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Auditor of State

Ohio Medicaid Program

*Audit of Medicaid Reimbursements Made to
Access Transit Company*

A Compliance Audit by the:

Medicaid/Contract Audit Section



Mary Taylor, CPA

Auditor of State

April 15, 2008

Mr. R. Dale Sinclair
Owner
C/O Mr. J. Edward Foley
Attorney At Law
140 E. Town Street, Suite 1070
Columbus, Ohio 43215

Dear Mr. Sinclair:

Attached is our report on Medicaid reimbursements made to Access Transit Company, Medicaid provider numbers 2146556 and 2516398, for services rendered for the period October 1, 2002 through September 30, 2005. We identified \$1,152,801.21 in findings plus \$234,981.95 in interest accruals that are repayable to the Ohio Department of Job and Family Services (ODJFS). After April 15, 2008, additional interest will accrue at \$252.67 a day until repayment occurs. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our interagency agreement with ODJFS. The specific procedures employed during this audit are described in the purpose, scope and methodology section of this report. Interest is calculated pursuant to Ohio Administrative Code 5101:3-1-25(A).

We are forwarding this report to ODJFS because as the state agency charged with administering Ohio's Medicaid program, ODJFS is responsible for making a final determination regarding recovery of the findings and any accrued interest. However, if you are in agreement with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are being sent to Access Transit Company, the Director and Legal Division of ODJFS, the Ohio Attorney General, and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website (www.auditor.state.oh.us).

Mr. R. Dale Sinclair
April 15, 2008
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Questions regarding this report should be directed to Jeffrey Castle, Chief Auditor of the Medicaid/Contract Audit Section, at (614) 466-7894, or toll free at (800) 282-0370.

Sincerely,

A handwritten signature in cursive script that reads "Mary Taylor".

Mary Taylor, CPA
Auditor of State

cc: Access Transit Company
Ohio Attorney General
Ohio Medical Transportation Board
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services

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ACRONYMS

BLS	Basic Life Support
CMS	Centers for Medicare & Medicaid Services
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EOMB	Explanation of Medicare Benefits
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Admin.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
PCF	Practitioner Certification Form
RDOS	Recipient Date(s) of Service

SUMMARY OF RESULTS

The Auditor of State performed an audit of Access Transit Company (hereafter called the Provider), provider numbers 2146556 and 2516398; doing business at 1574 Harrisburg Pike, Columbus, Ohio, 43223.¹ Within the Medicaid program, the Provider is listed as an ambulette and ambulance service provider. An ambulance is defined as a vehicle to transport individuals in a supine position. An ambulette is defined as a vehicle designed to transport individuals sitting in wheelchairs.

We performed our audit in accordance with Ohio Rev.Code §117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of the audit, we identified \$1,152,801.21 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest of \$234,981.95 are repayable to ODJFS. Additional interest of \$252.67 per day² will accrue after April 15, 2008 until repayment.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code. A fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services.³ The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

Ohio Admin.Code 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

¹ During the fieldwork portion of our audit, the Provider closed its business which was located at 1574 Harrisburg Pike, Columbus, Ohio 43223. In December 2006, the Provider surrendered its medical transportation license and provider number 2146556 was consequently revoked by ODJFS. As of April 2, 2008, provider number 2516398 was still listed as active within MMIS; however, no payment has occurred since March 2005.

² Ohio Admin.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Admin.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was September 28, 2005, the latest payment date in the random sample used for analysis.

³ See Ohio Admin.Code 5101:3-1-01(A) and (A)(6).

In addition, Ohio Admin.Code 5101:3-1-29(A) states in part: "...In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

Ohio Admin.Code 5101:3-1-29(B)(2) states: " 'Waste and abuse' are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an over utilization of medicaid covered services and result in an unnecessary cost to the medicaid program."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance.

Following a letter of notification, we held an entrance conference at the Provider's place of business on April 12, 2006 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 2002 through September 30, 2005. The Provider was reimbursed \$1,904,770.39 for 126,238 services rendered on 29,007 recipient dates of service. A recipient date of service (RDOS) is defined as all services received by a particular recipient on a specific date. The Provider's claims did not involve any Medicare cross-over claims.

Ambulette services accounted 123,671 services (rendered on 28,364 RDOS) for a total reimbursement of \$1,780,133.61. Ambulance services accounted for 2,567 services (rendered on 643 RDOS) for a total reimbursement of \$124,636.78.

We used the Ohio Revised Code and the Ohio Administrative Code as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's paid claims history from ODJFS' Medicaid Management Information System (MMIS), which contains an electronic file of services billed to and paid by the Medicaid program. This claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).⁴

⁴ These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.

Prior to beginning our fieldwork, we performed a series of computerized tests on paid claims to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for the following exceptions:

- Claims for attendant services even though the Provider did not employ attendants.
- Claims for second passenger codes when the Provider did not render such services.
- Claims for transport services billed and paid for while the recipient was a hospital inpatient.
- Duplicate billed services for the same recipient, on the same date, to the same point of transport.
- Claims for services rendered to deceased recipients after their date of death.
- Claims for services billed and paid using inappropriate point of transport modifiers.
- Claims for transports billed and reimbursed as both an ambulance and an ambulette service.
- Claims for billed mileage paid without a corresponding base transport code.
- Claims with reimbursement greater than the Medicaid allowed amount for a transport service.

The exception tests were negative for billed mileage paid without a corresponding transport code, and reimbursements greater than the Medicaid allowed amount. The remaining exception tests identified potentially incorrect reimbursements. We asked the Provider to submit supporting documentation for services believed to be appropriately billed and reimbursed.

Due to the large number of potentially duplicate ambulette services (8,727 or 1,488 RDOS), we reviewed a haphazard⁵ sample of 258 services (47 RDOS) during the entrance conference and determined they were not all duplicately billed. We, therefore, selected a stratified random sample of 1,068 services (152 RDOS) from the remaining ambulette duplicate services.

To facilitate an accurate and timely audit of the Provider's remaining services, we also analyzed two additional statistically selected random samples: 1) a simple random sample of 381 ambulance services (100 RDOS) and 2) a simple random sample of 424 ambulette services (107 RDOS).

We also performed a computerized test to identify ambulance transports that were provided to dually eligible recipients (those who receive benefits through Medicaid and through Medicare Part B). As this issue came to light after we completed our fieldwork, it was necessary to remove these specific services from the ambulance exceptions, the ambulance sample population, and the ambulance sample to avoid double counting of exceptions.

Our fieldwork was performed between January 2006 and May 2007.

⁵ A haphazard sample consists of sampling units selected without any conscious bias, that is, without any special reasons for including or omitting items from the sample. It does not consist of sampling units selected in a careless manner, and is selected in a manner that can be expected to be representative of the population.

RESULTS

We identified \$66,434.84 in findings from the ambulette exception tests, \$114,169.00 in projected findings from our ambulette duplicate services statistical sample and, \$970,489.00 in projected findings from our ambulette services statistical sample. We also found \$260.32 in findings from our ambulance exception tests and \$1,445.05 in actual findings from our ambulance service statistical sample. Our findings totaled \$1,152,801.21.

The circumstances leading to these findings are discussed below.

Ambulette Services – Exception Testing Results

Erroneously Billed Attendant and Second Passenger Services

Ohio Admin.Code 5101:3-15-01(A)(5) states in pertinent part:

“Attendant” is defined as an individual employed by the transportation provider separate from the basic crew of the ambulance or ambulette vehicle who...is present to aid in the transfer of medicaid covered patients...

Ohio Admin.Code 5101:3-15-03(E) “Service Limitations” states in pertinent part:

The following services are not covered:

(6) Transportation of passenger(s) accompanying the patient who requires the medical transportation services;

(10) Mileage and extra attendant charges for additional passengers;

Ohio Admin.Code 5101:3-15-04(C)(2) and 5101:3-15-04(C)(3) provide rules for the reimbursement of ambulette services for two or more Medicaid eligible passengers.

We identified 6,446 services where the Provider billed as if an attendant or a second passenger was in the vehicle during transport. During the entrance conference, the Provider explained these billings were for family members and/or nursing aids who accompanied the recipients on their transports. Since the Provider confirmed it did not employ attendants, or provide second passenger transports, a finding was made for \$62,007.80 which is the total reimbursement for these services.

Transports Billed for Hospital Inpatients

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

We performed an analysis of the Provider's billed services to determine if the Provider billed for transporting patients while the patients were in the hospital. Our analysis identified 155 billed services. The Provider did not submit documentation to substantiate transporting the patient on the dates of service in question. Therefore, we made a finding for \$2,271.62, the total reimbursed to the Provider for these services.

Duplicate Payments

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

Ohio Admin.Code 5101:3-15-03(E) "Service Limitations" states in pertinent part:

The following services are not covered:

(3) Excessive mileage charges, resulting from the use of indirect routes;

Ohio Admin.Code 5101:3-15-02(E) "Documentation requirements" states in pertinent part:

(1) Providers of...ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department...

(2) Records which must be maintained include, but are not limited to...

(a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage;

We identified a total of 4,443 duplicate combinations (8,985 services) where the Provider appeared to have billed for more than one transport for the same recipient, on the same date, to the same point of transport.

We reviewed documentation for a haphazard sample of 258 of these services (47 RDOS) to determine if the services were actual duplicate billings. Our review identified 122 errors as follows:

- The Provider billed twice for 116 services for the same patient, on the same date of service, causing duplicate reimbursement.
- The Provider did not retain a trip log to document the trip for four services. Therefore, we were unable to determine if the recipient was actually transported.
- The Provider's billed mileage for two services was overstated when compared to the documented mileage. Therefore, we recalculated the reimbursement using the documented miles.

Since we found errors in the Provider's billings for these services, we then selected a stratified random sample from the remaining 8,727 services (1,488 RDOS) to facilitate a timely and cost effective review of this population. The results of the sample review are found in this report under the "Ambulette Duplicate Services Sample" category.

Services Billed for Deceased Recipients

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

Our testing determined the Provider billed for 32 services (eight RDOS) with dates of services occurring after five recipients' dates of death. Two recipients had one RDOS billed after their date of death, while the other three recipients had two RDOS billed after their date of death. The Provider did not furnish any documentation to substantiate these services. Therefore, a finding was made for the reimbursed amount of \$460.04.

Invalid Point of Transport Modifier Billed

Ohio Admin.Code 5101:3-15-03(D) states in pertinent part:

(1) Modifiers for the point of transport is a two-position modifier that is constructed from the following values . . .

(3) The medicaid covered point of transport modifiers for non-emergency ground ambulance and ambulette services are DD, DE, DG, DH, DI, DJ, DN, DP,DR, ED, EE, EG, EH, EI, EJ, EN, EP, ER, GD, GE, GH, GI, GN, GP, GR, HD, HE, HH, HI, HJ, HN, HP, HR, ID, IE, IG, IH, II, IJ, IN, IP, IR, JD, JE, JH, JI, JJ, JN, JP, JR, ND, NE, NG, NH, NI, NJ, NN, NP, NR, PD, PE, PG, PH, PI, PJ, PN, PP, PR, RD, RG, RH, RI, RJ, RN, and RP.

We identified four services where the Provider billed and was reimbursed for a transport using a modifier other than those on the above approved list. Ohio Admin.Code 5101:3-15-03 (D)(6) explains that under special consideration providers may request prior authorization of coverage for additional points of transport. However, we do not have documentation to show the Provider made such a request. Therefore, we made a finding for \$67.19, the reimbursement received for these services.

Provider Simultaneously Billed for Ambulette and Ambulance Transports

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

We identified two instances where both an ambulette and an ambulance transport were billed for the same recipient, on the same day, with the same point of transport. A review of the documentation determined that the ambulance services were appropriately billed while the ambulette services were billed in error. Therefore, we made a finding for \$47.22, the reimbursement amount of the ambulette services.

Ambulette Services – Sample Results

Ambulette Duplicate Services Sample

We selected a stratified random sample of 1,068 services (152 RDOS) taken from a subpopulation of 1,488 potential duplicate ambulette transportation RDOS. We excluded all services already identified by our exception tests from this subpopulation.

Our review determined that 918 services (151 RDOS) had errors which resulted in projected findings of \$114,169.00. Some services had more than one error, however, only a single finding was made. The bases for these findings are presented below.

Duplicate Services

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

We identified 363 services that were billed twice for the same patient, on the same date of service. Some of the duplicate claims listed different mileage amounts for the same service. We allowed the mileage documented on the Provider's trip log.

Practitioner Certification Form (PCF) Not Received

Ohio Admin.Code 5101:3-15-02(E) "Documentation requirements" states in pertinent part:

(4) Practitioner Certification Form

(a) The attending practitioner, or a hospital discharge planner or a registered nurse acting under the orders of the attending practitioner...must complete a "Practitioner Certification Form" for all medical transportation services...

(d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission

(ii) The practitioner certification form must be maintained on file at the provider's office for a minimum of six years...

(g) Practitioner certification for patients who are nonambulatory at the time of transport, but are temporarily nonambulatory...the attending practitioner must certify the estimated length of time that individual is temporarily nonambulatory and transport by ambulance or ambulette would be required. The certification form...is valid for the estimated length of time as designated...unless the...length of time exceeds ninety days...[at which time] a new certification form must be obtained to certify a new estimated length of time...

We identified 40 services where the practitioner certification form (PCF) was not in the patients' files. Also, the PCF on file did not cover the date(s) of service in question of an additional 635 services. Therefore, we disallowed the reimbursement for these services.

Lack of Documentation

Ohio Admin.Code 5101:3-15-02(E) "Documentation requirements" states in pertinent part:

(1) Providers of...ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department...

(2) Records which must be maintained include, but are not limited to...

(a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage;

We found the Provider did not maintain documentation of 257 services on a trip sheet, or on a trip log. Also, documentation was not supplied by the Provider for the return leg of four round trip transports. Therefore, we disallowed the reimbursement for these services.

Overstated Mileage

Ohio Admin.Code 5101:3-15-03(E) "Service limitations" states in pertinent part:

The following services are not covered:

(3) Excessive mileage charges, resulting from the use of indirect routes;

We identified 12 services where the billed mileage of the transport was more than the documented mileage. We tested trips with a discrepancy of greater than one mile using data from two websites.⁶ Based upon this information, we reduced the mileage to that stated on the websites. We calculated the difference between the reimbursement received for the billed mileage and the reimbursement for the corrected mileage. The difference was used in the projection of the finding amount.

Non-Covered Transports

Ohio Admin.Code 5101:3-15-03(B)(2) "Covered ambulette transports" states in pertinent part:

(a) the ambulette services must be medically necessary as specified below:

(i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport...

⁶ Windows Live Local Maps and Yahoo! Local Maps

Ohio Admin.Code 5101:3-15-03 states in pertinent part:

(L) Transport of an individual to a medicaid covered service that was cancelled or unavailable may be reimbursed if:

(3) The medical transportation provider obtained written documentation, which can be handwritten, from the medicaid covered service provider before billing the department for transport. The written documentation must include:

- (a) A business name, address, and phone number of the medicaid covered service provider,
- (b) The date and time of the cancelled or unavailable service,
- (c) A description of the reason(s) for the cancellation or unavailability of the service,
- (d) A statement indicating that the medicaid covered service provider was unable to notify the medicaid transportation provider or the individual of the cancellation or unavailability of the service prior to the arrival at the destination, and
- (e) The printed name and signature of the business/office manager or nurse.

We identified 12 instances where the PCF indicated the patient was not “non-ambulatory.” However, the Provider billed and was reimbursed for these services. Additionally, eight of these transports were cancelled trips and the Provider did not have the required documentation to bill for them. Therefore, we disallowed the reimbursement received for these services.

Disallowed Services

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

We identified four services that based upon the Provider's documentation were errors in billing. The Provider's records indicated a contradiction in the timing of the transports for two services. Based upon the time listed on the Provider's documentation, the recipient was picked up for their second transport *prior* to returning from their first trip. Documentation for the other two services indicated only a one-way transport and that a return trip was not made. However, the Provider billed round trip services. Therefore, we disallowed the reimbursement received for these services.

Summary of Sample Findings for Ambulette Duplicate Services

We took exception with 151 of 152 RDOS (918 of 1,068 services) from a stratified random sample of the potential duplicate payments subpopulation of 1,488 ambulette RDOS. We calculated the audit findings repayable to ODJFS by projecting the error rate to the Provider's subpopulation of potentially dublicately paid ambulette services. Our projected audit findings were \$114,169.00, with a 95 percent degree of certainty the true population overpayment amount fell within the range of \$102,775.00 to \$125,562.00, a precision of \$11,394 (+/- 9.98 percent). A detailed summary of our statistical sample and projection results is presented in Appendix I.

Remaining Services from Ambulette Sample

We selected a simple random sample of 424 services (107 RDOS) from a subpopulation of 27,602 ambulette RDOS that excluded all services identified by exception testing and identified by our duplicate testing. Our review determined that 295 services (77 RDOS) were overpaid and resulted in projected findings of \$970,489.00. Some services contained more than one error; however, only a single finding was made. The bases for these findings are presented below.

Practitioner Certification Form (PCF) Not Received

Ohio Admin.Code 5101:3-15-02(E) "Documentation requirements" states in pertinent part:

(4) Practitioner Certification Form

(a) The attending practitioner, or a hospital discharge planner or a registered nurse acting under the orders of the attending practitioner...must complete a "Practitioner Certification Form" for all medical transportation services...

(d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days

after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission

(ii) The practitioner certification form must be maintained on file at the provider's office for a minimum of six years...

(g) Practitioner certification for patients who are nonambulatory at the time of transport, but are temporarily nonambulatory...the attending practitioner must certify the estimated length of time that individual is temporarily nonambulatory and transport by ambulance or ambulette would be required. The certification form...is valid for the estimated length of time as designated...unless the...length of time exceeds ninety days...[at which time] a new certification form must be obtained to certify a new estimated length of time...

We identified 52 services where the practitioner certification form (PCF) was not in the patients' files. Also, the PCF on file did not cover the date(s) of service in question of an additional 178 services. Therefore, we disallowed the amount reimbursed for these services.

Lack of Documentation

Ohio Admin.Code 5101:3-15-02(E) "Documentation requirements" states in pertinent part:

(1) Providers of...ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department...

(2) Records which must be maintained include, but are not limited to...

(a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage;

During our field review, we found the Provider did not maintain documentation for 106 services on either a trip sheet or on a trip log. Therefore, we disallowed the reimbursement for these services.

Overstated Mileage

Ohio Admin.Code 5101:3-15-03(E) “Service Limitations” states in pertinent part:

The following services are not covered:

(3) Excessive mileage charges, resulting from the use of indirect routes;

We identified 15 services where the mileage billed for the transport was more than the documented mileage. We tested trips with a discrepancy of greater than one mile using data from two websites.⁷ Based upon this information, we reduced the mileage to that stated on the websites. We calculated the difference between the reimbursement received for the billed mileage and the reimbursement for the corrected mileage. The difference in reimbursement was used in the projection of the finding amount.

Non-Covered Transports

Ohio Admin.Code 5101:3-15-03(B)(2) states in pertinent part:

(a) [For covered ambulette transports,] the ambulette services must be medically necessary as specified below:

(i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport...

(c) The transport must be either transportation to a medicaid covered service or transportation from a medicaid covered service as defined in paragraph (A)(17) of rule 5101:3-15-01 of the Administrative Code.

⁷ Windows Live Local Maps and Yahoo! Local Maps

During our field review, we identified eight services where the Provider billed and was reimbursed for services that are non-covered. Specifically, six services were billed for a recipient whom, according to the PCF, was not “non-ambulatory.” For the remaining two services, the Provider billed for a transport to a non-covered Medicaid service. Therefore, we disallowed the reimbursement the Provider received for these services.

Summary of Sample Findings for Remaining Ambulette Population

We took exception with 77 of 107 statistically sampled ambulette transportation services (295 of 424 RDOS) from the Provider’s total population of paid services. Based upon this error rate, our projected audit finding was \$1,100,118.00 with a precision of \$154,880.00 (+/-14.09 percent) at the 95 percent confidence level. However, since the obtained precision range was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower-limit estimate (equivalent to the method used in Medicare audits), and a finding was made for \$970,489.00. This allows us to say that we are 95 percent certain the population overpayment amount is at least \$970,489.00. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Ambulance Services – Results of Exception Testing

Duplicate Payments

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part:

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

(A) To...submit claims only for services actually performed...

Ohio Admin.Code 5101:3-15-04(A)(1)(c) states:

For total reimbursement, the provider must bill the most appropriate code for the base service and the code for the loaded land ambulance mileage. Both codes must be modified with the appropriate medicaid covered point of transport modifiers.

We identified duplicate ambulance service combinations where the Provider billed for more than one transport for the same recipient, on the same date, to the same point of transport.

We initially identified 29 such billings (58 services). However, after excluding services rendered to dually eligible Medicaid/Medicare patients,⁸ only four duplicate billings remained. We made a finding on the amount reimbursed for the duplicate services.

Additionally, we identified three errors where the Provider billed the ambulance transport instead of the mileage. We recoded these services from the ambulance transport, HCPCS code A0428 (BLS; Non-Emergent Transport), to the appropriate ambulance mileage service, HCPCS code A0425 (Ground Ambulance Mileage; one way, each mile). A finding was made on the difference between the amount reimbursed for incorrectly billed services and the proper payment amount for the mileage.

A total finding of \$260.32 was made for errors listed above.

Ambulance Services – Sample Results

We initially selected a simple random sample of 100 RDOS (381 services) from an ambulance services subpopulation of 637 RDOS (2,494 services). This subpopulation excluded all services already identified by our 100 percent exception testing. Subsequently, we removed services that were billed for potentially dually eligible Medicare/Medicaid patients from the population and sample to avoid double counting of overpayments.⁹

Due to our removal of the above services to dually eligible Medicaid/Medicare patient population, our sample was reduced to 29 RDOS (95 services) and was no longer projectable back to the sampled population as there were insufficient sample records remaining to perform a valid statistical projection. Our review determined that nine RDOS (30 services) were overpaid and resulted in actual findings of \$1,445.05. The bases for these findings are presented below.

Transports Lacked Adequate Number of EMT Personnel

Ohio Admin.Code 5101:3-15-03(A)(2)(e) states in pertinent part:

The transport must be staffed with the appropriate basic crew members corresponding to the level of service billed.

(i) The basic crew for a basic life support ambulance is defined as at least two emergency medical technicians (EMTs)...and the driver if the driver is not one of the two emergency medical technicians.

We identified 26 services where at least two EMT certified personnel were not in the transport vehicle. Specifically, for two of these services only one staff member was on the transport. For

⁸ Nine of the errors were duplicates and five errors were billed as the transport service instead of mileage.

⁹ We found errors within these 144 services during our record review however; we did not make findings as the claims were accounted for in the “Area of Interest” section of our audit report.

the remaining 24 transports, two personnel were in the vehicle but only one of them was a certified EMT. Therefore, we disallowed the reimbursement received for these services, for an actual finding of \$1,265.03.

Practitioner Certification Form (PCF) Not Received

Ohio Admin.Code 5101:3-15-02(E) "Documentation requirements" states in pertinent part:

(4) Practitioner Certification Form

(a) The attending practitioner, or a hospital discharge planner or a registered nurse acting under the orders of the attending practitioner...must complete a "Practitioner Certification Form" for all medical transportation services...

(d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission

(ii) The practitioner certification form must be maintained on file at the provider's office for a minimum of six years...

(g) Practitioner certification for patients who are nonambulatory at the time of transport, but are temporarily nonambulatory...the attending practitioner must certify the estimated length of time that individual is temporarily nonambulatory and transport by ambulance or ambulette would be required. The certification form...is valid for the estimated length of time as designated...unless the...length of time exceeds ninety days... [at which time] a new certification form must be obtained to certify a new estimated length of time...

We identified four services where the Provider's documentation did not contain the practitioner certification form. Therefore, we disallowed the reimbursement for these services which resulted in actual findings of \$180.02.

Ambulance Services – Area of Interest

Transportation Services Billed for Dually Eligible Medicaid/Medicare Recipients

Ohio Admin.Code 5101:3-1-05 states in pertinent part:

- (A) “Medicare” is a federally financed program of hospital insurance part A and supplemental medical insurance benefits part B for aged and disabled persons determined by the social security administration to be entitled to medicare.
- (B) Part A and part B of medicare pay for a basic program of medical coverage under which the patient has certain liabilities in the form of premium payments, deductibles, and coinsurance.
- (C) The medicaid program pays premiums for medicare coverage of all medicaid consumers eligible for medicare and qualified medicare beneficiaries described in this rule. Moreover, for individuals who are eligible under both medicare and medicaid or who are qualified medicare beneficiaries described in this rule, medicaid pays the medicare deductible and coinsurance amounts. The department will not pay for services denied by medicare for lack of medical necessity, although it will pay claims denied for reasons other than medical necessity as long as the services are covered under the medicaid program, and provided that a copy of medicare’s EOMB is attached to the claim. The department will not pay for any service payable by, but not billed to, medicare. Any medicare procedure inadvertently paid for by medicaid will be subtracted from future payments to the provider (except for long-term care facilities where adjustments for such payments will occur as a part of the interim settlement process).

We performed a computerized test for ambulance transports that were provided to dually eligible recipients (a person eligible to receive benefits through both Medicaid and to receive benefits through Medicare Part B.) As this issue came to our attention after we performed our field work, it was necessary to remove services rendered to these recipients from our other ambulance exception tests, ambulance sample, and ambulance sample population to avoid double impact on the same claim.

Based on our testing, we identified 1,949 services (496 RDOS) where it is possible the ambulance services were eligible for Medicare Part B payment. With Medicare Part B reimbursement, Medicaid would have been the secondary payer, and would have only reimbursed the Provider for the coinsurance and deductible amounts. We determined the potential impact on the Medicaid program of \$95,516.19 for these services.

We are not issuing any monetary findings in this area because:

- We discovered this issue after performing our field work and did not have documentation from the Provider for all these services.
- The documentation necessary to evaluate whether the recipients' conditions met Medicare criteria for ambulance transport would be kept in the referring physician's office and not necessarily with the transportation Provider, thus requiring the contacting of many physicians and physician offices.
- The evaluation of a recipient's medical record to determine whether Medicare ambulance transport criteria are met requires the use of medical decision making and judgment which we are not qualified to render.
- Many of the services potentially eligible for Medicare coverage were beyond the time limit in which they could be billed to Medicare, hence no longer recoverable.

Therefore, we are not issuing any findings in this area, but are instead referring this information to ODJFS for further consideration.

Management Comments

Provider Should Obtain All Required Personnel Documentation

Ohio Admin.Code 5101:3-15-02(B) states in pertinent part:

(2) Driver and attendant qualifications

Providers of ambulance services must maintain on file records verifying that drivers and attendants meet the following requirements on the date of the transportation service:

- (a) Each individual who functions primarily as an ambulance driver complies with local, state and federal laws and regulations.
- (b) The qualifications of each ambulance driver meets the specifications set forth in section 4765.43 of the Revised Code; and
- (c) Each ambulance attendant must have a current emergency medical technician (EMT) certification card issued by the division of emergency medical services (EMS) under the Ohio department of public safety; and
- (d) Ambulance attendants employed by out of state providers must have a current EMT certification issued by the appropriate agency in the state in which they are employed; and
- (e) The level of EMT certification must be appropriate to the level of service provided (i.e., advanced life support, basic life support, nonemergency).

Also, Ohio Admin.Code 5101:3-15-02(C) states in pertinent part:

(3) Driver and attendant qualifications

(ii) Each driver and each attendant must have a current card issued and signed by a certified trainer as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certificate or EMT certification. A copy of both sides of the card must be maintained by the provider and provided upon request to the department or their designee . . .

(iii) Each ambulette driver and each attendant must submit himself for criminal background checks in accordance with section 109.572 of the Revised Code. . . .

(iv) Each ambulette driver and each attendant must provide a signed statement from a licensed physician declaring that they do not have a medical condition, a physical condition, . . .

(v) Each ambulette driver must undergo testing for alcohol and controlled substances by a laboratory certified for such testing . . .

(vi) Each ambulette driver must provide from the bureau of motor vehicles his/her driving record at the time of application for employment and annually thereafter. . . .

(vii) Each ambulette driver and each attendant must have completed a passenger assistance training . . .

During our review of 29 ambulette drivers and 19 ambulance EMT drivers' personnel records, we identified deficiencies in the documentation contained in these records.¹⁰ EMT certifications were verified for the ambulance drivers reviewed; however, we determined the following required documentation was not present in the personnel files:

- 48 abstract driver's records
- 30 physician statements
- 23 background checks
- 19 alcohol/substance abuse test results
- 12 CPR certifications
- Six first aid certifications

¹⁰ Some personnel files contained more than one deficiency.

- One passenger assistance course certificate

The Provider is potentially putting patients' safety at risk by not obtaining all of the required documentation. While we are not issuing a monetary finding, we are recommending the Provider obtain all required personnel documentation to prevent further errors and avoid potential future overpayments.

Provider Should Complete Daily Vehicle Inspections as Required

Ohio Admin.Code 5101:3-15-02(C) states in pertinent part:

(2) All providers of ambulette services must comply with the following regulations and provide documentation of compliance to the department upon request:

(a) Each provider must conduct daily inspection and testing of the hydraulic lift or access ramp prior to transporting any wheelchair bound patient; and

(b) Each provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum that the following was performed: the daily inspection and testing of the wheelchair restraints, wheelchair lifts and/or access ramps, the lights, the windshield wipers/washers, the emergency equipment, mirrors, and the brakes; and

(c) Each provider must provide evidence that at least an annual vehicle inspection was completed on each vehicle by the Ohio state highway patrol safety inspection unit, or a certified mechanic, and the vehicle has been determined to be in good working condition.

Upon review of the Provider's inspection checklists, we noted the daily vehicle inspections did not include all of the required components. The forms show the Provider only checks the lights, wipers/washer, and brakes on a daily basis. The lifts/ramps are only checked on a weekly basis and the restraints, emergency equipment, and mirrors are not listed on any of the checklists. In addition, we did not receive evidence of annual vehicle inspections.

By not inspecting all of the required components, the Provider is potentially putting not only its personnel but also its patients at risk. While we are not issuing a monetary finding, we are recommending the Provider perform daily vehicle inspections as specified to prevent further errors and avoid potential future overpayments.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on February 5, 2008 in order to afford the Provider an opportunity to submit additional documentation or otherwise respond in writing. We were contacted by the Provider's legal counsel on February 8, 2008, requesting an extension in the response deadline due to the grave health condition of the Provider's owner. An extension was granted. Subsequently, we were informed of the death of the Provider's owner. The Provider's counsel also informed us that the owner had filed for

personal bankruptcy, and that any further review or response to our draft report would be a moot point. We requested and received documentation of the owner's bankruptcy filing which was forwarded to ODJFS. Our findings remain as \$1,152,801.21.

APPENDIX I
Ambulette Duplicate Services Sample
Summary of Statistical Sample Analysis of Access Transit Company
Audit Period: October 1, 2002 through September 30, 2005

Description	Audit Period Oct. 1, 2002 – Sept. 30, 2005
Type of Examination	Stratified Random Sample
Description of Sub-Population	Sub-population of Ambulette Duplicate Services excluding services selected for other sample and exception testing.
Number of Sub-Population Recipient Dates of Service (RDOS)	1,488
Number of Sub-Population Services	8,727
Number of Recipient Dates of Service (RDOS) Sampled	152
Number of Services Sampled	1,068
Total Medicaid Amount Paid for Population	\$124,252.04
Amount Paid for Population Services Sampled	\$16,500.54
Projected Population Overpayment Amount (Point Estimate)	\$114,169.00
Upper Limit Overpayment Estimate at 95% Confidence Level	\$125,562.00
Lower Limit Overpayment Estimate at 95% Confidence Level	\$102,775.00
Precision of population overpayment projection at the 95% Confidence Level	\$11,394 (+/- 9.98%)

APPENDIX II
Ambulette Services Sample
Summary of Statistical Sample Analysis of Access Transit Company
Audit Period: October 1, 2002 through September 30, 2005

Description	Audit Period Oct. 1, 2002 – Sept. 30, 2005
Type of Examination	Simple Random Sample
Description of Sub-Population Sampled	Sub-population of Ambulette Services excluding services selected for other sample and exception testing.
Total Medicaid Amount Paid For Sub-Population Sampled	\$1,587,712.35
Number of Population Recipient Dates of Service	27,602
Number of Population Services Provided	108,056
Amount Paid for Services Sampled	\$6,242.57
Number of Recipient Dates of Service Sampled	107
Number of Services Sampled	424
Estimated Overpayment using Point Estimate	\$1,100,118.00
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	\$154,880 (14.08%)
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	\$129,628 (11.78%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits).	\$970,489.00

APPENDIX III
Summary of Overpayment Results for
Access Transit Company
For the period October 1, 2002 to September 30, 2005

Description	Audit Period October 1, 2002 to September 30, 2005
Ambulette Service Results	
Exception Testing:	
Erroneously Billed Attendants and Second Passengers	\$62,007.80
Transports Billed for Hospital Inpatients	\$2,271.62
Ambulette Duplicates - Reviewed Prior to Sample	\$1,583.97
Services Billed for Deceased Recipients	\$460.04
Modifier not on Medicaid Covered Point of Transport List	\$67.19
Provider Billed for Ambulette and Ambulance Transport	\$47.22
Exception Testing Subtotal	\$66,437.84
Ambulette Duplicate Services Sample	\$114,169.00
Ambulette Services Sample	\$970,489.00
Ambulette Service Total	\$1,084,658.00
Ambulance Service Results	
Ambulance Duplicate Payments	\$260.32
Ambulance Services Sample	\$1,445.05
Ambulance Service Total	\$1,705.37
Grand Total	\$1,152,801.21
Interest	\$234,981.95
Grand Total of Findings and Interest	\$1,387,783.16

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Mary Taylor, CPA
Auditor of State

ACCESS TRANSIT COMPANY

FRANKLIN COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

**CERTIFIED
APRIL 15, 2008**