Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Emergency Medical Transport, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

October 19, 2009

Kenneth J. Joseph, Owner
Emergency Medical Transport, Inc.
2511 Waynesburg Dr. SE
Canton, Ohio 44707

Dear Mr. Joseph:

Attached is our report on Medicaid reimbursements made to Emergency Medical Transport, Inc., Medicaid provider number 2000051, 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 $66,481.79 in findings plus $10,068.80 in interest accruals totaling $76,550.59 that are 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 $14.57 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 Emergency Medical Transport, Inc.; the Director and Legal Divisions of ODJFS; the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; 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

Mary Taylor, CPA
Auditor of State

cc: Emergency Medical Transport, Inc.
Ohio Medicaid 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 Emergency Medical Transport, Inc., (hereafter called the Provider), provider number 2000051, headquartered at 2511 Waynesburg Dr. SE, Canton, Ohio 44707. Within the Medicaid program, the Provider is listed as an ambulance and ambulette service provider. Ambulances are defined as vehicles designed to transport individuals in a supine position, while ambulettes are designed to transport individuals sitting in wheelchairs.

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 $66,481.79 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] Additionally, we assessed accrued interest of $10,068.80, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $76,550.59, that is repayable to ODJFS as of the release of this audit report. Additional interest of $14.57 per day will accrue after October 19, 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

[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 April 9, 2008, to discuss the purpose and scope of our audit. The scope of our audit was limited to claims (not involving Medicaid co-payments for Medicare) for which the Provider rendered services to Medicaid patients and received payment during the period of April 1, 2004 to March 31, 2007. The Provider was reimbursed $881,808.68 for 32,949 services rendered on 9,221 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 non-emergency ambulance and ambulette claims to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for the following exceptions:

- Claims reimbursed with one-way mileage greater than 50 miles.

[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.*

- Ambulance services billed to Medicaid that are potentially covered by Medicare for dually eligible recipients.
- Potential duplicate payments where payments were made for the same recipient on the same date of service with the same procedure code and modifier.
- Transportation service claims where base codes are not accompanied with corresponding mileage codes.
- Potential duplicate claims for ambulance transport services billed to both the Medicaid and Medicare programs as the primary insurer for the same recipient, on the same date of service, for the same procedure codes, procedure code modifiers and units.

All of our exception tests identified potentially incorrect reimbursements. 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 two statistically random samples: one for ambulance services consisting of 215 RDOS and one for ambulette services consisting of 393 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 April and September 2008, and additional fieldwork was conducted between March and June 2009.

RESULTS

We identified findings of $9,864.23 for services in our exception testing. Additionally, we identified findings of $5,477.42 from our samples that when projected totaled $56,617.56. Together, our findings from our exception testing and samples total $66,481.79, 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: claims reimbursed with one-way mileage greater than 50 miles, ambulance services billed to Medicaid that are potentially covered by Medicare for dually eligible recipients, duplicate payments, transportation service claims where base codes are not accompanied with corresponding mileage codes, and duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs as the primary insurer. The results of our review are as follows.

Transports Greater than 50 Miles

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

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(H) Medical transportation providers, when providing a non-emergency ground ambulance, or ambulette service must document the reason for transport when the destination occurs outside of the patient's community, (a fifty mile radius from the patient's residence). Mileage greater than fifty miles will not be covered if the provider is unable to produce the documentation which gives the reason for the transport to be out of the patient's community.

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We initially identified 603 services for trips exceeding 50 one-way miles. Our analysis revealed four mileage services that lacked documentation to justify the transport to be out of the patient's community. We therefore disallowed the reimbursement for mileage in excess of 50 miles (one-way). For the remaining services we identified the following 54 errors that resulted in findings:

- 24 services where the Provider was unable to furnish proof that the driver or crewmember had the requisite certifications (i.e., EMT, CPR, and First Aid certification) and/or a valid driver's license;
- 13 services where the number of miles billed exceeded the amount supported in the Provider's documentation;
- 8 services where the CMN was not dated by the attending practitioner;
- 3 services where the patient was transported by ambulance and the Provider billed for an ambulance service; however, an ambulette CMN was supplied as support;
- 2 services where the Provider did not supply a certificate of medical necessity or CMN, which certifies the basis for the necessity of the transport;
- 2 services where the CMN supplied did not cover the date of service;
- 1 service where either no documentation was received to verify the services occurred or incomplete documentation (e.g., no trip log) was received to support that the service billed had actually been rendered; and
- 1 service where the Provider did not provide complete addresses for points of transport origin or destination.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $4,975.89 were made on the amount reimbursed to the Provider for the errors listed above.

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

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

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> (C) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.
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> ***

We identified ambulance transport services that were provided to dually eligible recipients (persons who are eligible to receive benefits through Medicaid and are also eligible to receive benefits through Medicare Part B for ambulance transportation services). We removed the services rendered to the dually eligible recipients from the remaining ambulance exception reports, the ambulance sample, and the sampled ambulance population to avoid double impact. We sent the Provider an exception report detailing those services potentially covered by Medicare that were still within 18 months of their date of service. The letter notified the Provider of our potential findings for 85 ambulance transport services, and requested supporting documentation showing proper billing to and reimbursement by Medicaid.

The Provider responded agreeing to some of the findings and furnished documentation that justified its billing Medicaid as primary payor for several services. However, for several services, the documentation provided ultimately substantiated the findings identified as the Provider supplied documentation showing Medicare had paid for the service. Therefore, we are disallowing the Medicaid reimbursement for 62 of the ambulance transport services totaling $3,319.25.

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...
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> ***

We identified 287 potential duplicate services where the Provider may have billed for more than one transport for the same recipient on the same date of service. Our analysis determined that none of the services were billed as duplicates. Based on our review of records for the 287 services, we identified the following 59 errors that resulted in findings:

- 49 services where the Provider was unable to furnish proof that the driver or crewmember had the requisite certifications (i.e., EMT, CPR, and First Aid certification) and/or a valid driver's license;
- 4 services where the Provider did not supply a CMN; and

- 4 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code; and
- 2 transport services where no documentation was received to verify the services occurred, which could indicate services not rendered or potentially duplicate billed services.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $1,223.77 were made on the amount reimbursed to the Provider for the errors listed above.

Transportation Service Base Codes without Corresponding Mileage Codes

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

> For the 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 medical covered point of transport modifiers.

Further, 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 72 potential services where the Provider appeared to bill base codes without corresponding mileage codes. Our analysis revealed that in many cases the Provider had miscoded the modifier on the mileage service code, resulting in a mismatch between the base service code and the corresponding mileage service code when billed, however, no findings were taken for this exception. Our analysis of these services identified the following 13 errors that resulted in findings:

- 5 services where the Provider was unable to furnish proof that the driver or crewmember had the requisite certifications (i.e., EMT, CPR, and First Aid certification) and/or a valid driver's license;
- 4 services where the Provider did not supply a CMN;
- 2 services that lacked sufficient documentation (e.g., trip log) to support that the service billed had actually been rendered;
- 1 services where the CMN supplied did not cover the date of service; and
- 1 service where the attending practitioner signed but did not date the signature on the CMN.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $277.72 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Claims for Ambulance Services Paid for by Both Medicaid and Medicare

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

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(A) Definitions.

(1) "Medicare" is a federally financed program of hospital insurance (part A) and supplemental medical insurance (also called SMI and/or part B) for aged and disabled persons.

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(6) "Dual Eligibles or Dually Eligible Consumers" are individuals who are entitled to medicare hospital insurance and/or SMI and are eligible for medicaid to pay some form of medicare cost sharing…

(7) "Medicare Crossover Claim" means any claim that has been submitted to the Ohio department of job and family services (ODJFS) for medicare cost sharing payments after the claim has been adjudicated and paid by the medicare central processor, medicare carrier/intermediary or the medicare managed care plan and the medicare central processor or medicare carrier/intermediary has determined the deductible, coinsurance and/or co-payment amounts. Claims denied by the medicare carrier/intermediary or the medicare managed care plan are not considered medicare crossover claims…

***

(B) Medicare crossover process.

(1) The medicare program determines the portion of medicare cost sharing, if any, due to the provider based on medicare's business rules…

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(3) For medicare crossover claims, the total sum of the payments made by ODJFS, medicare and/or all other third party payers is considered payment in full…

(b) If payment (other than the cost sharing amounts) is inadvertently received from both medicare and medicaid for the same service, the

> ODJFS claims adjustment unit must be notified in accordance with the provisions set forth in rule 5101:3-1-19.8 of the Administrative Code.
>
> ***

Furthermore, 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...
>
> ***

Finally, Ohio Admin.Code 5101:3-15-03(A)(2)(j) states,

> Ambulance services to all eligible medicare patient are to be billed to medicare. If the patient has medicare coverage, the department will reimburse only part-B co-insurance and deductible amounts.

Our exception test initially identified 21 potential services where the Provider appeared to bill both Medicaid and Medicare as the primary payer for the same patient and service. We identified these services by matching claims where Medicaid paid the Medicare co-insurance and deductible amounts with those where Medicaid was billed directly and paid as primary insurer. The matching was done by recipient, date of service, procedure code and procedure code modifier. Our review revealed that Medicaid was billed and made four payments for the same service as was paid by Medicare. More specifically, we determined that in all four cases Medicaid correctly identified that there was a Medicare payment for the claim and correctly denied the ambulance base service code. However, in all four cases, Medicaid paid for the corresponding mileage service code, resulting in an overpayment. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare.

Findings totaling $67.60 were made on the amount paid by the Medicaid program for the mileage already covered by Medicare.

Summary of Exception Testing

Total combined findings of $9,864.23 resulted from our exception tests. Some of the more common errors denoted during our exception testing included services where the Provider was unable to furnish proof that the driver or crewmember had the requisite certifications (i.e., EMT, CPR, and First Aid certification) and/or a valid driver's license; overbilled mileage; transportation services lacking a CMN to justify the medical necessity of the service; and ambulance services billed to Medicaid that should have been billed to Medicare for dually eligible recipients.

Results of Statistical Samples

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 two statistically random samples that were stratified based on the amount paid for services. One sample was for ambulance services and the other was for ambulette services. Our samples were chosen from the remaining population of services after removing all claims associated with our exception testing.

Ambulance Services Sample – Detailed Results

Our stratified random sample of 213 ambulance RDOS (involving 704 services) identified 10 RDOS (18 services) with a combination of 22 errors resulting in actual overpayments of $904.56. 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

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).

***

Additionally, 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; and…

***

(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.
>
> ***

During our review of the documentation submitted by the Provider, we found numerous errors with practitioner certification forms (i.e. CMNs), which certify the basis for the necessity of the transport. Based on our review, we took findings due to the following 20 errors:

- 6 services where the Provider did not supply a CMN;
- 4 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 4 services where the CMN was not dated by the attending practitioner; and therefore, we could not determine if it covered the date of the sampled services;
- 4 services where either the CMN was not signed by the attending practitioner or the licensure of the person signing the CMN could not be verified; and
- 2 services where the attending practitioner did not certify that the patient met the conditions for a covered transport.

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.

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

Additionally, 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 one service lacked documentation (e.g., trip log) to support the service billed had actually been rendered. We therefore disallowed the reimbursement for these services.

Issues with Driver and Attendant Qualifications

Ohio Admin.Code 5101:3-15-02 (B)(2) states in pertinent part:

> 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) Qualifications of each ambulance driver meets the specifications set forth in Chapters 4765. and 4766. of the Ohio 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
>
> ***

Ohio Admin.Code 5101:3-15-02(E)(2) states in pertinent part:

> 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. All records and

> documentation required by this rule must be retained in accordance with rules 5101:3-1-17.2 and 5101:3-1-27 of the Administrative Code.
>
> ***
>
> (d) Copies of the pilot's/driver's/attendant's certification or licensure, which must be current at the time of transport, in accordance with paragraph (D)(2) of this rule for air ambulance, paragraph (B)(2) of this rule for ambulance and paragraph (C)(3) of this rule for ambulette.
>
> ***

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

> The transport must be staffed with the appropriate basic crewmembers 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) as described in section 4765.43 of the Revised Code and the driver if the driver is not one of the two emergency medical technicians.
>
> (ii) The basic crew for an advanced life support ambulance is defined as at least two emergency medical technicians (EMTs) as described in section 4765.43 of the Revised Code and the driver if the driver is not one of the two emergency medical technicians.
>
> (iii)The basic crew for specialty care transport must be in accordance with Chapters 4765. and 4766. of the Revised Code.

We identified an ambulette mileage service incorrectly billed as an ambulance mileage service. However, the Provider was unable to furnish proof that the crewmember rendering this service had a valid CPR and First Aid certification at the time of service. We therefore disallowed the reimbursement for this service.

Summary of Ambulance Sample Findings

The overpayments identified for 10 of 213 RDOS (involving 18 of 704 services) from our stratified random sample of ambulance transportation services were not projected to the Provider's population of ambulance services. No projection was made because both the error rate and the overpayments identified fell below our criteria for projecting results of a sample.

Therefore, the findings for the services in our ambulance sample were limited to the actual identified overpayment of $904.56.

Ambulette Services Sample – Detailed Results

Our stratified random sample of 393 ambulette RDOS (involving 1,533 services) identified 76 RDOS (277 services) with a combination of 318 errors resulting in a projected population overpayment of $55,713. 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

(b) 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). Based on our review, we took findings due to the following 193 errors:

- 157 services where the CMN was not dated by the attending practitioner;
- 14 services where either the CMN was not signed by the attending practitioner or the licensure of the person signing the CMN could not be verified.
- 8 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 4 services where the CMN supplied did not cover the date of service;
- 4 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 4 services where the attending practitioner did not certify that the patient met the conditions for a covered transport; and
- 2 services where the Provider did not supply a CMN.

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.

Issues with Driver and Attendant Qualifications

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

> 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. All current employees must provide their current card (not a copy) for inspection upon request to ODJFS or its designee. Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or its designee.

Further, Ohio Admin.Code 5101:3-15-02 (C)(3)(a)(viii) states:

> Each ambulette driver must have a valid driver's license and be 18 years or older.

During our review of documentation submitted by the Provider for seven ambulette drivers, the Provider was unable to furnish proof that two drivers had current, valid CPR and First Aid certifications during a portion of the audit period. Furthermore, the Provider was unable to furnish proof that one of these same ambulette drivers had a current, valid driver's license during a portion of the audit period. We therefore disallowed the reimbursement for 110 services conducted by uncertified or unlicensed crew throughout the audit period where appropriate 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 12 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. We therefore disallowed the reimbursement for the excess billed mileage 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 three services lacked documentation (e.g., trip log) to support the service billed had actually been rendered. The amounts reimbursed for these services were used in calculating the projected finding.

Summary of Ambulette Sample Findings

The overpayments identified for 76 of 393 RDOS (involving 277 of 1,533 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 $72,129 with a precision of plus or minus $15,375 (21.32 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).

Because of the moderate skewness in the sample results an additional lower limit adjustment was made[4] and a final adjusted lower limit finding was made for $55,713. This allows us to say that we are 95 percent certain the population overpayment amount is at least $55,713. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Summary of Findings

A total of $66,481.79 in findings was identified. These findings result from the combination of our exception testing ($9,864.23) and our statistical samples ($56,617.56). 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

[4] *Correction in lower limit confidence level using method described in "Sampling Methods for the Auditor, an Advanced Treatment" by Herbert Arkin, McGraw-Hill, 1982. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, vol. 1, Cambridge University Press, New York, 1954, table 42.*

agency responsible for the Medicaid program in Ohio, ODJFS is well positioned to educate providers and improve system controls to curtail these issues.

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

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

> ***
>
> (C) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.
>
> ***

Based on our testing, we identified 328 ambulance services that were provided to dually eligible recipients that were paid for by Medicaid that were potentially covered by Medicare Part B. With Medicare Part B reimbursement, Medicaid would have been the secondary payor, and would have only reimbursed the Provider for the Medicare coinsurance and deductible amounts. However, since 243 of these services were beyond the time period in which they could have been re-billed to Medicare, no final determination could be made or finding collected. Medicaid paid $12,210.22 for these services.

In order to avoid future findings in this area, we recommend that the Provider review its procedures to ensure that recipient eligibility is fully determined and that Medicare and other insurance carriers are billed prior to Medicaid, as it is the payor of last resort.

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 for 31 drivers (24 ambulance drivers and 7 ambulette drivers) to determine if required procedures were followed and required documentation was kept on file. Our results are as follows:

Lack of Driving Record Reviews

Ohio Admin.Code 5101:3-15-02(B)(2)(f) states:

> Effective January 1, 2004, each ambulance 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 ambulance driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

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.

Our review of 31 driver personnel files found 19 files (4 of 7 ambulette drivers and 14 of 24 ambulance drivers) where there was no evidence of a BMV or equivalent driving record review.

Lack of Criminal Background Checks for Drivers

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

> ***
> (a)(iii)
> Each ambulette driver and each attendant must submit himself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been convicted of or pleaded guilty to violations cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the Revised Code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply.
>
> ***
>
> (b) A provider may employ an applicant on a temporary provisional basis pending the results of the required information set forth in paragraphs (C)(3)(a) (iii), (C)(3)(a)(iv) and (C)(3)(a)(v) of this rule if the following conditions are met . Providers who are in

the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.

(i) The length of the temporary provisional period shall be sixty days or the period established by another state government agency or board with the authority under Ohio law to regulate providers of ambulette services, whichever is greater.

(ii) No applicant shall be accepted for permanent employment as an ambulette driver or attendant unless all the requirements of paragraph (C)(3)(a) of this rule have been met.

***

Our review of seven ambulette driver personnel files found one where there was no evidence that a criminal background check was performed.

Lack of Medical and Drug Screening

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

***

(a) (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, including a vision impairment (not corrected), and a hearing impairment (not corrected), or mental condition which could interfere with safe driving, safe passenger assistance, the provision of emergency treatment activity, or could jeopardize the health or welfare of patients being transported.

***

(v) Each ambulette driver must undergo testing for alcohol and controlled substances by a laboratory certified for such testing under CLIA and be determined to be drug and alcohol free…

***

(b) A provider may employ an applicant on a temporary provisional basis pending the results of the required information set forth in paragraphs (C)(3)(a) (iii), (C)(3)(a)(iv) and (C)(3)(a)(v) of this rule if the following conditions are met. Providers who are in the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.

(i) The length of the temporary provisional period shall be sixty days or the period established by another state government agency or board with the

> authority under Ohio law to regulate providers of ambulette services, whichever is greater.
>
> (ii) No applicant shall be accepted for permanent employment as an ambulette driver or attendant unless all the requirements of paragraph (C)(3)(a) of this rule have been met.

Our review of seven ambulette driver personnel files found that two lacked medical statements and three lacked drug screen results.

Lack of Required Training

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

> ***
>
> (a)(vii)Each ambulette driver and each attendant must have completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.
>
> ***

Our review of seven ambulette driver personnel files found that two lacked evidence of passenger assistance training.

PROVIDER'S RESPONSE

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on June 29, 2009. The Provider was afforded 10 business days from the receipt of the draft report to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. The Provider requested several extensions to provide additional documentation in response to the findings in our draft report. The documentation was received on August 7, 2009, and findings were adjusted where appropriate. At the request of the Provider, exit conferences were held on August 19, 2009 and September 8, 2009 to discuss audit findings and to provide additional documentation for consideration. A final draft audit report was sent to the Provider on September 29, 2009, for review and response. A discussion of the September 29th draft report was held on October 8, 2009 after which findings were adjusted as appropriate.

A formal response was received from the Provider on October 14, 2009 and is presented in Appendix II.

APPENDIX I

Summary of Sample Record Analysis for Emergency Medical Transport, Inc.
For the period April 1, 2004 through March 31, 2007
Ambulette Sample Population – Provider Numbers 2000051

Description	Audit Period [April 1, 2004 – March 31, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulette services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$481,186***
Number of Population Recipient Dates of Service	***6,991***
Number of Population Services Provided	***26,661***
Amount Paid for Services Sampled	***$25,578***
Number of Recipient Dates of Service Sampled	***393***
Number of Services Sampled	***1,533***
Estimated Overpayment using Point Estimate	***$72,129***
Upper Limit Overpayment Estimate at 95% Confidence Level (corrected for skewness)	***N/A***
Lower Limit Overpayment Estimate at 95% Confidence Level (corrected for skewness)	***$55,713***
Adjusted Precision: Lower Limit	***+/- $16,429 (22.77%)***[5]
Finding Amount	***$55,713***

[5] *Correction to upper and lower limit confidence levels using method described in "Sampling Methods for the Auditor, an Advanced Treatment" by Herbert Arkin, McGraw-Hill, 1982. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, vol. 1, Cambridge University Press, New York, 1954, table 42.*

JOHN A. MURPHY, JR

Appendix II: Provider's Response

October 14, 2009

VIA ELECTRONIC MAIL:
AND BY REGULAR U.S. MAIL

Auditor of State, Mary Taylor, CPA
Attn: Jeffrey A. Castle, Chief Auditor
88 East Broad Street, 5th Floor
Columbus, OH 43215

RE: Emergency Medical Transport's Response to Auditor's Report

Dear Mr. Castle:

Emergency Medical Transport, Inc. or "EMT" continues to serve Ohio residents during their most desperate times of need. Services have been provided to Ohioans regardless of race, age, religion, social status, or ability to pay. As a result of EMT's willingness to serve some of Ohio's less fortunate citizens, it has agreed to participate in the Medicaid program and serve Medicaid recipients. The services provided to these Medicaid recipients resulted in this audit which was conducted during a time period when the State of Ohio is in a fiscal crisis. Notably, the present audit is not an Ohio Department of Job and Family Services audit and it has not been adopted nor approved by Ohio Department of Job and Family Services.

The audit findings in no way suggest that patient care was sacrificed, diminished, compromised, or affected by the issues raised. None of the findings suggest, infer, or even mention allegations of fraud or anything untoward by EMT. The Auditor's findings pertain to a lack of documentation while at the same time prove that EMT's file documentation met or exceeded the stringent Medicaid requirements over 98% of the time. In short, the Auditor's findings bear no relation to the integrity and the high quality of service EMT has and continues to provide to Ohioans, including those eligible for Medicaid.

While in no way impugning the professionalism of the Auditor's Office, EMT takes issue with a number of the findings and intends to appeal through the proper channels. Particularly troublesome are the findings that failed to consider the circumstances or common sense. For instance, some findings resulted from the emergency transport of newborn children and the subsequent utilization of the mother's Medicaid identification number when billing. In each of these instances there is no question that the services were provided and in fact the mother rode along during the transport. Stringent reliance upon the letter, not the spirit, of regulations results in the proverbial free ride.

Additionally, approximately one-half of the findings resulted from the transport of a wheelchair bound patient to and from dialysis treatment. At some point in the audit process, the patient's file, including certificates of medical necessity were misplaced. Nonetheless, there can be no doubt the transports took place and it was medically necessary to transport this disabled patient to and from dialysis treatment. Unfortunately, the Auditor's office is hamstrung, and is not permitted to exercise any common sense.

As a final example, EMT points to findings resulting from the failure to retain a copy of a driver's license. This issue should have been quickly resolved through a records request to the Ohio Bureau of Motor Vehicles. Such a request was made months ago and has not yet been responded to by that sister state agency. Thus, one state agency looks to recover money as a result of another state agency's failure to satisfy its statutory duties and comply with records requests. This web of bureaucracy should not be utilized by the State to raise funds during a period of fiscal crisis or any other time.

Emergency Medical Transport, Inc. will continue to serve the citizens of Ohio by providing transportation to citizens in need. In the meantime, EMT is anticipating that this audit will soon be in the jurisdiction of Ohio Department of Jobs & Family Services and that all matters will be resolved to everyone's satisfaction.

Very truly yours,

John A. Murphy, Jr.

JAM/gms

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Mary Taylor, CPA
Auditor of State

EMERGENCY MEDICAL TRANSPORT, INC.

STARK 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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