Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Canal Transport Corporation

A Compliance Audit by the:

Medicaid/Contract Audit Section

October 2009 ***AOS/MCA-10-005C***

Mary Taylor, CPA
Auditor of State

October 19, 2009

Lou Jessie Jackson
President/Treasurer
Canal Transport Corporation
2182 Romig Road
Akron, Ohio 44320-4061

Dear Ms. Jackson:

Attached is our report on Medicaid reimbursements made to Canal Transport Corporation, Medicaid provider number 2396750, for the period April 1, 2004 to March 31, 2007. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified $518,954.04 in findings plus $90,539.71 in interest accruals totaling $609,493.75 that is repayable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After October 19, 2009, additional interest will accrue at $113.74 per day until repayment occurs. Interest is calculated pursuant to Ohio Administrative Code 5101:3-1-25.

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 Canal Transport Corporation; the Director and Legal Divisions of ODJFS; the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

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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,

Mary Taylor, CPA
Auditor of State

cc: Loretta Colvin, Vice President/Secretary, Canal Transport Corporation
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Medicaid Fraud Control Unit, Ohio Attorney General
U.S. Dept. of Health and Human Services/Office of Inspector General
Ohio Medical Transportation Board

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ACRONYMS

AOS	Auditor of State
CMN	Certification of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
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
RDOS	Recipient Date of Service

SUMMARY OF RESULTS

The Auditor of State performed an audit of Canal Transport Corporation, (hereafter called the Provider), provider number 2396750, headquartered at 2182 Romig Road, Akron, Ohio 44320-4061. Within the Medicaid program, the Provider is listed as an ambulette service provider. An ambulette is designed to transport individuals sitting in a wheelchair.

We performed our audit in accordance with Ohio Rev. Code Section 117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified $518,954.04 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] Additionally, we assessed accrued interest of $90,539.71, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $609,493.75 which is repayable to ODJFS as of the release of this audit report. Additional interest of $113.74 per day will accrue after September 17, 2009, 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 and the Ohio Medicaid Provider Handbook. 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.[2] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules to ensure that services billed are properly documented and consistent with professional standards of care; medical necessity; and sound fiscal, business, or medical practices.

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."

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

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[1] *Compliance testing was based on the rules as they existed at the time the service was rendered.*
[2] *See Ohio Admin Code 5101:3-1-01(A) and (A)(6).*

date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

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."

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 notification letter, we held an entrance conference at the Provider's headquarters on August 27, 2008, 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 April 1, 2004 to March 31, 2007, excluding services reviewed by ODJFS' Surveillance and Utilization Review Section. The Provider was reimbursed $1,014,006.85 for 73,437 services rendered on 18,610 recipient dates of service. A recipient date of service (RDOS) is defined as all services received by a particular recipient on a specific date.

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).[3]

Prior to beginning our fieldwork, we performed a series of computerized tests on the Provider's Medicaid payments for ambulette claims to determine if reimbursements were made for potentially inappropriate services or service code combinations. Of these tests, the following resulted in potential overpayments:

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[3] *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.*

- Transportation service claims where base codes are not accompanied with corresponding mileage codes.
- Potential duplicate payments where payments were made for the same recipient on the same date of service with the same procedure code and modifier.
- Claims for transport services billed while the recipient was a hospital inpatient.
- Payments made for services to deceased recipients for dates of service after the date of death.

All exception tests were positive except for the test for services to deceased recipients. When performing our audit fieldwork, we reviewed all available documentation for claims identified by our exception testing (i.e., 100 percent review). All claims analyzed as part of our exception testing were separated from the remainder of the Provider's population of claims so as not to double count and overstate any potential findings.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we selected a statistically random sample of 454 ambulette services on 98 RDOS. The total results were then projected across the entire population to determine the total findings.

When performing our audit fieldwork, we requested the Provider's supporting documentation for the sampled RDOS and all potentially inappropriate service code combination claims identified by our exception analyses.

Our fieldwork was primarily performed between August 2008 and March 2009.

RESULTS

We identified findings of $1,901.04 for services in our exception testing. Additionally, we identified findings from our sample that when projected totaled $517,053. Together, our findings from our exception testing and projected samples total $518,954.04, the bases of which are discussed below.

Results of Exception Testing

We performed exception testing on the Provider's paid claims for the following issues: ambulette transportation service claims where base codes are not accompanied with corresponding mileage codes, duplicate payments, and services billed while recipient was a hospital inpatient. The results of our review are as follows.

Transportation Service Base Codes without Corresponding Mileage Codes

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

> For the total reimbursement, the provider must bill the appropriate code for ambulette base service and the code for the loaded mileage. Both codes must be modified by the appropriate Medicaid point of transport modifier.

We identified 87 services where the Provider appeared to bill base codes without corresponding mileage codes. Our review of the Provider's documentation for these services revealed the following 97 errors that resulted in findings:

- 27 services where the Provider did not supply a CMN;
- 20 services that lacked sufficient documentation (e.g., trip log) to support that the service billed had actually been rendered;
- 20 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 14 services where the CMN supplied did not cover the date of service;
- 5 services where the patient's non-ambulatory status was in question;
- 4 services where the CMN was not signed or the illegible signature was not accompanied with identifying information;
- 3 service where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code.
- 2 services where the CMN received lacked the medical condition to support the medical necessity of the transport; and
- 2 services where the ambulette driver was ineligible to render Medicaid transport services because of excessive points on his/her driver's license.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $1,652.70 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Payments

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part that by signing an agreement to provide Medicaid services, a provider certifies and agrees to:

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

We identified 14 services where the Provider appeared to have billed for more than one transport for the same recipient on the same date of service. While our analysis revealed that the Provider miscoded some services resulting in apparent duplicates, our review of documentation identified the following 14 errors that resulted in findings:

- 8 services where the Provider did not supply a CMN;
- 4 services where the attending practitioner did not certify that the patient met the conditions for a covered transport; and
- 2 services where an incorrect procedure code was billed.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $194.32 were made on the amount reimbursed to the Provider for the errors listed above.

Transportation Services 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…
>
> ***

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

> ***
>
> (E) Service Limitations
>
> The following services are not covered:
>
> (1) Unloaded transports (i.e., no Medicaid patient in the vehicle) …

Our initial claims analysis identified six transportation services where the Provider appeared to have billed for an ambulette transport while the patient was a hospital inpatient. Our review of documentation identified the six errors that resulted in findings:

- Four services which lacked documentation (e.g., trip report) to support that the service billed had actually been rendered; and
- Two services where the Provider did not supply a CMN.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $54.02 were made on the amount reimbursed to the Provider for the errors listed above.

Summary of Exception Testing

Total combined findings of $1,901.04 resulted from our exception tests. Some of the more common errors identified during our exception testing included transportation services lacking

requisite supporting documentation, including a CMN to justify the medical necessity of the service; and services where the CMNs provided were not completed by authorized practitioners, were missing required information (e.g., medical condition), or indicated that the patients did not meet conditions for a covered transport.

Results of Statistical Sample

Ohio Admin.Code 5101:3-1-27 (B)(1) states:

> "Audit" means a formal postpayment examination, made in accordance with generally accepted auditing standards, of a medicaid provider's records and documentation to determine program compliance, the extent and validity of services paid for under the medicaid program and to identify any inappropriate payments. The department shall have the authority to use statistical methods to conduct audits and to determine the amount of overpayment. An audit may result in a final adjudication order by the department.

We selected a statistically random sample of ambulette services that was stratified based on the amount paid for services. Our sample was chosen from the remaining population of services after removing all claims associated with our exception testing.

The findings were then projected across the total sampled population, resulting in a total finding of $517,053.

Ambulette Services Sample – Detailed Results

Our stratified random sample of 98 ambulette RDOS (involving 454 services) identified 65 RDOS (298 services) with a combination of 505 errors resulting in a projected population overpayment of $517,053. There were services that had more than one error; however, only one finding was made per service. The bases for these errors are presented below.

Issues with Certificates of Medical Necessity

Additionally, Ohio Admin.Code 5101:3-15-01 states in pertinent part:

(A) The following definitions are applicable to this chapter:

(6) "Attending practitioner" is defined as the practitioner (i.e., primary care practitioner or specialist) who provides care and treatment to the patient on an ongoing basis and who can certify the medical necessity for the transport. …Practitioners must hold a valid and current license or certification to practice as at least one of the following:

(a) A doctor of medicine
(b) A doctor of osteopathy

(c) A doctor of podiatric medicine
(d) An advance practice nurse (APN).

***

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

(1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if documentation specified is not maintained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.

(2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule.

***

(b) The original "practitioner certification form", completed by the attending practitioner, documenting the medical necessity of the transport, in accordance with this rule;

***

(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 in accordance with paragraph (E)(4)(b) of this rule, must complete a "Practitioner Certification Form" for all medical transportation services…

(b)…a registered nurse, with an order from the attending practitioner, may write the practitioner's name on the ordering line of the practitioner certification form, sign his or her own full name and the professional letters "R.N." after the practitioner's name on the signature line and enter the date of the signature. The professional letters "R.N." must follow the nurse's last name or;

A hospital discharge planner with a written order from the attending practitioner, may write the practitioner's name on the ordering line of the practitioner certification form, sign his or her own full name on the signature line and enter the date of signature…

(c) Medical condition

The practitioner certification form must state the specific medical conditions related to the ambulatory status of the patient which contraindicate transportation by any other means on the date of the transport, and use the correct form which specifies the mode of medical transportation (ambulance or ambulette) the patient will require. The attending practitioner must clearly specify the condition of the patient which renders transport by ambulance or ambulette medically necessary.

(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.

***

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

(a) The ambulette services must be medically necessary…

***

During our review of the documentation submitted by the Provider, we found numerous errors with the practitioner certification form (i.e., CMN), which certifies the basis for the necessity of the transport. Based on our review, we took findings due to the following 348 errors:

- 126 services where the Provider did not supply a CMN;
- 76 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 52 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 52 services where the CMN supplied did not cover the date of service;
- 16 services where the CMN received lacked the medical condition/diagnosis to support the medical necessity of the transport;
- 14 services where the CMN was not signed or the illegible signature was not accompanied with identifying information; and
- 12 services where the CMN's date is incomplete.

Without a properly completed CMN, we could not determine the medical necessity of the transportation service. We therefore disallowed the reimbursement for those services with an improperly completed CMN and used this amount in calculating the projected finding.

Transportation Services Lacking Supporting Documentation

Ohio Admin.Code 5101:3-15-02 (E)(2)(a) states:

> 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; and

Ohio Admin.Code 5101:3-1-17.2 (D) states:

> 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.

We determined that 130 services lacked documentation (e.g., trip report) to support the service billed had actually been rendered. The amounts reimbursed for these services were used in calculating the projected finding.

Incomplete Point of Transport Information

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

> (1) Providers of air ambulance, ambulance and 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, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .
>
> (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; and

***

We identified 14 services where the Provider did not provide complete addresses for points of transport origin or destination. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Patients' Non-Ambulatory Status in Question

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

(B) Ambulette services coverage and limitations

***

(2) Covered ambulette transports:

Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements in this paragraph are met.

(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 as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code;

***

Additionally, Ohio Admin.Code 5101:3-15-01 states in pertinent part:

(A) The following definitions are applicable to this chapter

***

(20) "Nonambulatory"…is defined as those permanently or temporarily disabling conditions which preclude transportation in motor vehicle(s) or motor carriers as defined in section 4919.75 of the Revised Code that are not modified or created for transporting a person with a disabling condition. . . .

Our review of the Provider's documentation identified four services where the patients' non-ambulatory status was in question. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Issues with Driver Qualifications

Ohio Admin.Code 5101:3-15-02(C)(3)(a)(vi) states:

> 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. The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment. Persons having six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

Based on our analysis, we identified six services where the driver had six or more points on his/her driver's license at the time the transport was performed. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Incorrectly Billed Mileage

Ohio Admin.Code 5101:3-15-01(A)(14) states in pertinent part:

> ***
>
> "Loaded mileage" is defined as the number of miles a patient is transported in the ambulance or ambulette to or from a Medicaid covered service….
>
> ***

Additionally, Ohio Admin.Code 5101:3-1-17.2 states in pertinent part that by signing an agreement to provide Medicaid services, a provider certifies and agrees to:

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

We identified three services where the Provider was over paid mileage for transports. In these instances, we determined that the Provider billed in excess of what its records supported or the mileage was greater than that listed on independent map engines. We therefore disallowed the reimbursement for the excess billed mileage and used this amount in calculating the projected finding.

Summary of Ambulette Sample Findings

The overpayments identified for 65 of 98 RDOS (involving 298 of 454 services) from our stratified random sample of ambulette transportation services were projected across the Provider's population of ambulette paid recipient dates of service, excluding those already selected for 100 percent review. This resulted in a projected overpayment amount of $623,108 with a precision of plus or minus $126,372 (20.28 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 using the lower limit of a 90 percent confidence interval (equivalent to the method used in Medicare audits), and a finding was made for $517,053. This allows us to say that we are 95 percent certain the population overpayment amount is at least $517,053. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Summary of Findings

A total of $518,954.04 in findings was identified. These findings result from the combination of our exception testing ($1,901.04) and our statistical sample projections ($517,053). For those services selected in our exception testing and samples, we reviewed all corresponding records in their entirety (i.e., 100 percent review).

Matters for Attention

Although the following matters did not result in monetary findings during the current audit, we are bringing them to the attention of the Provider as areas of non-compliance as they could result in future findings. We are also bringing these issues to the attention of ODJFS as the state single agency responsible for the Medicaid program in Ohio, ODJFS is well positioned to educate providers and improve system controls to curtail these issues.

Incomplete Patient Certification on Ambulette CMNs

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

> <u>Covered ambulette transports</u>
>
> Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements are met.
>
> (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 as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code; and
>
> (ii) The attending practitioner has certified that the individual does not require ambulance services: the individual does not use passenger

vehicles as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code as transport to non-Medicaid services.; and the individual is physically able to be safely transported in a wheelchair.

***

During the course of our audit, we identified 56 services where the attending practitioner did not certify that an ambulance was not required on the ambulette CMN supplied by the Provider, per the Ohio Admin.Code. A majority of these services occurred in conjunction with other errors, including those related to the CMN.

In order to avoid potential future findings in this area, we recommend that the Provider review its procedures to ensure that ambulette CMNs used to support services billed are completed in their entirety.

Other Observations

We reviewed the Provider's employee files and other documentation maintained to determine if the Provider complied with driver requirements per the Ohio Administrative Code.

The results, as follows, did not result in monetary findings; however, failure to comply with applicable regulations could place patients in harm's way and jeopardize the Provider's status with the Medicaid program.

Required Documentation Lacking for Drivers

We reviewed the Provider's employment files and conducted additional analysis to determine if required procedures were followed and required documentation was kept on file. We specifically tested the employment files for 5 of 67 ambulette drivers listed by the Provider in response to a questionnaire given at the start of our audit. We found numerous problems with those drivers tested that would have precluded the driver from being allowed to render services under Medicaid rules. The more notable problems identified include the following:

- One driver had a prior conviction for felony drug possession.
- Two drivers had their licenses suspended at various times during the audit period.
- Two drivers lacked CPR certification at various times during the audit period.
- Five drivers lacked proof of insurance coverage either throughout or at various times during the audit period.

Due to poor documentation, however, we could not always identify the driver who rendered the service. In those instances where a service could be tied to a driver listed above, the reimbursements were ultimately disallowed for other reasons in all cases.

PROVIDER'S RESPONSE

Detailed lists of services for which we took findings were first mailed to the Provider on June 23, 2009; however, the letter and attachment were returned undeliverable as the Provider has closed its Romig Avenue location. Ultimately, the detailed list of services for which we took findings was received by the Provider on August 3, 2009. The Provider was afforded 10 business days from receipt of the detailed lists to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. After having not received a response, a draft audit report was then mailed to the Provider on August 27, 2009, for final review and response.

APPENDIX I

Summary of Sample Record Analysis for Canal Transport Corporation
For the period April 1, 2004 through March 31, 2007
Ambulette Sample Population – Provider Number 2396750

Description	Audit Period [April 1, 2004 - March 31, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulette services excluding exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$1,011,631***
Number of Population Recipient Dates of Service	**18,596**
Number of Population Services Provided	**73,330**
Amount Paid for Services Sampled	***$7,531***
Number of Recipient Dates of Service Sampled	***98***
Number of Services Sampled	***454***
Estimated Overpayment using Point Estimate	***$623,108***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $126,372 (20.28%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/- $106,054 (17.02%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$517,053***

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Mary Taylor, CPA
Auditor of State

CANAL TRANSPORT CORPORATION

SUMMIT 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
OCTOBER 19, 2009

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