
6 Baptist of Downtown, Baptist Health Care Center
7 Downtown. It happens the paperwork doesn't match
8 up, it's just they need to get rid of them, and they
9 have Medicare, even though they don't qualify for
10 it.
11 They just don't take the time to make that
12 effort to make sure the paperwork counts to send a
13 patient out. They assume it's on us. Just take
14 this patient, sometimes is the response we get.
15 (Exhibit C was marked for identification.)
16 BY MR. BREW:
17 Q Let me show you a document that I'm going
18 to refer to as Exhibit C to the deposition and ask
19 you if you're familiar with that.
20 A Yes, sir. I was given this document when
21 I first started at Liberty Ambulance three years
22 ago, and I believe I have a copy of it at home to
23 this date.
24 Q I'd like for you to turn, if you would, to
25 the section dealing with hospital discharges and

1 nonemergency transports.

2 A How far back is it? The one that says,

3 Get a face sheet? There it is. Yes, sir.

4 Q In reviewing down those numbered

5 requirements, if you turn to Number 12 on the next

6 page, can you read that for us, please?

7 A Number 12: On non-emergencies and

8 hospital discharges, bold and underlined, never

9 write "patient ambulated to stretcher" -- that was

10 in parentheses -- or patient was sitting in a

11 wheelchair. While this may be pertinent information

12 on scene before a trip to the ER it is immaterial

13 information on other types of transports.

14 Q And why is that, in your understanding?

15 A We are told it's like this because Liberty

16 can't bill Medicare for these types of patients, and

17 therefore either you do this call without getting

18 paid or we fraudulently write this down and submit

19 it to Medicare legally.

20 But no one talks about it. It's you hush-

21 hush. They pretty much tell us to do this so the

22 company gets paid so we have a job with the company.

23 Q And is it routinely done at Liberty?

24 A Every day.

25 Q Are you concerned that Liberty is engaging

1 in submitting false claims to Medicare?
2 A Yes, sir. I'm worried that with my name
3 and EMT number on these reports, that's -- it can
4 come back and get me in trouble, losing my ability
5 to work in the state as a certified emergency
6 medical technician.
7 MR. BREW: Well, I appreciate your time in
8 coming down here and cooperating with us. At
9 this time I don't have any further questions.
10 THE WITNESS: Thank you.
11 MR. BREW: Thank you, sir.
12 (Whereupon, at 12:16 p.m., the statement
13 was concluded.)
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1
2
3 CERTIFICATE OF OATH
4
5 STATE OF FLORIDA)
6 COUNTY OF DUVAL)
7 I, the undersigned authority, certify that
8 ANDREW B. RATLIFF personally appeared before me and
9 was duly sworn.
10
11 WITNESS my hand and official seal this 2nd day
12 of February 2011.
13
14 Marianne Branson
15 MARIANNE BRANSON
16 Commission # DD 948085
Expires January 25, 2014
Bonded Thru Troy Fain Insurance 800-385-7019
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1
2 C E R T I F I C A T E
3
STATE OF FLORIDA)
4
COUNTY OF DUVAL)
5
I, Marianne Branson, RPR-CP, certify that I was
6
authorized to and did stenographically report the
7
statement of ANDREW B. RATLIFF and that the
8
transcript is a true and complete record of my
9
stenographic notes.
10
I further certify that I am not a relative,
11
employee, attorney, or counsel of any of the
12
parties, nor am I a relative or employee of any of
13
the parties' attorney or counsel connected with
14
the action, nor am I financially interested in the
15
action.
16
Dated this 2nd day of February 2011.
17
18
19
20
Marianne Branson
21
Marianne Branson, RPR-CP
Court Reporter
22
23
24
25

EXHIBIT D

1
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3
4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
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7
8
9 SWORN STATEMENT OF
10 ROBERT BRIAN BROWN
11
12 DATE TAKEN: January 16, 2011
13 TIME: 11:42 a.m.
14 PLACE: 6817 Southpoint Parkway
Suite 1804
15 Jacksonville, FL 32216
16
17 PRESENT: George K. Brew, Esquire
18 REPORTED BY: Marianne Branson, RPR
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1 ROBERT BRIAN BROWN,
2 having been produced and first duly sworn as a
3 witness, testified as follows:
4 EXAMINATION
5 BY MR. BREW:
6 Q Mr. Brown, would you please tell us your
7 full name?
8 A It's Robert Brian Brown.
9 Q Mr. Brown, where do you currently reside?
10 A I reside at [redacted]
11 [redacted]
12 Q Mr. Brown, is this an accurate copy of
13 your driver's license?
14 A Yes, it is.
15 MR. BREW: We'll go ahead and mark that as
16 Exhibit A to the statement.
17 (Exhibit A was marked for identification.)
18 BY MR. BREW:
19 Q Mr. Brown, where do you currently work?
20 A I work at Liberty Ambulance Service.
21 Q And where are their offices located?
22 A They have an office at Atlantic University
23 Circle. They have a suboffice at -- in Orange Park
24 off of Peoria Avenue, and they also have an office
25 on U.S. 1 towards Callahan.

1 Q What are your duties and responsibilities
2 at Liberty?
3 A I'm a critical care paramedic.
4 Q Do you hold any licenses or
5 certifications?
6 A Yes.
7 Q What are they?
8 A I have a paramedic ACLS certification,
9 Basic Life Support certification, Pediatric Advanced
10 Life Support certification, critical care paramedic,
11 emergency vehicle operation. I also have -- I have
12 Advanced Medical Life Support and Prehospital Trauma
13 Life Support certifications.
14 Q How long have you worked at Liberty?
15 A I've been there coming up on three years.
16 Q And who are your supervisors at Liberty?
17 A I have Dean Jaycox as a supervisor. David
18 Gray is a supervisor. Jimmy Barefoot is a
19 supervisor. Dwayne Perkins and Jim Timmer.
20 Q Prior to Liberty, where did you work?
21 A I've worked at Advanced Patient
22 Transportation and Ambulance Service, Incorporated.
23 Q Have you ever worked for Century?
24 A No.
25 Q How do you go about ensuring that your

1 runs that you conduct on behalf of Liberty are paid
2 for billing purposes?
3 A I -- I write my runs according to how I
4 see them when I walk into the room. And if they see
5 that changes need to be met to be paid, they inform
6 us and have us change reports.
7 Q What are your responsibilities in terms of
8 write-up when you transport a patient?
9 A As a --
10 Q What type of paperwork do you have to fill
11 out?
12 A Oh. We have state run reports that they
13 provide for us. And also if we have discharges out
14 of the hospitals we're supposed to have physician
15 certification forms that tell us what kind of need
16 that's supposed to be met to meet Medicare
17 criteria.
18 Q Are their names for those certificates?
19 A Physician certification forms.
20 Q Okay. What -- again, what is the purpose
21 of those forms?
22 A To justify eligibility for Medicare to pay
23 for the transports.
24 Q What is necessary to justify Medicare
25 paying for a transport?

1 A That I'm not sure of. I don't know all
2 the rules and regulations of what Medicare -- I know
3 that they're supposed to be bed bound or certain
4 criteria met.
5 Q Are there criteria that you are aware of
6 that would disqualify Medicare reimbursement?
7 A If the patient walks or is completely, you
8 know, wheel -- a wheelchair patient that, you know,
9 they say are supposed to go by stretcher and
10 whatnot.
11 Q That would be the types of individuals
12 that would not qualify for Medicare reimbursement?
13 A Right.
14 Q Have you had occasions when you've arrived
15 at facilities and had patients who were ambulatory
16 or walking or wheelchair patients that did not
17 require assistance that you transported by
18 ambulance?
19 A Yes.
20 Q Were the certificates of medical necessity
21 that you received from the facilities incorrect or
22 false in describing the patient?
23 A Yes.
24 Q Have you ever gone into a facility and
25 inquired why the certificate doesn't match the

1 patient you were picking up in terms of description?
2 A Yes, I have.
3 Q And what have you been told?
4 A Don't worry about it, just write the
5 report, and -- and we'll deal with it later.
6 Q Does Liberty have transport vehicles that
7 accommodate stretcher and ambulatory patients other
8 than ambulances?
9 A They have wheelchair vans. And if they're
10 a -- what they call a nonmedical stretcher we're
11 supposed to take those also, but they get billed
12 separately to either the patient or the facility we
13 pick them up from.
14 Q Who would tell you not to worry about the
15 description on a certificate of necessity?
16 A I've had people in dispatch tell me that,
17 to not question the facility and just do the
18 reports.
19 Q And when you say people in dispatch,
20 you're talking about dispatchers at Liberty?
21 A Yes.
22 Q What about representatives of the
23 hospitals, would they tell you not to worry about
24 it?
25 A No, I've never had them -- I try not to

1 confront them to stir up anything. You know, I mean
2 I ask the nurse: What's going on? You know, is
3 this patient ambulatory?
4 You know, I ask appropriate questions
5 about their mental status and their eligibility to
6 go by stretcher, and I write my report according to
7 what I -- my findings.
8 Q Would your findings often be different
9 than what's on the certificate of necessity?
10 A Sometimes, yes.
11 Q Okay. Do you have any knowledge as to why
12 the facility would write a certificate of necessity
13 that wasn't correct on a patient?
14 A I have no idea.
15 Q As far as your run reports describing the
16 patient's activity, have you ever been told to alter
17 those run reports?
18 A Yes, I have.
19 Q By whom have you been told to alter them?
20 A When we go and pick up -- or when we used
21 to pick up our paychecks, there would be a folder
22 with run reports in there, and it would, you know,
23 say you need to make these changes. And it didn't
24 really be specific who is telling us to do it, but
25 we would have to be -- make these changes prior to

1 being able to receive our paycheck in the past.
2 Q And this would come from management and
3 supervisors at Liberty?
4 A Yes.
5 (Exhibit B was marked for identification.)
6 BY MR. BREW:
7 Q Let me show you a document which I'll mark
8 as Exhibit B to the deposition and ask you if you've
9 ever seen that document.
10 A Yes, I have.
11 Q What -- where did you first see this
12 document?
13 A I saw this in -- hanging in the window in
14 dispatch.
15 Q And who is this from?
16 A This is from Captain James Barefoot. He's
17 a supervisor.
18 Q At Liberty?
19 A Yes.
20 Q Would you read Item Number 5, please?
21 A Number 5? On discharge, omit all positive
22 findings. Just don't write them.
23 Q What was -- what did that mean? What was
24 your understanding of that?
25 A To me, I mean, you know, I say a positive

1 finding would be somebody that's, you know, not bed
2 bound, able to walk or sit up and, you know, could
3 be a dementia patient that is at this time lucid and
4 actually with it.
5 Q Why would you omit those types of
6 findings?
7 A I don't omit those types of findings. But
8 I'm thinking that they put this to be able to have
9 Medicare pay for these calls.
10 Q Would these positive findings disqualify
11 that patient transport for Medicare reimbursement?
12 A Yes.
13 (Exhibit C was marked for identification.)
14 BY MR. BREW:
15 Q Let me show you a composite document that
16 I'll mark as Exhibit C to the deposition and ask you
17 if you can identify that.
18 A Yes, I can. This is what we received in
19 orientation.
20 Q If you would turn to the section for
21 Hospital Discharges and Non-Emergency Transports,
22 please, and read Item Number 12. It's on the next
23 page.
24 A What section was that, I'm sorry?
25 Q Item Number 12.

1 A Okay. On non-emergency and hospital
2 discharges, never write patient ambulated to
3 stretcher or patient was sitting in wheelchair.
4 While this may be pertinent information on scene
5 before a trip to the ER it is immaterial information
6 on other types of transports.
7 Q Why would you be told not to write those
8 types of findings?
9 A Basically so they can bill Medicare and
10 actually get payment for this call.
11 Q If such a finding is included on your run
12 report, would it disqualify the run for Medicare
13 reimbursement, in your understanding?
14 A Yes.
15 Q Have you had occasion to transport
16 dialysis patients?
17 A Yes.
18 Q And would those transports take place by
19 your ambulance rather than by a wheelchair van, for
20 instance?
21 A Yes.
22 Q In your experience in transporting those
23 patients by ambulance, approximately how many or
24 what percentage of those patients can, in fact, walk
25 to the ambulance?

1 A Probably about 50 percent.
2 Q If you write that they ambulated to the
3 ambulance, will you be required to change that
4 report by the management at Liberty?
5 A Yes.
6 Q Are you instructed by Liberty personnel
7 not to write that they've ambulated or walked to the
8 ambulance?
9 A Yes.
10 Q Do you omit that finding on your reports?
11 A No, I don't. I will not do that.
12 Q And if you write it, are your reports
13 altered for billing purposes?
14 A That I have no idea of. Once I turn them
15 in, I never see them again unless --
16 Q Have you been required to alter them in
17 the past when you first started?
18 A Yes.
19 Q Have you stopped doing that?
20 A Yes.
21 Q Okay. Are you currently working for
22 Liberty?
23 A Yes.
24 Q Do you know whether or not Liberty is
25 currently altering run reports so that they get paid

1 by Medicare?
2 A That, I do not know.
3 Q Do you have any reason to believe or
4 suspect that the practice has ceased, during your
5 tenure, of altering run reports?
6 A I'm not sure.
7 MR. BREW: Okay. Mr. Brown, I appreciate
8 your time. I don't believe I have any further
9 questions at this time.
10 THE WITNESS: Okay.
11 MR. BREW: Thank you for your cooperation.
12 THE WITNESS: You're welcome.
13 (Whereupon, at 11:55 a.m., the statement
14 was concluded.)
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3 CERTIFICATE OF OATH
4
5 STATE OF FLORIDA)
6 COUNTY OF DUVAL)
7 I, the undersigned authority, certify that
8 ROBERT BRIAN BROWN personally appeared before me and
9 was duly sworn.
10
11 WITNESS my hand and official seal this 2nd day
12 of February 2011.
13
14 Marianne Branson
15
16 MARIANNE BRANSON
Commission # DD 948085
Expires January 25, 2014
Bonded Thru Troy Fain Insurance 800-385-7019
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1
2 C E R T I F I C A T E
3
STATE OF FLORIDA)
4
COUNTY OF DUVAL)
5
I, Marianne Branson, RPR-CP, certify that I was
6
authorized to and did stenographically report the
7
statement of ROBERT BRIAN BROWN and that the
8
transcript is a true and complete record of my
9
stenographic notes.
10
I further certify that I am not a relative,
11
employee, attorney, or counsel of any of the
12
parties, nor am I a relative or employee of any of
13
the parties' attorney or counsel connected with
14
the action, nor am I financially interested in the
15
action.
16
Dated this 2nd day of February 2011.
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21
Marianne Branson, RPR-CP
Court Reporter
22
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EXHIBIT E

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4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
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9 SWORN STATEMENT OF
10 AMANDA STRICKLAND
11
12 DATE TAKEN: January 16, 2011
13 TIME: 12:27 p.m.
14 PLACE: 6817 Southpoint Parkway
15 Suite 1804
Jacksonville, FL 32216
16
17 PRESENT: George K. Brew, Esquire
18 REPORTED BY: Marianne Branson, RPR
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1 AMANDA STRICKLAND,
2 having been produced and first duly sworn as a
3 witness, testified as follows:
4 EXAMINATION
5 BY MR. BREW:
6 Q Ms. Strickland, would you please tell us
7 your full name?
8 A Amanda Strickland.
9 Q Where do you currently reside?
10 A [redacted]
11 Q All right. Let me show you Exhibit A. Is
12 this a true and accurate copy of your driver's
13 license?
14 A Yes.
15 MR. BREW: Okay. We'll mark that as
16 Exhibit A to your statement.
17 (Exhibit A was marked for identification.)
18 BY MR. BREW:
19 Q Ma'am, are you currently employed?
20 A Yes.
21 Q Where are you employed?
22 A Southeast Georgia Health System.
23 Q And what do you do for that health system?
24 A I am a patient care assistant.
25 Q Okay. And how long have you been employed

1 there?
2 A About six months.
3 Q Okay. And prior to then or there, where
4 were you employed?
5 A Liberty Ambulance Service.
6 Q How long did you work at Liberty?
7 A I left on the anniversary of my seventh
8 year.
9 Q What were your duties and responsibilities
10 at Liberty?
11 A I was an EMT, and I also was dispatch
12 supervisor.
13 Q As an EMT did you work as an ambulance
14 driver or --
15 A Ambulance driver, patient care, worked in
16 the field, did that for about a year, and then got
17 moved -- or wanted to cross-train into dispatch, and
18 then so I flopped and did dispatch and did in the
19 field as well.
20 Q And did that -- was that your duties and
21 responsibilities throughout your tenure there?
22 A Yes.
23 Q Okay. Were you ever just full-time
24 dispatch?
25 A Yes. I -- after the birth of my first

1 child, which was in 2001, I went to dispatch full
2 time and was dispatch supervisor full time up until
3 2009.
4 Q What was your reason for leaving Liberty?
5 A I was terminated. The actual reason for
6 termination I still don't really know. I was having
7 issues with Jim Timmer, who is basically second in
8 charge, and I was having issues with him with
9 derogatory comments towards me and his demeanor and
10 his attitude and his temper.
11 And we had an ongoing thing to where we
12 would, you know, pick at each other back and forth,
13 but it got to a point to where when he would come in
14 in the morning he would make derogatory comments
15 towards me.
16 For example, if we were having a bad
17 morning, we didn't have enough trucks, the stress
18 level was high, and I wasn't very talkative because
19 I was busy getting my job done, he'd come in and
20 say: Did your husband not knock you around hard
21 enough last night? Come to my office and I'll knock
22 you around a little bit and get you back on track.
23 You're being extremely bitchy today. What's wrong
24 with you today?
25 And it got to a point to where every time

1 that he spoke to me it was in that demeanor. And I
2 went to Michael Assaf, who was the owner of the
3 company, and made several complaints against him on
4 it. And nothing was ever done. Or Jim would, you
5 know, not talk to me for a couple of days, but then
6 it would start right back up.
7 At the very end of my employment there, I
8 went to Michael on a Friday and told him that I'd
9 had it, that either Jim needed to stop or I was
10 going to have -- something was going to have to be
11 done because I couldn't handle it anymore.
12 And that Monday I come in at 9:00, and Jim
13 called me on my phone and said, Come to my office,
14 and was told to go home.
15 Q Let me ask you about your duties and
16 responsibilities as a dispatcher. Tell us about
17 them.
18 A As dispatcher you're responsible for
19 taking in the phone calls and then dispatching the
20 units, getting all the billing information that's
21 needed for the transportation, responsible for
22 making sure that what's coming in is payable, what's
23 going out is payable, speaking to the case managers
24 and to the nursing homes, and at that nature to get
25 transportation done, set up doctors' appointment

1 transportation, dialysis transportation, and
2 basically deal with the crew members one on one.
3 The first person they see is dispatch; that's who
4 they deal with mainly. That's what your duties are
5 as dispatcher.
6 Q On an average day at Liberty, were there
7 other dispatchers other than yourself?
8 A During the day there's two dispatchers, up
9 until 11:00 p.m. And then at 11:00 p.m. there's one
10 dispatcher until 7:00 a.m. Then you start with two
11 dispatchers in the morning.
12 Q Are there other office personnel at the
13 office itself other than the dispatchers?
14 A Yes. All of administration is in the same
15 building, and the billing department is in the same
16 building.
17 Q All right. Let's start from the top
18 down. Describe to me who are the personnel at
19 Liberty on average when you left there that would be
20 in the main office.
21 A Michael Assaf, Jim Timmer, Clint Randolph,
22 Dwayne Perkins, Lisa Assaf, Barbara Manning, Kaylie
23 Assaf. Those are basically the administration
24 people. Billing was Wynn Hale (phonetic), Frances,
25 Georgette, and Terry.

1 Q Do you know their last names?
2 A Terry's last name is Bass. Frances is
3 Drummond, and Georgette Meadows, yeah. And Wynn
4 Hale.
5 Q How much time at your tenure at Liberty
6 were you a dispatcher as opposed to a driver or EMT?
7 A I was more of a dispatcher than I was a
8 driver, patient care. When I went in to be cross-
9 trained, I guess I picked it up very quickly and was
10 good at it, so they'd rather have me in dispatch to
11 be useful in dispatch than on a truck, because they
12 were hurting for people in dispatch.
13 Turnover rate in dispatch is extremely
14 high, so they needed somebody in there that could do
15 it.
16 And for the longest time, it was only me
17 in there during the day, and it got so busy to where
18 we had to put two people in there.
19 So I would -- I had way more time in
20 dispatch than I did in the field. I would -- if
21 there wasn't enough manpower on the roads and I was
22 qualified -- I'm qualified to be on the road. If
23 something had to get done, I would jump on a truck,
24 get that run done, and go back into dispatch.
25 Q On an average day, how many units would

1 Liberty have in the field?
2 A When I left there were, I believe, 15
3 trucks on the road, and four or five wheelchair vans
4 on the road.
5 Q For a total of 19?
6 A Uh-huh.
7 Q You have to answer out loud --
8 A Yes.
9 Q -- for the court reporter.
10 A Uh-huh.
11 Q All right. Were you ever familiar or
12 involved in the billing process for Liberty's runs?
13 A Yes.
14 Q And what aspects were you involved in
15 billing?
16 A When I first started in the dispatch
17 before they -- they got a new computer system. But
18 before they got the new computer system, dispatch
19 was responsible for breaking down the run sheets and
20 for inputting the runs into the computer.
21 I did that -- I believe in 2000 is when
22 they converted to the new system, and dispatch --
23 because they had not upgraded the dispatch system,
24 dispatch and billing were then two different
25 computer systems. So billing started doing the

1 breaking down of the run sheets and putting all them
2 into the computer.
3 I became very familiar with what was
4 payable by Medicare and Medicaid and commercial
5 insurances, what wasn't payable, what needed
6 authorizations, that sort of thing with the
7 transportation.
8 So that's what I did with the billing was
9 when they would call me, this is payable, not
10 payable, you need to get authorization, and so on.
11 You need a certificate of medical necessity or
12 whatever paperwork they needed to get it paid, or
13 what they needed to do to get it paid.
14 Q When you say "they," are you meaning the
15 drivers and the people who were operating the units?
16 A Who -- when the caller would call me,
17 mainly hospitals, the case manager, nursing homes,
18 it's usually the charge nurse or whoever, they would
19 call and I would say: You need to -- this is not
20 payable, but if you do this you can get it paid.
21 Or if it's Blue Cross and Blue Shield,
22 well, you have to have an authorization number for
23 that. And then the same with the crews. They would
24 call and say: Well, how are we getting this paid?
25 Well, you need to get the form filled out. This is

1 how you get it paid, and so on.
2 Q Were there criteria that you were aware of
3 which if they existed would result in the bill not
4 getting paid for a particular patient?
5 A Oh, yeah. There was -- I mean with being
6 in the field, with knowing what was payable and
7 wasn't payable, if a crew called and said --
8 Q Let me ask you a more specific question.
9 What types of criteria were necessary in order to
10 get reimbursed for Medicare, for instance?
11 A For Medicare they would have to be in a
12 constricted position, meaning they could not bend
13 their legs out, they couldn't sit in a chair, so to
14 speak. They would have to stay laying down in a
15 constricted position; they would have an altered
16 mental status, or they would have to basically be a
17 threat to themself.
18 They couldn't -- oxygen used to be a
19 criteria for Medicare to pay, but it -- we didn't go
20 with oxygen a lot because oxygen is portable, and
21 anyone can basically get oxygen. It doesn't have to
22 be on a rescue to have oxygen. Those are some of
23 the big ones.
24 Or patient is able to walk, or patient is
25 able to stand up from a wheelchair; that's not

1 payable.
2 Basically patient had to be completely bed
3 bound and require medical supervision.
4 Q How would Liberty bill for a run if the
5 patient did not meet the criteria for billing? Say
6 if the patient was ambulatory and walked to the
7 unit, how would they bill that?
8 A They would get a certificate of medical
9 necessity filled out by the nurse or -- because it
10 either had to be signed by the nurse or by the
11 physician.
12 And I would tell the nurse, or whoever the
13 caller was at that time at the hospital, if they
14 meet one of these things on the certificate of
15 medical necessity, then they'll qualify for
16 Medicare.
17 And if they would say: Well, they don't
18 have any of those, well, dig a little deeper, see
19 what their medical history is. If they are -- if
20 they have a history of dementia, then put they have
21 a mental status change to get it paid.
22 If crews called and said: This patient is
23 up walking around his room, what am I putting on my
24 run sheet? Just put that you found the patient
25 laying there and that you just transferred the

1 patient over to the stretcher. Don't put all the
2 other information.
3 Q Essentially you would tell them to omit
4 positive findings?
5 A Oh, yeah. Whatever got that run sheet
6 paid is what you put on that run sheet.
7 Q And is that what you were taught by
8 management --
9 A Yes.
10 Q -- at Liberty?
11 A Yes. Whatever got that run paid is what
12 we were told. Because basically at Liberty, if we
13 weren't doing runs and we weren't getting billing
14 done, we weren't getting a paycheck.
15 Q What do you mean by that? You wouldn't
16 get paid?
17 A There had been many a times to where we
18 would get paid on a Friday and our checks would
19 bounce. And there was several people that would
20 come in on a Monday and say: My check bounced.
21 And it was because they didn't have the
22 money in the account at the time, or there was
23 always some underlying reason as to why it didn't
24 get done, but -- and management never actually told
25 you what the reason was, but me being behind the

1 lines and being in dispatch and being involved with
2 the administration and being in the same building,
3 you knew it was because they were not getting the
4 runs out fast enough because they were trying to
5 find probable cause for the transport or whatever.
6 So it got to the point to where you knew
7 what was payable and you knew that you'd get paid.
8 So that's where we --
9 Q Why wouldn't the money for the paychecks
10 be in the accounts, though?
11 A Not sure. Because I -- there had been
12 several incidents to where you would -- I would be
13 told, well, you know, Medicare is supposed to pay on
14 this day but they didn't pay in time for us to get
15 our paychecks, or, you know, they didn't get their
16 deposits in fast enough.
17 Q Were employees ever required to falsify
18 the run reports in order to make the patient qualify
19 for Medicare reimbursement?
20 A Yes.
21 Q Okay. Tell us about that.
22 A If you walk into a patient's room and you
23 find the patient sitting in a wheelchair, which
24 is -- Medicare guidelines are if a patient can sit
25 in a wheelchair, Medicare doesn't pay for wheelchair

1 service; they can go by wheelchair, not ambulance.
2 We would tell them: Don't put that you
3 found the patient sitting in a wheelchair. All you
4 needed to say was: Patient was found laying in bed
5 and you transferred patient over to stretcher.
6 You never put in the run sheet that the
7 patient was, you know, sitting up in the bed. The
8 patient was always laying in the bed. And you would
9 make sure that you dug up enough history of that
10 patient's medical history to put into your run sheet
11 to make it payable.
12 Because dementia, like I said, the altered
13 mental status, that type of stuff, if you put that
14 in there as a current, then they'll pay it. So
15 that's what we would have the crews do.
16 Q Are you saying or testifying that they
17 would falsify the current condition by utilizing the
18 past medical history?
19 A Yes.
20 Q Would they be reporting the past medical
21 history as current medical history?
22 A Yes.
23 Q Even though that wasn't true?
24 A Exactly. And the way that they word it
25 into the narrative of a run sheet, it doesn't make

1 it look that way. They just basically say: Patient
2 has a history of whatever the history was to make it
3 payable, and this is what the patient is in the
4 emergency -- or in the hospital for.
5 They wouldn't so much say, you know, seven
6 years ago the patient had this. The way that we had
7 them write it made it look like that that's what
8 they were in the hospital for at that given time.
9 Q Were there supervisors or management at
10 Liberty that created and enforced such a policy of
11 falsification?
12 A Basically, for my knowledge, the way that
13 it all came about is during orientation all the
14 employees are given an orientation pamphlet, and
15 during orientation they were verbally told how to
16 write their run sheets.
17 (Exhibit B was marked for identification.)
18 BY MR. BREW:
19 Q Let me pause you for a moment and ask you
20 if you can identify what I'll mark as Exhibit B to
21 your statement.
22 A Yes.
23 Q What is Exhibit B?
24 A This is the training manual for new
25 employees.

1 Q Who would conduct the training sessions
2 for new employees on behalf of Liberty?
3 A Several members of administration did
4 orientation. It was set up in blocks. Barbara
5 Manning always did the human resources part for
6 benefits and payroll and so forth.
7 This -- the training, the run sheets, is
8 done by Jimmy Barefoot. He was the captain at
9 Liberty Ambulance Service. If Jimmy is not
10 available to do it, then Clint Randolph does it.
11 Majority of the orientation class is taught by Clint
12 Randolph.
13 Q What is Mr. Randolph's position with the
14 company?
15 A I believe when I left, his position was
16 basically safety officer and training. He had been
17 demoted several times because of Jim. But I believe
18 that's what his current position was when I left was
19 training officer and safety officer.
20 Q Let me ask you to turn to a section of
21 Exhibit B that starts out, Get a face sheet,
22 Hospital Discharges and Non-Emergency Transports.
23 It's about seven or eight pages in. Do you see
24 that?
25 A Uh-huh. Yes, sir.

1 Q All right. Would you turn to the second
2 page, Item 12, and would you read that for us,
3 please?
4 A The reason why patient was bed confined?
5 Q Item 12 is on the --
6 A On Non-Emergency and hospital discharges,
7 never write patient ambulated to stretcher or
8 patient was sitting in wheelchair.
9 Q Why would a crew member never write that
10 on a run report?
11 A Because if they wrote that on a run report
12 and Medicare seen that, it would not be payable,
13 because that means the patient was able to go by a
14 private vehicle or by a wheelchair van or nonmedical
15 stretcher, which is not payable by Medicare.
16 Q Do you have any personal knowledge of
17 management at Liberty requiring run reports to be
18 altered so that that information did not appear in
19 the run report?
20 A Yes. I am -- I was the person that made
21 the crews do that. We had a thing --
22 Q Did anyone direct you to do it?
23 A Yes. Billing. And it would come from
24 upper management. You did not get your paycheck
25 unless you fixed your run sheet to make it payable.

1 Q So describe for me how that would come
2 down the chain of command to you.
3 A On Fridays, payday Fridays, I was given a
4 red folder, which is called the kickback folder, and
5 in there is a set of run sheets from several crew
6 members that did not meet the guidelines for
7 payable, whether it be signature, or they had put
8 information in there that needed to be omitted, or
9 they didn't put enough information in there to make
10 it payable, or some of that nature.
11 What I would do was put the paycheck of
12 that crew member with that run sheet, and that crew
13 member would have to either rewrite the run sheet
14 and add information into the narrative, or would
15 omit information from the narrative to make it
16 payable. And then they would get their paycheck
17 once I received my corrected run sheet.
18 Q How would you omit information from an
19 existing run sheet? Would you redo it over?
20 A Yes. They would rewrite it and just not
21 put that information in there.
22 Q What would you do with the original run
23 sheet?
24 A It was shredded.
25 Q And who would do the shredding?

1 A Billing.
2 Q The billing. So someone in the billing
3 department would shred the original?
4 A I would give -- Wynn is the one who I
5 always dealt with. The other three girls, you never
6 really dealt with them. I don't know exactly what
7 their duties were.
8 Wynn was the one that was kind of like the
9 billing manager, so to speak. I would give her the
10 corrected run sheet, and I would give her the run
11 sheet that had to be corrected, so the old one and
12 the new one. And what she did with them after that
13 is -- I mean I know that I've seen her shred the run
14 sheets, but I don't know that she shredded all the
15 run sheets. I know I'd give her the stuff, and what
16 she did with it after that is beyond me.
17 Q And how often would that take place,
18 falsifying run sheets?
19 A Oh, that was an every -- every payday
20 thing. Every payday I would have at least 30
21 kickback run sheets on a given day. Any -- there
22 was never a payday Friday that I did not have
23 kickback run sheets.
24 Q Of the kickback run sheets, how many in
25 your knowledge were outright fraudulently completed

1 or amended?
2 A I would say out of the -- if there was 30,
3 I would say at least 15 of them were because they
4 were nonpayable or there wasn't any information.
5 The others were because one of the partners didn't
6 sign it or -- it was signature issues; there needed
7 to be another signature on the run sheet.
8 Those two -- that's the only thing that
9 was ever on a kickback folder was either a signature
10 or it was not payable or the run sheet needed to be
11 fixed.
12 Q Did you ever have a driver or EMT
13 personnel that worked in the field that was just
14 eventually fired for not falsifying reports?
15 A Liberty never made it -- administration
16 never made it to where they were fired because of
17 that. What they would do is, say you had an
18 employee that was giving me a hard time and was
19 giving administering a hard time and billing a hard
20 time about this is not -- you know, they were
21 following their guidelines and their rules, and they
22 knew what was right and what was wrong, and they
23 were not doing it the Liberty way, what Liberty
24 would do was just cut their hours.
25 Because our pay -- the schedules were done

1 on a weekly basis, and you signed up on the schedule
2 as you were available, and they just wouldn't put
3 that person on the schedule.
4 Or they would put that person on the
5 schedule with somebody that could not drive or
6 something so that that employee did not write the
7 run sheets because he would have to be driving.
8 So they always made it to where if there
9 was a conflict with somebody, they basically just
10 made sure that they didn't have to deal with that
11 because they would find something else for that
12 person to do, regardless of if it was just not
13 having him do patient care or if they just didn't
14 schedule him.
15 And then eventually the employee leaves
16 because he's not getting his hours, or he knows that
17 this is why he's always put with somebody that can't
18 drive, and so eventually they just leave.
19 Liberty never just blatantly out said:
20 You're fired because you didn't write the run sheet
21 the way I wanted it. They always had an underlying
22 way of doing it.
23 Q Was the most prevalent way of providing a
24 run sheet that would be -- would get reimbursed from
25 Medicare through simply omitting positive findings

1 that would disqualify the patient?
2 A Yes.
3 (Exhibit C was marked for identification.)
4 BY MR. BREW:
5 Q Okay. Let me show you what I'm going to
6 mark as Exhibit C to your statement and ask you if
7 you've ever seen that document before.
8 A No, I haven't seen this document. This
9 document was posted after I left.
10 Q Okay. Thank you. I'll just mark that,
11 then.
12 A I mean that's not to say that -- I haven't
13 seen that one, but those type of memos were posted
14 all the time.
15 Q When you say this type of memos, can you
16 describe that for us?
17 A The memo posting stating of when -- how to
18 write your run sheet, basically, what your history
19 is, what your findings are, what you need to put in
20 your run sheet, what you don't need to put in your
21 run sheet. Those type of memos were posted on a
22 daily basis.
23 Q Number 5 of Exhibit C states: Omit all
24 positive findings, parenthesis, just don't write
25 them, closed parenthesis. Was that something that

1 was told to all the drivers --
2 A Yes.
3 Q -- during your tenure at Liberty?
4 A Yes. The employees would call me on the
5 phone from the hospital and say: What am I putting
6 this patient -- what am I putting to get this paid?
7 Just put whatever you have to put to get it paid.
8 Well, I found this patient walking.
9 Don't put that in there. And that's what
10 we were -- that's how it happened. That's what we
11 would tell them: Just don't put it in there.
12 One of Liberty's big things are dialysis
13 patients, and I was, I guess you'd say, the
14 coordinator for the dialysis patients. And Medicare
15 pays for dialysis transports if you meet the
16 requirements.
17 Q What are the requirements, in your
18 understanding?
19 A You have to be completely bed bound,
20 unable to sit or stand for a long period of time.
21 Those are the two big ones. Most of the dialysis
22 patients that we transported did not need BLS
23 transportation, but because they were --
24 Q What do you mean by BLS?
25 A Basic life support. They did not need

1 a -- basically they did not need medical supervision
2 for transportation. They could get in their private
3 vehicle and go to dialysis. And --
4 Q Why were they being transported by
5 ambulance, then, in your understanding?
6 A Because they were $46,000 a year. And if
7 it was payable, it was payable.
8 Q What do you mean by -- how did you come up
9 with the number 46,000 a year?
10 A Because Jim, we used to call him the money
11 man, because --
12 Q What is his last name?
13 A Timmer.
14 Q Okay.
15 A Whenever I would go to him with a dialysis
16 patient and say the crew was calling numerous times
17 saying Mr. So-and-so is -- this patient is getting
18 from our ambulance, from our stretcher, walking off
19 of our stretcher into a van and going grocery
20 shopping. And the crew would call and tell me this
21 numerous times about this one patient.
22 And I would go to Jim Timmer each and
23 every time and say: Mr. So-and-so is not meeting
24 Medicare qualifications. He's -- the crew was
25 literally letting him -- opening the back door and

1 saying: Okay, there you go, and he's getting into
2 his personal van and driving away. He doesn't meet
3 the requirements.
4 Oh, well, I'll have Clint go out there and
5 look at him, is what I was always told.
6 And if a patient -- if a dialysis patient
7 was to pass away, he would always say: Well, there
8 goes $46,000. Because I'm assuming that he had
9 added up the figures of what it was, each transport,
10 and that's what the number he came up with.
11 So we -- the joke in dispatch was, well,
12 there goes a $46,000 patient. So that's where that
13 came from, is because he would always tell us:
14 Well, Hospice -- or dialysis patients make us an
15 average of $46,000 a year.
16 Q All right.
17 A Or there would be dialysis patients to
18 where the family would call me and say: My mother
19 needs to go to the urologist, but she also has
20 dialysis the same day.
21 Now, Medicare doesn't pay for a patient to
22 go from home to a doctor's office, to a urologist;
23 they're not going to pay for that. So we would take
24 the -- I would arrange somehow to get that patient
25 from home to dialysis, and then Medicare requires

1 you to do -- we call them leg trips, patient -- if
2 we did Leg 1, we had to do Leg 2 unless the patient
3 was going to the emergency room or so on.
4 So if that patient had that doctor's
5 appointment, we would make sure that the patient got
6 to dialysis and back from dialysis in time enough to
7 make the doctor's appointment, if it was -- whether
8 calling dialysis and saying: So-and-so has a
9 doctor's appointment; can you see them earlier?
10 And I would go to Jim and say: If this
11 patient's family can take her to the urology
12 appointment, why can't they take her to dialysis?
13 If she meets the requirements for -- she doesn't
14 meet the requirements if she's going from, you know,
15 home to dialysis and back and forth. If they can
16 take her, then she doesn't meet the requirements.
17 And it would just get brushed under the
18 rug: Oh, just don't worry about it. Just take her.
19 Q Now, in those instances, what would the
20 run report indicate as a medical necessity for
21 transporting by ambulance?
22 A For dialysis patients, what I did was I
23 would get a current face sheet with the medical
24 history on the patient. Numerous trucks' run books
25 would have a face sheet for each one of the patients

1 that they were transporting for dialysis, because
2 they were frequent -- I mean they went every third
3 day, and you knew you were transporting them every
4 third day.
5 So I -- they would put the face sheet in
6 their run book so that they could go back and see
7 what their past medical history was to see what
8 would be payable, and that's how they would write
9 their run sheets up.
10 And if you were to ever pull the run
11 sheets for dialysis patients, every single one of
12 them are going to say the same thing every day,
13 because it never changes. And that -- they would
14 just -- each crew member would just -- they'd get
15 familiar with that patient and they would know what
16 the medical history was on that patient, and they
17 would -- I've had crew members who would prewrite
18 the run sheet and already know what they're going to
19 write in there before they even get the patient,
20 because they had transported them so much and that
21 this is what they're going to put to make it
22 payable. That's what they would do to get it
23 payable.
24 For the urology appointment, we never
25 dealt with that one. There were times where -- we

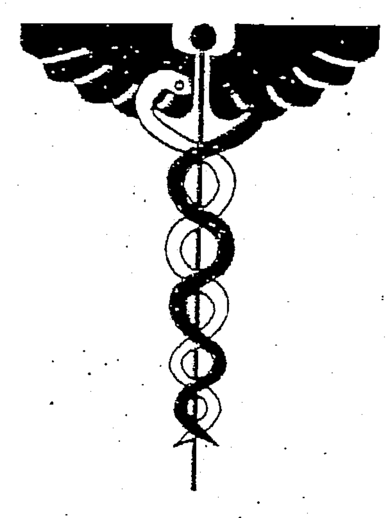
1 had a nonmedical stretcher rate, which is we used to
2 call it NES, nonemergency stretcher, and it -- the
3 family would have to pay for that. So if we were
4 to -- we would take the patient home, then we would
5 start another run sheet on a different -- it's not a
6 state form, it's a private form, and they would just
7 write that form out and the family would pay for
8 that transportation, is how they would do it.
9 Q I'm not sure I quite understand what you
10 mean, you'd write out the -- how would the family
11 get paid?
12 A Well, the family would pay Liberty.
13 Q All right.
14 A They would -- the BLS form and the NES
15 form are two different forms. The BLS form is a
16 state form, and the NES form is a form that we typed
17 up.
18 Q What does NES stand for, nonemergency
19 services?
20 A Nonemergency stretcher.
21 Q Got you.
22 A Or nonmedical stretcher. They don't meet
23 BLS requirements, Medicare requirements, so the
24 family has to pick up the bill. So it would go on a
25 different form; you didn't have to write a

1 narrative. You didn't have to write any vital
2 signs, nothing. All you would have to put on the
3 form is where you picked them up from, where you
4 took them, and the mileage, and the family would be
5 responsible for that bill.
6 Q Do you have any idea approximately what
7 percentage of your dialysis patients would be billed
8 to Medicare even though they didn't qualify?
9 A I would have to say, in a given week, if I
10 had -- I had probably about 25 patients when I left,
11 and I would say probably 20 of those did not meet
12 the requirements. I mean there were some legit
13 patients that did meet the requirements, but a
14 majority of them did not meet the requirements.
15 Or they met the requirements when we first
16 started taking them, but they got better but we
17 never stopped taking them; we just continued to take
18 them.
19 MR. BREW: All right. Let's take a break
20 for a moment.
21 (Brief recess 1:02 p.m. through 1:04 p.m.)
22 MR. BREW: Ms. Strickland, I appreciate
23 your cooperation. I don't have any further
24 questions at this time. Thank you for coming
25 in.

1 THE WITNESS: No problem. Thank you.
2 (Whereupon, at 1:05 p.m., the statement
3 was concluded.)
4 - - -
5
6
7
CERTIFICATE OF OATH
8
9
STATE OF FLORIDA)
10
COUNTY OF DUVAL)
11
I, the undersigned authority, certify that
12
AMANDA STRICKLAND personally appeared before me and
13
was duly sworn.
14
15
WITNESS my hand and official seal this 2nd day
16
of February 2011.
17
18
Marianne Branson
19
20
MARIANNE BRANSON
Commission # DD 948085
Expires January 25, 2014
Bonded Thru Troy Fain Insurance 800-385-7019
21
22
23
24
25

1
2 C E R T I F I C A T E
3
4 STATE OF FLORIDA)
5 COUNTY OF DUVAL)
6 I, Marianne Branson, RPR-CP, certify that I was
7 authorized to and did stenographically report the
8 statement of AMANDA STRICKLAND and that the
9 transcript is a true and complete record of my
10 stenographic notes.
11 I further certify that I am not a relative,
12 employee, attorney, or counsel of any of the
13 parties, nor am I a relative or employee of any of
14 the parties' attorney or counsel connected with
15 the action, nor am I financially interested in the
16 action.
17 Dated this 2nd day of February 2011.
18
19
20
21 Marianne Branson, RPR-CP
Court Reporter
22
23
24
25

EXHIBIT F



Liberty Ambulance Service Run Report Training Course

RELATIONSHIP BETWEEN OPERATIONS AND THE BUSINESS OFFICE

Throughout the ambulance industry, there are often complaints by the operations staff that the billing office does not understand the problems encountered in the field. The billing office personnel often feel that the crews have a lot of free time on their hands and could do a better job in getting information. Both sides are correct up to a point.

Both the operations department and the billing office need each other. Operations cannot upgrade their equipment and get new ambulances if the billing office can't collect on the transports. The billing office can't get the carriers to reimburse the claim if they don't have the necessary information. Neither side can justify pay raises without income from the service.

The most efficient ambulance services are those where each department has a clear understanding of each other's role in keeping the company stable, and create an atmosphere of mutual respect and cooperation.

RUN REPORTS
What needs to be included?

Writing run report narratives for non-emergency transports is among the hardest tasks paramedics and EMT's are required to do outside of saving * lives. As Medicare requirements get increasingly stricter, more focus is being placed on field personnel to supply the necessary information for the billing office to accurately bill claims and get reimbursed. (The burden is now on you to meet medical necessity requirements and document WHY the particular service is needed.) Ambulance providers must paint a picture of why a patient could not have safely been transported by other means without endangering their health.

* Medical Necessity is Supposed to be Established Before TXP! Crew is to ensure it's accurate!

1. **<u>Reason patient is being taken to the hospital</u>**

Why reason for stretcher????

a. Very few crews have problems identifying why their patient need to go to the hospital. Remember to fully explain the nature of the call as it was dispatched, the patients complaints, and the crews assessment.

b. Fully document any treatment given.

1. Splinting without the normal use of splint board, be sure to explain what you used (ie-pillow, sand bags, etc).
2. If you start an IV, be sure to document the site of the Iv and the drip flow rate. If you increase or decrease the rate, document why. Document how the patient is responding.
3. If you administer drugs, explain whether you put it down an ET tube, injected it through Iv port, or injected it into an arm.

Remember the billing office does not know what you did or witnessed in the field and they are called upon by the insurance carrier to explain the events. They have to rely on your narrative to deliver these explanations.

2. **<u>Reason patient is being discharged from the hospital</u>**
   <u>WHY BED BOUND!</u>

a. Document exactly **<u>WHY</u>** this patient could only have traveled by an ambulance. Define bed confined!!!

b. If an ambulance was dispatched but there was no patient transport, explain why!

As example. the following reasons, or combinations thereof are not sufficient to justify ambulance transport: (Some of these reasons were taken from actual claims for transport from the hospital to a nursing facility or residence.)

1. Debilitating weakness due to old age
2. Altered level of consciousness
3. Reactive confusion
4. Contractures (no location or severity shown)
5. Decubitus Ulcer
6. Senile dementia
7. Organic brain syndrome.
8. Alzheimers disease

BED CONFINDED

Defination per HCFA.
Inability to ambulate even with assistance of another person, walker, cane or wheel chair or unable to transfer from bed to chair.

The fact that a definition of bed-confined has been noted does not suggest that bed-confinment is the sole determinant of medical necessity nor does it relieve the supplier of the responsibility to submit information supporting the reason for a bed-confinded determination.

Furthermore, bed-confined does not mean that the patient needs "assistance into the ambulance" or "stays in bed most of the time." It means "before" and "after" the ambulance trip. A patient may only be considered "bedridden" or "bed confined" when they meet the three conditions noted above.

* The term "non-ambulatory" does NOT qualify a beneficiary for Medicare covered transportation. If a beneficiary can sit up and there are no emergency circumstances or situations which are at issue, they do not quality for Medicare covered transportation. *

Note: Using "bed confined" on a claim as a medical reason for coverage when the beneficiary is not bed confined is considered falsification and could result in exlusion from the Medicare program and/or referral to the Ofice of the Inspector General for investigation. Criminal and/or Civil prosecution may also result.

ON ALL RUN REPORTS

1. FULLY DESCRIBE PHYSICAL CONDITION OF THE PATIENT
   a. Was the patient bed confined? What caused the condition (ie, CVA residuals - Advanced Alzheimer's) → NOT A QUALIFIER BY PREVIOUS PAGE
   b. Contractures? Where? (all four extremeties (fetal) Upper - Lower)
   c. Does the patients skin tear easily?
   d. Is the patient frail and emaciated? Wasted appearance?
   e. Is the patient experiencing muscle tremors?
   f. Does the patient constantly grab at tubes (foley - Peg -etc)?
   g. Does the patient require posey restraints? Why? (only use "restraint" bubble if posey vest or wrist restarints are used, NOT the stretcher straps.)
   h. Is patient post hip replacement? Do they have foam wedge?
   i. Is the patient paraplegia? Quadriplegia? Hemiplegic? WHY?
   j. Are any decubistus ulcers present. Document the site of ulcer.
   k. Is this a Hospice patient? Document pt is suffering from ______ (Hospice charts are always pre-made before a patient is admitted, so a face sheet with diagnosis is always available to you.)
   l. Is the patient status post surgery? TYPE OF SURGERY? BUT DON'T INCLUDE DATE, of Surgery! IE ·1985

2. FULLY DESCRIBE THE PATIENT'S MENTAL CONDITION
   a. Do not use "A & O x1 or 2 as per norm" Fully describe what the patient is oriented to (ie - patient oriented to name only, patient oriented to pain stimuli only)
   b. If the patient groans when moved, describe it. If the patient mumbles incoherently, describe it.

3. PAST MEDICAL HISTORY
   Include everything you can about the patient's past history. This can often substantiate the reasons why the patient's physical and mental description are deteriorated. Important factors are Alzheimer's, Parkinson's, COPD, severe cardiac problems, residuals from multiy CVA's, dementia and OBS.

4. CHIEF COMPLAINT
   Alerts billing to things to watch for when reading the narrative.

5. VITAL SIGNS OF THE PATIENT

Whenever the patient's vital signs are well outside the normal ranges, that can be used to document and support the patients current condition. For instance, a patient with a BGL 30 is going to be exhibiting a number of other symptoms and will require treatment by the paramedic to bring their blood sugar up. A patient with a BLG 210/150 is generally having a serious problem. If this is compounded by a history of cardiac problems, it becomes more dangerous.

6. TREATMENT RENDERED TO PATIENT ENROUTE

Crews will render treatment to the patient based on their initial assessment of the patient's condition. These can encompass a number of conditions that a biller needs to be alerted to. A few of these are:

a. Crew decided that it is necessary to put the patient on oxygen. Why was it necessary (ie,rales or ronchi heard in the lungs.)

b. The crew may; also render a breathing treatment.

c. The patient has a pulse oximeter reading of 80. This will cause the crew to use more oxygen (remember 15 liters is the maximum) in order to bring up the O2 saturation.

d. The patient has severe chest pain and the crew uses nitroglycerin tablets or spray to try to ease the pain.

e. If the crew puts the patient on an EKG, watch for the findings the crew interpreted. Forced to do EKG even IF NOT WARRANTED!

ALL OF THESE TREATMENTS HELP TO GET A CLAIM PAID - IF IT DOCUMENTED

7. AMBULATORY STATUS OF THE PATIENT

There are pertinent facts to watch for and utilize when billing * Medicare. The regulations specifcally state that the patient must have a medical condition that requires transport by ambulance or is bed confined to the extent that they cannot safely be transported by another mode of transportation. The following are some of the things to watch for:

a. The patient is completely bed confined due to a specific condition and cannot ambulate at all, even with assistance.

1. Obvious decubitus ulcers on buttocks
2. Severly contractures all extremities

3. Multiple strokes - patient bed confined muscle atrophy.

b. The patient cannot tolerate a transfer sitting in a wheelchair.

1. Metastatic cancer caused excruciating pain when sitting
2. Severe dyspsneic when sitting for any lenght of time
3. Motor control/coordination is such patient is unable to sit
4. Morbid Obese unable to transport via wheelchair
5. Orthopedic device that renders patient unable to sit
6. Physician order to keep legs elevated
7. Spinal headache caused by elevated position
8. Heavily sedated during transport

OTHER MEDICAL REQUIREMENTS

Billers need to explain any facts to the Medicare carrier that indicate the patient's condition is such that it requires special equipment to be used and monitored by individuals specifcally trained to handle the patient's needs should the equipment fail. Some of these include:

a. Ventilator
b. Patient requires IV (drip or pump)
c. Oxygen therapy that is not maintained by patient alone
d. Suspected fracture the requires immobilization
e. Restraints. Give reason for restraints
f. Suctioning during transport
g. Isolated due to contagious condition
h. Cardiac monitor required
i Psychiatric condition
j Decubitus that require special positioning of patient

ORDER OF DIAGNOSIS CODES

Pay attention to the cause and effect when determining which diagnosis code should be first, second or third. If the patient has pain and deformity to the hip due to a fall, the fall is the primary diagnosis.

HOSPITAL TO HOSPITAL TRANSFERS

GET A FACE SHEET

Remember that Medicare wants to know why it was necessary to move the patient to a second hospital. State the patient was "admitted to receiving hospital for higher level of care not available at sending hospital. Describe the facility needed. *

HOSPITAL DISCHARGES AND NON EMERGENCY TRANSPORTS

GET A FACE SHEET

The following list of diagnoses have, in the past, proven successful in aiding claims successfully through the payment process. It is strongly suggested that you use these wordings when writing your run reports. Only use the description if the truly is applicable to the patient. **Never under any circumstance falsify a report!** Your narrative is a legal document and a permanent part of the patients medical file.

1. Contractures, either upper or lower extremeties or all (fetal)
2. Completely unable to sit, stand or walk due to (describe condition rendering patient immoble
3. Vegetative state. This is chronic condition, not something that can change from day to day
4. Comatose or semi-comatose. This can be temporary or drug induced
5. Alert to pain only. State what patient is oriented to (ie, person - place - time - event)
6. Physiologic muscular atrophy (upper or lower extremities, trunk
7. Mental statis. Organic Brain Syndrome, senile dementia, Alzheimers. Need GCS score

NON QUALIFIERS !

8. Oxygen. Must state why patient needs O2. Also must state portable oxygen was not available
9. CVA with hemiparesis. State which side.
10. Hospital to hospital transfers. Two key items that must be documented (first) care is not available at sending hospital (second) must state patient was admitted to receiving hospital
11. The patient's condition must always be documented to include

the reason why the patient was bed confined. *If patient is bed confined due to "old age", coverage requirements HAVE NOT been met.*

12. On Non-emergencies and hospital discharge. **NEVER write "patient ambulated to stretcher" or patient was sitting in wheelchair".** While this may be pertinent information on scene before a trip to the ER it is immaterial information on other types of transports.

INSURANCE INFORMATION

The billing office needs you to get as accurate as possible any insurance information the patient has. As a rule, ALWAYS PICK UP A FACESHEET FROM THE HOSPITAL OR NURSING FACILITY. The hospital sheet will give you information about the history of the present illness, while the nursing home facesheet can give you a picture of the over all history. Always be careful when transferring insurance information on your runsheet to **COPY CORRECTLY!!!**

SIGNATURES

Signatures are an important factor in writing a good run report. The filing of claims using "Signature of file" without signatures being present on either the run report or in the record constitutes fraud.!!! If the billing office states that the patient was uanble to sign, the carrier will not pay the provider for services rendered. Instead payment will go to the patient, and trying to get that money from them is like trying to take the rosary beads from the Pope!.

Signatures are also a protection for the crew. They verify that the patitent granted permission for you to treat them. In litigation cases, they will further protect you by verifying that this particular run report was acknowledged by the patient or family member. There are times that you just cannot get the patient or family signature. If you state that the patient was uable to sign, be sure your narrative reflects the legaitimacy of that statement. You must document a valid reason why the patient is uanble to sign. If a family member is signing for the patient, be sure to add this person's relationship to the patient.

MEDICARE

If it ends in "A" the number is truly the social security number of the patient.

If it ends in anything other that an "A" the number and social security number WILL BE DIFFERENT.

If it begins a letter the patient has Railroad Medicare

PRIVATE INSURANCE

If the insurance is through an employer, be sure to get the group number, policy number, insured if other than patient, the employers name, insurance company name, claims address

If the insurance is secondary to Medicare, get the policy number and the insured name, claims address.

AUTO INSURANCE

It is next to impossible to get a policy nubmer when you are on scene of an MVA. Therefore ask the patient for the name and location of their insuranc agency and agent. This will give the billing office enough information to start the claims process.

WORKMAN'S COMP INSURANCE

Policy numbers are not needed in these cases. But the employer name and address is important. Remember to have your narrative reflect the cirmcumstances of the injury that reflect employer liability. This includes circumstances where the patient was driving a company vehicle when incident occured or location of injury on company property

There may be times when the transport was due to an injury that was sustained many months ago, and the employer's policy is still liable for payment of claims. In most of these cases, there will be a claim number that will have to be used on the claim.

ACTIVE DUTY VERSUS CHAMPUS

Active dute personnell DO NOT have CHAMPUS. They have full coverage payable by the Federal Goverment based on the branch of

service. Therefore, always give the billing office the branch of service information, as well as rank, social security number, and duty station.

Dependents of active duty personnell and retirees and their dependents are the only ones who have CHAMPUS coverage. In these situations, you need to get the sponsor's social security number, name, date of birth. The sponsor is the person who is or was a member of the armed forces.

Also remember that ALL retirees and their spouses and covered under TRICARE FOR LIFE.

PHYSICIAN'S CERTIFICATION STATEMENT OR MEDICAL NECESSITY FOR NON-EMERGENCY TRANPORT (PCS or CMN)

GET CMN AT TIME OF DISCHARGE

Medicare requires ambulance providers to obtain a PCS or CMN. The certification must be obtained/retained for all non-emergency ambulance transports, scheduled or unscheduled for the patient who are bed confined or are considered to be uanble to be transported by other than ambulances. No certification is required for those beneficiaries living at home or in facility where they do not receive direct physician care.

Before submitting a claim for non-emergency transport, ambulance suppliers must obtain a signed CMN from the attending physician. The ambulance supplier must obtain the CMN from the attending physician within 60 days prior to a scheduled transport or within 48 hours of a non-scheduled transport.

LAST NOTES.......

PRINT CLEAR - PRINT CLEAR - PRINT CLEAR

1. Make certain you always fill in EVERY available bubble or space.
2. Always document your call status, to and from scene.
3. The call level, BLS or ALS, is determined by the level of care given to your patient. It is not determined by the certification level of your unit or whether or not a parmedic is on board.
4. Always fully complete the "Patient Info" section of the run report.

Even if u DIDNT DO it

To BILL medicare 2 ALS evel A Paramedic must be onBoard + on an ALS Licensed vehicle!!

This is a crucial area for the billing process to be properly completed.
5. Vital signs you record as your initial vitals are always forwarded to the insurance carrier as documentation of the patients condition.
6. By Florida state law, you are REQUIRED to bubble the interventions you treat your patient with. Just because you document treatment in narrative does not excuse you from bubbling the appropriate space. You must document and bubble.
7. Cardiac monitor, please document the rhythum the patient was in
8. Elevated temperature, DOCUMENT WHAT THE TEMP IS and who took the temperature.
9. Obese, state the approximate weight of patient in narrative.
10. Do Not document pulse ox on discharge to home or nursing facility.
11. SPELLING COUNTS, this is a tough one and not everyone has top-notch spelling skills, but proper spelling and grammar are important. Remember if a jury looks at your run report and the report has errors, it may lead a jury to conclude you are sloppy with patient care as you are at documentation. Nobody's perfect in this department and medical terminolgy can be especially tricky to spell properly. Use an EMT or medical dictionary.
12. PRINT CLEARLY - PRINT CLEARLY - PRINT CLEARLY use your beginner writing alphabet from grammar school. Do not get fancy with the lettering

DOCUMENTATION REQUIREMENTS

It is incumbent upon all Medicare providers to remain abreast of Medicare rules, policies and payment guidelines and make an independent determination if the service is medicallly necessary and have available supporting medical documentation. The issue of medical necssity extends to the provider ordering the service, as well as to the provider of service. Medical necsessity must be obtained at all levels of care.

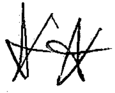
Ambulance suppliers are required to retain documentation on file supporting ambulance service billed. The purpose of documentation is to provide a permanent record of patient's medical condition at the time of transport and the reason for transport. This information must meet ambulance transport medical necessity criteria.

Beneficiary name, address, phone number, health insurance claim number (HIC), date of transport

Date and time of transport

DOCUMENTATION SUGGESTIONS

The following suggestions will help claims be processed in a more accurate and timely manner.



1. Indicate SNF, ICF or NH claim where a nursing home is indicated
2. Clearly seperate the patient's history and the reason they are being transported on this date of service
3. Indicate the dates, if known, of fractures (state if the fracture is stable or unstable), CVA's MIs, etc.
4. For specialized services such as dialysis , radiation therapy, CAT scan, physical therapy, chemo, etc. INCLUDE ALL RELEVANT INFORMATION. Indicate why the patient had to travel by ambulance. Include completed CMN with the claim.

NON-COVERED SERVICES

The following are some commonly billed non-covered services:

1. Doctors office (regardless of the location)
2. Preferred physician or preferred hospital
3. Closed to home/family
4. Hospital just to receive VA benefits
5. Funeral home

DISCHARGES

DISCHARGES ARE OFTEN DENIED BECAUSE THE CONDITIONS LISTED ARE ADMISSION DIAGNOESES. In most cases, these conditions are resolved while the patient is in the hospital. The following are examples of both covered and non-covered discharges.

COVERED DISCHARGES

1. Unstable fractured hip

2. Bed confined before and after transport
3. ventilator dependent

NON-COVERED DISCHARGES
1. Post surgery fracture
2. Dehydration
3. Possible fracture
4. GI bleeding
5. Pneumonia

CONDITIONS/SYMPTOMS DEFINED AS EMERGENCY

Abdominal Pain - Severe or incapaciatating
Back Pain - Severe or incapaciatating
Bloody Stools
Breathing Difficulty - acute onset
Cardiorespiratory arrest
Cerebral Vascular Accident (CVA) - new or debilitating
Chest Pain
Choking
Diarrhea - severe or incapaciatating
Dizziness - severe or incapaciatating
Fever
Hypothermia
Paralysis - onset
Palpitation
Pregnancy - child birth - miscarriage
Seizures - convulsions
Syncopal episode
Unresponsive - unconscious
Vagianl bleeding
Vomiting - persistent - incapacitating
Weakness (malaise) - incapaciatiting
Acute servious injury :
    Amputation
    Burn

Crash injury
Dislocation or fracture
Gunshot
Head Injury
Laceration
Puncture wound

SIMPLE WAY TO IMPROVE DOCUMENTATION SKILLS

Good documentation is important to you and your service for many reasons. Good documentation can facilitate good patient care, help protect you from liability and can favorable impact the company's reimbursement.

1. **Paint a Picture**

At an MVA think of your documentation as painting a picture of the incident. Set the scene. For insurance, at an MVA - where are the cars? Is there significant damage to the vehicles and was the passenger compartment compromised?

2 **Use Chronological Narratives**

Avoid jumping around. Stay focused, write narrative so it flows in chronological order - dispatch, assessment, treatment and transport are documented in logical order. Document when call is fresh not after the fact.

3. **Stick to the Facts** → PT WAS IN A wheelchair

A well written patient report is *objective* not *subjective.* This means that your charts should stick to the facts. Example - don't say patient was "intoxicated". Instead document the fact such as "slurred speech - odor of alcohol on breath - pt admitted drinking alcohol.

4. **Abandon Home Grown Abbreviations**

Abbreviations are fine but stick to ones that are common and accepted in the health care profession. Medical documentation tends to be lengthy and time consuming. Use accepted medical abbreviations. (See listed provided)

EXHIBIT G

To; All Crews

From: James Barefoot

Over the last few weeks I have been working alongside the billing dept. evaluating the run sheets that are being turned in, and we have found a significant increase in reports that cannot be forwarded or billed. You must understand that "Every run MUST stand on its own" and that we can never become complacent about the content of each run that is executed. For the most part, reports for emergency responses have been satisfactory, and the patient care provided has been excellent. It is with discharges and Hospice runs that the reports have been lacking in substance. We've seen that all the proper lines and spaces have been addressed, but find there is no *"Reason for transport"* or "Medical necessity". Remember, we must have a reason why each pt. needs our services, and this reason usually lies within their PMHX. Elaborate on this history and describe the pt. condition, don't just bubble in the spaces. If a patient is being discharged to a nursing facility, it is *that admitting Dx* coupled with their PMHX that will generally be the reason for transport.

Below are some points to remember as you write your report.
1. Describe the Pt. current condition
2. Elaborate on their PMHX
3. Establish a reason they need our services
4. Include the reason for admittance to the hospital
5. on discharges, OMIT ALL POSITIVE FINDINGS. (Just don't write them.)
6. On Hospice pts, provide comfort care en route (O2 if needed or appropriate)
7. Document all care given during transport
8. Document in who's care you left the pt. and the paperwork (Jane Doe RN)

If you have any questions or comments, see any officer, or make an appt. to meet with the billing dept. It is vital that we address this matter and make the necessary improvements.

EXHIBIT H

27. 2009 12:59PM NO. 0300 P. 3/3

To: Ashley Johnson CFO Memorial Hospital

From: Chief Dwayne A. Perkins, Liberty Ambulance Service

Reference: Fee Schedule

Type of transport	one way base	mileage
Advanced Life Support	$185.00	$5.20*
Ventilator Transport	$285.00	$5.20*
Basic Life Support	$155.00	$5.20*
Non Medical Stretcher Service	$45.00	$3.00*
Wheelchair	$30.00	$1.50*
Intra-campus Ambulance DRG **ALS/BLS** (Example- Southside Cancer Center)	$50.00	$0.00
Oxygen or Supplies Charge	$0.00	

EXHIBIT I

[illegible] Rosselle Street
Jacksonville, FL 32204
(904) 356-2828
Fax 356-9677

Century Ambulance Service, Inc.

March 16, 2009

Ashley Johnson
Chief Financial Officer
Memorial Health
3625 University Blvd S
Jacksonville, FL 32216

Re: Healthcare Transportation Service Agreements

Dear Ashley,

Please take a few minutes to consider the following regarding your selection of a different ambulance service to provide your ambulance transportation under a contract, especially where Memorial is responsible for payment of these transports. This development is troubling from several respects not to mention the potential loss of revenue for Century Ambulance.

Century prides itself in its ability and commitment to provide quality patient care. We invest heavily in new equipment and work diligently to provide the very best in patient care. To that end some time ago we built an ambulance station at Bowden and I-95 specifically to enable us to be more responsive to Memorial's transportation needs. We have stationed enough equipment and manpower to provide you with the best on time service in the industry. We trust that Memorial recognizes those features, and that it will continue to call upon Century for its emergency ambulance transport needs. Century hopes that it can continue to serve a large majority of the ambulance transports of Memorial, but understands if the bulk of the "inpatient" transports for which Memorial is responsible for payment are instead offered to another ambulance provider.

That being said, however, it is our understanding that the other ambulance service may have offered a "significant discount" off of the Medicare allowable (for ambulance transportation) under the Part A and/or Part B services. In addition, it is our understanding that significant discounts have been offered on wheelchair and non-emergency stretcher rates that may be less than the actual cost of the services provided. The rate charged by Century has always been at or around the Medicare Allowable amount for ambulance transportation, as well at the cost of providing non –emergency transportation services, which is consistent with Medicare standards. While we are prepared to deviate from the Medicare Allowable amount in order to maintain contractual relations with Memorial, for the reasons further outlined below, we are unable to offer a "significant discount" and urge

you to refuse to enter into any arrangements that include "significant discounts" for your own protection and benefit.

We have sought the opinion of legal counsel to determine whether we can legally offer discounts as low as the Medicare "payable" rate. This rate is 20% less than the allowable rate. We have found that we can offer those discounts and continue to be within the Safe Harbor guidelines of the Medicare Reimbursement Act. We have also determined that we cannot offer services below the cost of providing those services such as non-medical and wheelchair services and remain within the "Safe Harbor" provision of the Medicare Reimbursement Act.

While we certainly understand and respect that payment levels offered by the government (both the ambulance fee schedule amount and the DRG payment) are, at times, woefully inadequate, we also recognize that compliance with all laws is critically important to the health care industry that is so heavily regulated by the Medicare program. With such a low payment, having to then make significant payment from those DRG funds to an ambulance provider has an obvious financial impact. However, the fact that another ambulance service has offered to charge "substantially less" for other services in order to possibly induce favorable treatment for contractual consideration is troubling from the perspective of the federal Anti-kickback Statute (AKS).

When a facility such as Memorial Health, requests, or is offered Part A or B discounts or inappropriate wheelchair rates from an ambulance service, it puts itself at risk of violating the AKS. The statute provides for criminal penalties and civil monetary penalties (CMP) of up to $50,000, exclusion from the Medicare program, and other damages. This federal law is rather broad and has significant penalties for violations. Neither an ambulance service nor a health care facility want to be involved in violating these statutes.

Please note that generally speaking, relatively few ambulance transports are actually the responsibility of the facility. While it is understood that using another ambulance service that has offered a cheaper rate for the Part A covered ambulance services may be beneficial from a financial perspective, an important question to ask is whether it is worth risking an AKS violation (and its heavy penalties) for a relatively low number of transports, and a small level of cost savings.

There is another possible violation that may be triggered as a result of charges for ambulance service that are "substantially less" than the Medicare Allowable Rate known as "Swapping". This concern assumes that the other ambulance service would also be called upon to provide transports that are covered under "Part B" or that are separately billable by the ambulance service, and not billable to Memorial. Any arrangement that involves a discount for Part A rates in exchange for the right to access Part B patient transports is referred to as "swapping," and is a violation of the AKS and poses a compliance risk for both the ambulance service and the facility.

Another consideration may be that if a facility pays a "discounted" rate to an ambulance service for Part A transports that could trigger the "substantially in excess" portion of the Medicare regulations. While a proposed regulation to clarify some of the terms used in this law was published in 2003 but was later rescinded, the law itself is still valid. Ultimately, Medicare likes to pay at the "best rate." When Medicare pays an ambulance service at the Medicare allowable amount, but a facility pays the ambulance service at a "substantially lower" rate than the Medicare allowable amount, Medicare is no longer paying at the "best rate." As a result, the ambulance service that charges Medicare "substantially in excess" could be excluded from the Medicare program, a penalty that would directly affect Memorial's ability to continue to contract with that provider.

Ultimately, while economic factors are important in making business decisions, in the health care field so heavily regulated by Medicare, compliance and regulatory factors are equally, if not more so, important. Century is an ambulance service that has a longstanding relationship with Memorial, is deeply rooted in compliance, is a longstanding provider in the community, and has a deep concern for patient care. In making contracting decisions, it is important for a facility to compare whether the "better" or the "cheaper" ambulance service should be trusted with the care of its patients during inter- and intra-facility transports. While some ambulance services are willing to slash prices to gain a competitive edge in the market, Century continues to focus its attention on patient care and remaining in compliance with all laws in order to remain competitive.

Ultimately, since Memorial is contracting with an ambulance service to temporarily take control and care of a patient, and the hospital will retain some ultimate liability in the event of harm, contracting with a reputable, compliant, and experienced ambulance service, instead of one offering the cheapest rate, should be of utmost concern.

We will be happy to provide you with past Advisory Opinions and documentation of past penalties that have been imposed upon parties that participated in illegal arrangements (those outside the safe harbors act) upon request. These situations typically involve AKS and "swapping" concerns. Century strives to maintain compliance with the Medicare laws and rules, and hopes that its business partners, including Memorial, choose to do the same. Century hopes that Memorial will avoid a significant compliance risk by entering into a "swapping" arrangement with an ambulance service that offers a "cheaper" transport alternative, and will consider the long term financial affects of such an arrangement, as opposed to the short term cost saving effects.

In the past the Office of Inspector General has investigated other ambulance services to ensure that ambulance service providers remain in compliance as we are all mandated to do. The outcome of some of these investigations has resulted in significant fines totaling in the millions. We all should endeavor to remain in compliance with all the many rules and regulations promulgated by the Medicare Program.

There is one last item for your consideration. Until March 1, 2009 Century Ambulance had been your preferred provider as evidenced by our long standing contract for services. In those twelve (12) years we were cautioned to avoid using any insignia, logo, symbols or other proprietary identifications that would identify us as being affiliated or part of the HCA or Memorial Hospital entity on any brochure or other advertizing medium. We took care to comply with your rules and regulations regarding this practice. Now within one week of awarding the contract for services to Liberty Ambulance we find that they have printed your HCA Memorial Hospital Logo on their tri-fold brochure that is circulating through the local EMS system as evidenced by the enclosed brochure. Perhaps your rules have changed.

We hope that Memorial will continue to use Century Ambulance for a majority of its ambulance transport needs just as they have in the past. Please feel free to contact me at your convenience to negotiate rates for neonatal/pediatric services. I look forward to meeting with you in an attempt to resolve any and all issues at hand.

We are willing to prepare any information that you may request or desire to help Memorial make a fully-informed decision, even retrospectively.

Sincerely,

Marsha Morrell
Vice President
Century Ambulance Service, Inc.

Enclosure: New Liberty Ambulance brochure with HCA logo

EXHIBIT J

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

UNITED STATES OF AMERICA
ex rel. SHAWN PELLETIER,

Plaintiff,

v. Case No. 3:11-cv-911-J-37JRK

CENTURY AMBULANCE SERVICE, INC., A Florida Corporation, SOUTHERN BAPTIST HOSPITAL OF FLORIDA, INC., MEMORIAL MEDICAL CARE GROUP, INC., ORANGE PARK MEDICAL CENTER, INC., and SHANDS JACKSONVILLE MEDICAL CENTER, INC.,

FILED UNDER SEAL

Defendants.
_______________________________/

SWORN DECLARATION OF CENTURY AMBULANCE SERVICE, INC., BY AND THROUGH MARSHA MORRELL

1. My name is Marsha Morrell and I am the Executive Vice President of Century Ambulance Service, Inc. ("Century Ambulance"), a Florida corporation which furnishes ambulance services to various health care facilities in the Jacksonville, Florida area. I provide this declaration under penalty of perjury. I swear that the statements contained in this declaration are truthful and accurate to the best of my knowledge. I base these statements on my own experience and on information provided to me by Century Ambulance employees. These statements describe the actions of the parties specifically named herein only, and should not be generalized to apply to any other parties.

2. From 1997 to 2009, Century Ambulance had a contract for ambulance transport services with Memorial Healthcare Group, Inc., d/b/a Memorial Hospital Jacksonville or its predecessors, which operated the hospital located at 3625 University

Boulevard South, Jacksonville, Florida 32216 ("Memorial Hospital"). Pursuant to that contract, Century Ambulance transported patients to and from Memorial Hospital.

3. In 2009, Memorial Hospital requested competitive bids for its ambulance transport work. Memorial Hospital's Chief Financial Officer, Ashley Johnson, asked Century Ambulance to submit a proposal in connection with this competitive bidding process. Ms. Johnson asked that the Century Ambulance proposal include, among other things, response times and rates for Facility Responsible Transfers.

4. Century Ambulance submitted a competitive bid for ambulance transport work to Memorial Hospital. Century Ambulance offered Memorial Hospital the lowest Facility Responsible Transfer rates that it believed were permissible at the time. In the course of preparing these Facility Responsible Transfer rates, Century Ambulance took into consideration the Medicare profile for the region served by Century Ambulance, Century Ambulance's costs of furnishing ambulance transport services, and other relevant factors. Century Ambulance was advised that it should not propose rates that would be below those arrived at after examining the above factors, as doing so might potentially raise legal concerns. I informed Ms. Johnson of this position, including via letter dated March 16, 2009, a copy of which is attached as Exhibit A.

5. Ultimately, Memorial Hospital opted not to continue its twelve year contractual relationship with Century Ambulance. Memorial Hospital instead chose Liberty Ambulance as its ambulance provider in the 2009 competitive bidding process. Century Ambulance does not know the Facility Responsible Transfer rates proposed by Liberty Ambulance to Memorial Hospital in its 2009 competitive bid for this ambulance transport work. Century Ambulance is, however, familiar with the Medicare profile for the region

served by Century Ambulance, its own costs for furnishing ambulance transport services, and what Facility Responsible Transfer rates it believed were permissible at the time.

6. As a general matter, in 2009, Century Ambulance was unable to offer the following rates to hospitals for ambulance transport services, as they were below Century Ambulance's own costs for furnishing the ambulance transport services, and in particular costs for furnishing wheelchair and non-medical stretcher services: (a) intra-campus transports for $50.00 per transport, (b) unlimited transports between the facility known as Specialty Hospital of Jacksonville, located at 4901 Richard Street, Jacksonville, Florida 32207, and Memorial Hospital for $1,000.00 a month, with no additional charges for mileage, and (c) waiving any charges for indigent discharges to home or nursing homes.

7. To illustrate how the rates described in Paragraph 6, above, were below the costs to Century Ambulance for furnishing ambulance transport services, Century Ambulance would have been required to spend more than $50.00 to transport a patient on an intra-campus basis. This is because each transport requires, at a minimum, two employees, wear and tear on the ambulance vehicle, and other administrative costs. Further, providing unlimited transports between two hospitals, such as Specialty Hospital of Jacksonville and Memorial Hospital, would have cost Century Ambulance well more than $1,000.00 per month. Again, this is due to the need to pay for appropriate numbers of staff, wear and tear on the ambulance vehicle, and other administrative costs.8. Since 2009, Century Ambulance has contacted Memorial Hospital on a few occasions in an attempt to discuss the possibility of entering into a new contractual relationship for ambulance transport services. To the best of my recollection, I have not received a response from

Memorial Hospital. I understand that Memorial Hospital continues to use Liberty Ambulance as an ambulance transport provider to this day.

SIGNED UNDER PENALTY OF PERJURY

CENTURY AMBULANCE SERVICE, INC.

By: ______________________
Marsha Morrell
Executive Vice President

00890559.DOCX

2144 Roselle Street
Jacksonville, FL 32204
(904) 356-2828
Fax 356-9677

Century Ambulance Service, Inc.

March 16, 2009

Ashley Johnson
Chief Financial Officer
Memorial Health
3625 University Blvd S
Jacksonville, FL 32216

Re: Healthcare Transportation Service Agreements

Dear Ashley,

Please take a few minutes to consider the following regarding your selection of a different ambulance service to provide your ambulance transportation under a contract, especially where Memorial is responsible for payment of these transports. This development is troubling from several respects not to mention the potential loss of revenue for Century Ambulance.

Century prides itself in its ability and commitment to provide quality patient care. We invest heavily in new equipment and work diligently to provide the very best in patient care. To that end some time ago we built an ambulance station at Bowden and I-95 specifically to enable us to be more responsive to Memorial's transportation needs. We have stationed enough equipment and manpower to provide you with the best on time service in the industry. We trust that Memorial recognizes those features, and that it will continue to call upon Century for its emergency ambulance transport needs. Century hopes that it can continue to serve a large majority of the ambulance transports of Memorial, but understands if the bulk of the "inpatient" transports for which Memorial is responsible for payment are instead offered to another ambulance provider.

That being said, however, it is our understanding that the other ambulance service may have offered a "significant discount" off of the Medicare allowable (for ambulance transportation) under the Part A and/or Part B services. In addition, it is our understanding that significant discounts have been offered on wheelchair and non-emergency stretcher rates that may be less than the actual cost of the services provided. The rate charged by Century has always been at or around the Medicare Allowable amount for ambulance transportation, as well at the cost of providing non –emergency transportation services, which is consistent with Medicare standards. While we are prepared to deviate from the Medicare Allowable amount in order to maintain contractual relations with Memorial, for the reasons further outlined below, we are unable to offer a "significant discount" and urge

you to refuse to enter into any arrangements that include "significant discounts" for your own protection and benefit.

We have sought the opinion of legal counsel to determine whether we can legally offer discounts as low as the Medicare "payable" rate. This rate is 20% less than the allowable rate. We have found that we can offer those discounts and continue to be within the Safe Harbor guidelines of the Medicare Reimbursement Act. We have also determined that we cannot offer services below the cost of providing those services such as non-medical and wheelchair services and remain within the "Safe Harbor" provision of the Medicare Reimbursement Act.

While we certainly understand and respect that payment levels offered by the government (both the ambulance fee schedule amount and the DRG payment) are, at times, woefully inadequate, we also recognize that compliance with all laws is critically important to the health care industry that is so heavily regulated by the Medicare program. With such a low payment, having to then make significant payment from those DRG funds to an ambulance provider has an obvious financial impact. However, the fact that another ambulance service has offered to charge "substantially less" for other services in order to possibly induce favorable treatment for contractual consideration is troubling from the perspective of the federal Anti-kickback Statute (AKS).

When a facility such as Memorial Health, requests, or is offered Part A or B discounts or inappropriate wheelchair rates from an ambulance service, it puts itself at risk of violating the AKS. The statute provides for criminal penalties and civil monetary penalties (CMP) of up to $50,000, exclusion from the Medicare program, and other damages. This federal law is rather broad and has significant penalties for violations. Neither an ambulance service nor a health care facility want to be involved in violating these statutes.

Please note that generally speaking, relatively few ambulance transports are actually the responsibility of the facility. While it is understood that using another ambulance service that has offered a cheaper rate for the Part A covered ambulance services may be beneficial from a financial perspective, an important question to ask is whether it is worth risking an AKS violation (and its heavy penalties) for a relatively low number of transports, and a small level of cost savings.

There is another possible violation that may be triggered as a result of charges for ambulance service that are "substantially less" than the Medicare Allowable Rate known as "Swapping". This concern assumes that the other ambulance service would also be called upon to provide transports that are covered under "Part B" or that are separately billable by the ambulance service, and not billable to Memorial. Any arrangement that involves a discount for Part A rates in exchange for the right to access Part B patient transports is referred to as "swapping," and is a violation of the AKS and poses a compliance risk for both the ambulance service and the facility.

Another consideration may be that if a facility pays a "discounted" rate to an ambulance service for Part A transports that could trigger the "substantially in excess" portion of the Medicare regulations. While a proposed regulation to clarify some of the terms used in this law was published in 2003 but was later rescinded, the law itself is still valid. Ultimately, Medicare likes to pay at the "best rate." When Medicare pays an ambulance service at the Medicare allowable amount, but a facility pays the ambulance service at a "substantially lower" rate than the Medicare allowable amount, Medicare is no longer paying at the "best rate." As a result, the ambulance service that charges Medicare "substantially in excess" could be excluded from the Medicare program, a penalty that would directly affect Memorial's ability to continue to contract with that provider.

Ultimately, while economic factors are important in making business decisions, in the health care field so heavily regulated by Medicare, compliance and regulatory factors are equally, if not more so, important. Century is an ambulance service that has a longstanding relationship with Memorial, is deeply rooted in compliance, is a longstanding provider in the community, and has a deep concern for patient care. In making contracting decisions, it is important for a facility to compare whether the "better" or the "cheaper" ambulance service should be trusted with the care of its patients during inter- and intra-facility transports. While some ambulance services are willing to slash prices to gain a competitive edge in the market, Century continues to focus its attention on patient care and remaining in compliance with all laws in order to remain competitive.

Ultimately, since Memorial is contracting with an ambulance service to temporarily take control and care of a patient, and the hospital will retain some ultimate liability in the event of harm, contracting with a reputable, compliant, and experienced ambulance service, instead of one offering the cheapest rate, should be of utmost concern.

We will be happy to provide you with past Advisory Opinions and documentation of past penalties that have been imposed upon parties that participated in illegal arrangements (those outside the safe harbors act) upon request. These situations typically involve AKS and "swapping" concerns. Century strives to maintain compliance with the Medicare laws and rules, and hopes that its business partners, including Memorial, choose to do the same. Century hopes that Memorial will avoid a significant compliance risk by entering into a "swapping" arrangement with an ambulance service that offers a "cheaper" transport alternative, and will consider the long term financial affects of such an arrangement, as opposed to the short term cost saving effects.

In the past the Office of Inspector General has investigated other ambulance services to ensure that ambulance service providers remain in compliance as we are all mandated to do. The outcome of some of these investigations has resulted in significant fines totaling in the millions. We all should endeavor to remain in compliance with all the many rules and regulations promulgated by the Medicare Program.

There is one last item for your consideration. Until March 1, 2009 Century Ambulance had been your preferred provider as evidenced by our long standing contract for services. In those twelve (12) years we were cautioned to avoid using any insignia, logo, symbols or other proprietary identifications that would identify us as being affiliated or part of the HCA or Memorial Hospital entity on any brochure or other advertizing medium. We took care to comply with your rules and regulations regarding this practice. Now within one week of awarding the contract for services to Liberty Ambulance we find that they have printed your HCA Memorial Hospital Logo on their tri-fold brochure that is circulating through the local EMS system as evidenced by the enclosed brochure. Perhaps your rules have changed.

We hope that Memorial will continue to use Century Ambulance for a majority of its ambulance transport needs just as they have in the past. Please feel free to contact me at your convenience to negotiate rates for neonatal/pediatric services. I look forward to meeting with you in an attempt to resolve any and all issues at hand.

We are willing to prepare any information that you may request or desire to help Memorial make a fully-informed decision, even retrospectively.

Sincerely,

Marsha Morrell
Vice President
Century Ambulance Service, Inc.

Enclosure: New Liberty Ambulance brochure with HCA logo

EXHIBIT K

From: Dwayne A Perkins [mailto:dwaynep@liberty-ambulance.com]
Sent: Thursday, October 24, 2013 10:26 AM
To: Lynch Eleanor
Cc: Miller Gregory - Jacksonville; Riley Amy - Jacksonville
Subject: Liberty Ambulance

We need to set up a meeting with Orange Park Hospital. It is important not only to HCA but Memorial Hospital that we work out an agreement with Orange Park/HCA to offset the huge loss of revenue from the stand alone Emergency Departments. We cannot continue the $365,000 loss that we have had over the past year supplying Memorial's Julington Creek ED with 24 hours service.

Chief Dwayne A Perkins