Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Pickaway Plains Ambulance Service, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

October 7, 2008

Clyde Cook
President
Pickaway Plains Ambulance Service, Inc.
1950 Stoneridge Road
Circleville, OH 43113

Dear Mr. Cook:

Attached is our audit report on Medicaid reimbursements made to Pickaway Plains Ambulance Service, Inc., Medicaid provider numbers 0768941, 2155966, 2166098, and 2169415 for the period January 1, 2003 to December 31, 2005. 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 $308,822.09 in findings plus $62,475.13 in interest accruals totaling $371,297.22 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 7, 2008, additional interest will accrue at $67.69 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 Pickaway Plains Ambulance Service, Inc., the Director and Legal Division of ODJFS, the Ohio Attorney General, and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

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Questions regarding this report should be directed to Jeffrey Castle, Chief Auditor, Medicaid/Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: Pickaway Plains Ambulance Service, Inc.
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Ohio Attorney General
Ohio Medical Transportation Board

TABLE OF CONTENTS

SUMMARY OF RESULTS 1

BACKGROUND 1

PURPOSE, SCOPE, AND METHODOLOGY 2

RESULTS 3
- Results of Statistical Samples 3
- Unsupported Services in Sample 3
  - Lack of Documentation for Transportation Services 4
  - Transports Over Fifty Miles 4
  - Incorrectly Billed Mileage 5
  - Certificates of Medical Necessity 5
  - Ambulance Services' Documentation did not indicate why an Ambulance Transport was Necessary 6
  - Non-Covered Psychiatric Transports 7
- Summary of Sample Findings 8
  - Provider #0768941 – Ambulance Services 8
  - Provider #0768941 – Ambulette Services 8
  - Provider #2169415 – Ambulance Services 9
- Results of Exception Testing 9
  - Transportation Services Reimbursed by Both Medicare and Medicaid 9
  - Duplicate Payments 10
    - Ambulance and Ambulette Services Billed under Provider Number 0768941 10
    - Ambulance Services Billed under Provider Number 2169415 11
    - Ambulance Services Billed under Provider Number 2166098 11
    - Ambulance Services Billed under Provider Number 2155966 12
- Summary of Exception Testing 12
- Summary of Findings 12
- Ambulance Services – Area of Interest 13
  - Transports Billed for Dually Eligible Recipients 13
- Other Observations 13
  - Required Documentation Lacking for Drivers 14
    - Lack of Required Training 14
    - Lack of Driver Criminal Background Checks 14
    - Lack of Medical Statements 15
    - Inconsistent Annual Review of Driving Record 15
    - Improper Use of Modifiers 16

PROVIDER'S RESPONSE 16
APPENDIX I 17
APPENDIX II 18
APPENDIX III 19

ACRONYMS

AOS	Auditor of State
AMA	American Medical Association
CMN	Certificate of Medical Necessity Form
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 Pickaway Plains Ambulance Service, Inc., (hereafter called the Provider) headquartered at 1950 Stoneridge Road, Circleville, Ohio 43113. The following four provider numbers were audited: 0768941, 2155966, 2166098, and 2169415.[1] Within the Medicaid program, the Provider is listed as an ambulance service provider.

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 the audit, we identified $308,822.09 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. In accordance with Ohio Admin.Code 5101:3-1-25, when including interest of $62,475.13, a total of $371,297.22 is repayable to ODJFS as of the release of this audit report. Additional interest of $67.69 per day will accrue after October 7, 2008 until repayment.

BACKGROUND

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

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code 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.

Ambulance, land ambulance, or ground ambulance are vehicles designed to transport individuals in a supine position and meets the standards and license requirements specified in Chapter 4766 of the Ohio Revised Code. Additionally, Ohio Admin.Code 5101:3-15-03(A)(2)(c) states in part, "The transport must be either transportation to a medicaid covered service or transportation from a medicaid covered service…"

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

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[1] *Provider numbers 2155966, 2166098, and 2169415 were all voluntarily terminated in April 2008.*
[2] *See Ohio Admin.Code 5101:3-1-01(A) and (A)(6).*

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

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

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of transportation 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 July 18, 2006, to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of January 1, 2003 to December 31, 2005. The Provider was reimbursed $1,801,192.51 (excluding Medicare coinsurance and deductible payments made by Medicaid) for 83,835 services rendered on 22,615 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 codes from the 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 to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for the following exceptions:

[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.*

- Potentially duplicate payments where payments were made for the same recipient on the same date of service for the same procedure codes and procedure code modifiers, and for the same dollar amount.
- Payments made for services to deceased patients for dates of service after the date of death.
- Potentially inappropriate service code combinations on claims.

The exception tests for duplicate payments and for services to deceased patients identified potentially incorrect reimbursements. When performing our audit fieldwork, we reviewed all available documentation for claims identified by our exception testing.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we analyzed statistically random samples from provider number 0768941 (ambulance and ambulette) and provider number 2169415 (ambulance).

The claims for provider number 0768941 were divided into ambulance and ambulette subpopulations, from which separate samples were drawn. The ambulance sample contained 309 services (100 RDOS), while the ambulette sample contained 550 services (135 RDOS). Since only ambulance services were billed under 2169415, a single sample of 420 ambulance services (131 RDOS) was taken.

Claims from provider numbers 2155966 and 2166098 were not sampled because combined they counted for less than 8 percent of services and 10 percent of payments received by the Provider.

Our fieldwork was performed between July 2006 and July 2007.

RESULTS

We identified findings that when projected totaled $270,514 for services in three sampled populations. Additionally, we identified findings of $38,308.09 for services in our exception testing. Together, our findings totaled $308,822.09. The bases for our results are discussed below.

Results of Statistical Samples

Unsupported Services in Sample

As explained above, we selected three samples for review from two of the four provider numbers under which the Provider billed Medicaid. All samples were chosen from corresponding subpopulations (excluding all Medicare coinsurance and deductible payments made by Medicaid) and all services already identified by our exception testing for 100 percent review.

During our review, we identified findings including, but not limited to: ambulette services billed as ambulance services, lack of certificates of medical necessity (CMN), lack of documentation for billed services, incorrectly billed mileage, billing for non-covered transportation services, and third-party insurance liabilities.

Some services had more than one deficiency; however, only one finding was made per service. Our findings were projected to their corresponding subpopulations for a total projected finding of $270,514. The bases for this finding are given below.

Lack of Documentation for Transportation Services

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

> ***
>
> (D) 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.
>
> ***

While reviewing our respective samples for ambulance and ambulette services, we identified multiple situations where the Provider lacked sufficient documentation to support that the billed services were rendered as follows:

- 55 ambulance services under provider number 2169415;
- 41 ambulance services under provider number 0768941; and
- 30 ambulette services under provider number 0768941.

The amounts reimbursed for all of the above services were used in calculating the projected findings for their respective sampled populations.

Transports Over Fifty Miles

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

> ***
>
> (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.
>
> ***

While reviewing our respective samples for ambulance and ambulette services, we identified multiple instances where the Provider lacked documentation to justify one-way transports in excess of 50 miles. Therefore, we disallowed the reimbursement amount for mileage over 50 as follows:

- 11 ambulance services for provider number 2169415;
- 3 ambulance services for provider number 0768941; and
- 42 ambulette services for provider number 0768941.

The respective overpayments for all the above services were used in calculating the projected findings for their respective sampled populations.

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….

While reviewing our respective samples for ambulance and ambulette services, we identified multiple situations where the Provider over-billed mileage for transports. This was based on comparisons between the drivers' trip logs and mileage billed to Medicaid. Therefore, we disallowed the reimbursement amount for the overstated mileage as follows:

- 6 ambulance services with overstated miles for provider number 2169415;
- 2 ambulance services with overstated miles for provider number 0768941; and
- 1 ambulette service with overstated miles for provider number 0768941.

The respective overpayments for all the above services were used in calculating the projected findings for their respective sampled populations.

Certificates of Medical Necessity

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

> (B) Ambulette services coverage and limitations
>
> ***
>
> (2) Covered ambulette transports
>
> (a) The ambulette services must be medically necessary…

Additionally, Ohio Admin.Code 5101:3-15-02 states in pertinent part:

> ***
>
> (E) Documentation requirements
>
> (1) Providers of air ambulance and ambulette services must maintain records which fully describe the extent of services provided. ...
>
> (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 …
>
> ***

While reviewing our respective samples for ambulance and ambulette services, we identified multiple situations where the Provider either lacked a certificate of medical necessity (CMN) or it was considered invalid due to lack of required information. Therefore, the reimbursement for these services was disallowed as follows:

- 4 ambulance services lacked a CMN and 27 services had an invalid CMN for provider number 2169415;
- 24 ambulance services lacked a CMN and 18 had an invalid CMN for provider number 0768941; and
- 68 ambulette services lacked a CMN and 40 services had an invalid CMN for provider number 0768941.

The reimbursements for these disallowed services were used in calculating the projected findings for their respective sampled populations.

Ambulance Services' Documentation Did Not Indicate Why an Ambulance Transport was Necessary

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

> ***
>
> The criteria listed in this paragraph must be met for a land ambulance service to be covered.
>
> **(a)** The land ambulance service must be medically necessary as specified below in this paragraph

***

(iii) For non-emergency transports, ambulance services are medically necessary when the patient needs either prescheduled transportation or unscheduled transportation for which an immediate response is not required; and the patient's medical condition meets one of the descriptions in paragraphs (A)(2)(a)(iii)(a) to (A)(2)(a)(iii)(c) of this rule.
(a) An individual is nonambulatory and unable to use an ambulette because the individual is unable to get up from bed without assistance; the patient is unable to sit in a chair or wheelchair; and can only be moved only by a stretcher and/or needs to be restrained; or
(b) An individual is not in a life-threatening situation, but requires continuous medical supervision or treatment during the transport; or
(c) An individual does not meet the criteria in paragraph (A)(2)(a)(iii)(a) or paragraph (A)(2)(a)(iii)(b) of this rule, but requires oxygen administration during the transport ; , and the patient is unable to self administer or self-regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.

While reviewing our respective samples for ambulance services, we identified multiple instances where the Provider's documentation did not sufficiently justify an ambulance versus an ambulette transport. Upon reviewing the documentation, none of the above listed requirements in Ohio Admin.Code 5101:3-15-03 (A)(2) were noted. Therefore, the transports were recoded from ambulance to ambulette services, and because ambulance services pay at a higher rate than ambulette services, overpayments occurred as follows:

- 17 ambulance services were recoded as ambulette services for provider number 2169415; and
- 8 ambulance services were recoded as ambulette services for provider number 0768941.

The overpayments for the above services were used in calculating the projected findings for their respective sampled populations.

Non-Covered Psychiatric Transport

Ohio Admin.Code 5101:3-15-03 states:

(E) Service Limitations

The following services are not covered:

***

(11) Transportation to outpatient services provided in psychiatric hospitals

***

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

(I) Transportation to and from psychiatric hospitals

(1) Covered transportation services include the ambulance or ambulette transport of medicaid patients to and from public and private psychiatric hospitals for inpatient psychiatric hospital services only when the patient is age twenty-one and younger, or sixty-five and older, and the inpatient psychiatric services are eligible for reimbursement by medicaid in accordance the Chapter 5101:3-2 of the Administrative Code.

(2) Psychiatric hospital is defined as a hospital that is eligible to participate in the medicaid program only for the provision of inpatient psychiatric services.

While reviewing records for sampled ambulance services billed under provider number 0768941, we identified two services where a patient was transported for psychiatric services. These transportation services are non-covered and therefore an overpayment occurred. The reimbursement amount for the above services was used in calculating the projected findings for this sampled population.

Summary of Sample Findings

Provider #0768941 – Ambulance Services
The overpayments identified for 33 of 100 RDOS (involving 98 of 309 services) from our stratified statistical random sample of ambulance transportation services were projected across the Provider's total subpopulation of paid recipient dates of service. This resulted in a projected overpayment amount of $34,610 with a precision of plus or minus $15,990 (46.20 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 $21,191. This allows us to say that we are 95 percent certain the population overpayment amount is at least $21,191. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Provider #0768941 – Ambulette Services
The overpayments identified for 58 of 135 RDOS (181 of 550 services) from our stratified statistical random sample of ambulette transportation services were projected across the Provider's total subpopulation of paid recipient dates of service. This resulted in a projected overpayment amount of $287,015 with a precision of $94,141 (+/-32.80 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 $208,009. This allows us to say that we are 95 percent certain the population overpayment amount is at least $208,009. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Provider #2169415 – Ambulance Services

The overpayments identified for 46 of 131 RDOS (involving 124 of 420 services) from our stratified statistical random sample of ambulance transportation services were projected across the Provider's total subpopulation of paid recipient dates of service. This resulted in a projected overpayment amount of $58,844 with a precision of plus or minus $20,888 (35.50 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 $41,314. This allows us to say that we are 95 percent certain the population overpayment amount is at least $41,314. A detailed summary of our statistical sample and projection results is presented in Appendix III.

Results of Exception Testing

We performed exception testing on the provider's paid claims for the following issues: duplicate payments, Medicare and Medicaid payments for the same service for the same recipient, transportation services billed for patients while they were hospital inpatients and services billed for deceased recipients. Our tests for services billed while recipients were hospital inpatients and for deceased recipients were negative. However, the results of the other tests were positive, therefore, we performed a 100 percent review of all the identified services. The results of our review are as follows.

Transportation Services Reimbursed by Both Medicare and Medicaid

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.

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

> (A) "Medicare" is a federally financed program of hospital insurance part A and supplemental medical insurance benefits part B for aged and disabled persons determined by the social security administration to be entitled to medicare.
> (B) Part A and part B of medicare pay for a basic program of medical overage under which the patient has certain liabilities in the form of premium payments, deductibles, and coinsurance.
> (C) The medicaid program pays premiums for medicare coverage of all medicaid consumers eligible for medicare and qualified medicare beneficiaries described in this rule. Moreover, for individuals who are eligible under both medicare and medicaid or who are qualified medicare beneficiaries described in this rule, medicaid pays the medicare deductible and coinsurance amounts. The department will not pay for services denied by medicare for lack of medical necessity, although it will pay claims denied for reasons other than

> medical necessity as long as the services are covered under the medicaid program, and provided that a copy of medicare's EOMB is attached to the claim. The department will not pay for any service payable by, but not billed to, medicare. Any medicare procedure inadvertently paid for by medicaid will be subtracted from future payments to the provider (except for long-term care facilities where adjustments for such payments will occur as a part of the interim settlement process).

***

Medicare and Medicaid should not normally both be billed as the primary payer of a specific service. Therefore, we performed a data match between the Provider's services for which Medicaid paid Medicare co-insurance and deductible co-payments (i.e., Medicare was primary payer) and services for which Medicaid was billed as the primary payer.

Our test found 398 services (196 RDOS) where both Medicaid and Medicare were billed as primary payers for the same services. Because Medicaid paid both as a primary insurer and the Medicare co-payment amounts, a duplicate payment occurred. As Medicaid is the payer of last resort, we made a finding of $18,470.80, which is the total amount Medicaid paid as a primary insurer.

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 performed exception testing on the Provider's paid claims to determine whether payments were made more than once for the same service rendered on the same date of service for the same recipient (i.e., duplicate payment). We identified services which were only rendered once; however, they were duplicately billed by the Provider and subsequently reimbursed. However, there were other services billed on the claims on which duplicate services occurred. Findings were made for some of these additional services due to other issues as discussed below:

Ambulance and Ambulette Services Billed under Provider Number 0768941

Our testing identified 884 services where it appeared the Provider billed and was paid twice for identical services on the same date of service. Upon review of documentation supplied by the Provider, we found 339 services were properly documented. However, of the remaining 545 services, we identified the following issues which resulted in findings (Note: some services had multiple issues; however, only one combined finding was made per service):

- 188 duplicately billed services;
- 70 services where the CMN was incomplete;
- 49 services where no CMN was received;
- 34 services where no documentation was received;
- Eight services where an incorrect service code was billed;
- Two ambulette services billed as ambulance services; and
- Two non-covered transports to psychiatric hospitals.

Findings totaling $10,438.24 were made on the amount reimbursed to the Provider for the services listed above.

Ambulance Services Billed under Provider Number 2169415

Our testing identified 256 services where it appeared the Provider billed and was paid twice for identical services on the same date of service. Upon review of documentation supplied by the Provider, we found 128 services were properly documented. However, of the remaining 128 services, we identified the following issues which resulted in findings (Note: some services had multiple issues; however, only one combined finding was made per service):

- 59 transports where the mileage billed was greater than 50, however, the documentation did not indicate why the transport was over 50 miles;
- 30 duplicately billed services;
- 13 services where no CMN was received;
- 12 services where the CMN was incomplete;
- 10 services where no documentation was received;
- Three services billed without the appropriate modifier showing an ambulance was used as an ambulette; and
- One incorrectly billed base transport service.

Findings totaling $5,919.75 were made on the amount reimbursed to the Provider for the services listed above.

Ambulance Services Billed under Provider Number 2166098

Our testing identified 150 services, where it appeared the Provider billed and was paid twice for identical services on the same date of service. Upon review of documentation supplied by the Provider, we found 62 services were properly documented. However, of the remaining 88 services, we identified the following issues which resulted in findings (Note: some services had multiple issues; however, only one combined finding was made per service):

- 43 transports where the mileage billed was greater than 50, however, the documentation did not indicate why the transport was over 50 miles;
- 20 services where the CMN was incomplete;
- 11 services where no CMN was received;
- Two transports to non-covered psychiatric hospitals; and

- Two services billed without the appropriate modifier showing an ambulance was used as an ambulette.

Findings totaling $2,969.70 were made on the amount reimbursed to the Provider for the services listed above.

Ambulance Services Billed under Provider Number 2155966

Our testing identified 22 services, where it appeared the Provider billed and was paid twice for identical services on the same date of service. Upon review of documentation supplied by the Provider, we found 11 services were properly documented. However, of the remaining 11 services, we identified the following issues which resulted in findings (Note: some services had multiple issues; however, only one combined finding was made per service):

- Four services where no documentation was received;
- Three transports where the mileage billed was greater than 50, however, the documentation did not indicate why the transport was over 50 miles;
- Two services where no CMN was received; and
- One service where the CMN was incomplete.

Finally, we identified one instance where the Provider billed 15 units of mileage as 15 base codes (i.e., 15 separate transports).

Findings totaling $509.60 were made on the amount reimbursed to the Provider for the services listed above.

Summary of Exception Testing

Total combined findings of $38,308.09 resulted from our exception tests, which included findings for transportation services reimbursed by both Medicare and Medicaid as primary insurers, services billed without the appropriate modifier showing an ambulance was used as an ambulette, duplicate payments, services lacking CMNs, services lacking complete CMNs, services lacking supporting documentation, transports with mileage greater than 50 without explanatory documentation, and incorrectly billed transport services.

Summary of Findings

A total of $308,822.09 in findings was identified. These findings result from the combination of our statistical sample results ($270,514) and our exception test results ($38,308.09), where records were reviewed in their entirety.

Ambulance Services – Area of Interest

Transports Billed for Dually Eligible Recipients

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

> ***
>
> (C)…for individuals who are eligible under both medicare and medicaid or who are qualified medicare beneficiaries described in this rule, medicaid pays the medicare deductible and coinsurance amounts…The department will not pay for any service payable by, but not billed to, medicare…

An additional computerized test was performed during the audit on all provider numbers to identify ambulance transports that were provided to dually eligible recipients (identified as a person who is eligible to receive benefits through Medicaid and is also eligible to receive benefits through Medicare Part B for ambulance transportation services). Because the issue came to attention after fieldwork had begun, it was necessary to remove the services rendered to the dually eligible patients from the remaining ambulance exception reports, the ambulance samples, and the ambulance sample populations to avoid double impact.

Based on our testing, we identified 1,049 services (399 RDOS) that may have been covered under the Medicare Part B plan. Subsequently, Medicaid would have reimbursed the amount of the coinsurance and deductible co-payments for the appropriate services. However, since we discovered this area of interest post fieldwork, we did not have the Provider's records for these services to review. Also, since the CMNs differ between Medicare and Medicaid, information required to determine coverage would be kept in the referring physician's files, not necessarily in the records of the Provider. Therefore, we normally request the transportation provider under audit to bill Medicare for the potentially dually eligible services. However, in this case, because of the late discovery of the issue, these claims could no longer be timely billed to Medicare. As a result, we are not issuing any monetary findings but are raising this as an area of interest and referring this concern to ODJFS for further consideration. We determined that the total potential impact for these dually eligible services was $49,475.00.

Other Observations

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

The results, as outlined below, did not result in monetary findings because we were not able to tie each deficiency to a specific service in our sample. However, failure to comply with applicable regulations could place patients in harms way and jeopardize the Provider's status with the Medicaid program.

Required Documentation Lacking for Drivers

We reviewed the Provider's employment files to determine if required procedures were followed and required documentation was kept on file. Our results are as follows.

Lack of Required Training

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

> ***
>
> (a)(ii)Each driver and each attendant must have a current card issued and signed by a certified trainer as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certificate or EMT certification. A copy of both sides of the card must be maintained by the provider and provided upon request to the department or their designee. . . . Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or their designee.
>
> ***
>
> (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 77 employee personnel files for CPR/EMT certifications and proof of passenger assistance training revealed the following:

- Eight did not have CPR certificates or an alternate EMT certificate; and
- 21 did not contain documentation that the employees underwent passenger assistance training.

Lack of Driver Criminal Background Checks

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

> ***
>
> 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.
>
> ***

Our review of employee personnel files showed that one of 77 personnel files did not contain evidence that a criminal background check had been performed on the employee.

<u>*Lack of Medical Statements*</u>

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

> ***
>
> (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…
>
> ***

Our review of employee personnel files showed that nine employees lacked medical statements and six employees lacked drug screen results.

<u>*Inconsistent Annual Review of Driving Record*</u>

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 employee personnel files found one file where driving record results were not noted.

Improper Use of Modifiers

Ohio Admin.Code 5101:3-15-03(D)(1) states:

> Modifiers for the point of transport is a two-position modifier that is constructed from the following values. The first position alphabetic value is used to report the origin or "from" service. The second position alphabetic value is used for the destination or "to" of service.

In the Provider's billing, we noted trips where the modifiers for the base rate billing code and the mileage billing code were not the same. The Ohio Administrative Code requires the use of modifiers. Without the proper modifiers being used, improper payments could result. In fact, our exception analysis revealed several instances where ambulance services were mis-billed because of the lack of the appropriate modifier showing that the ambulance was being used to provide an ambulette service.

PROVIDER'S RESPONSE

A draft report along with a detailed listing of services for which we took findings was mailed to the Provider on August 18, 2008. The Provider was afforded 10 business days to provide additional documentation to substantiate the services for which we took findings or otherwise respond in writing. On September 3, 2008, we received correspondence from the Provider's counsel indicating that the Provider received the report and would respond as expeditiously as possible.

After discussions with the Provider's counsel, we extended the deadline to September 19, 2008, in order for the Provider to inform us as to when the Provider would respond to the draft audit report. After the deadline was missed, we contacted the Provider's counsel on September 22, 2008, indicating that we would move forward with the audit's release. Our findings remain as $308,822.09.

APPENDIX I

Summary of Statistical Sample Analysis for Pickaway Plains Ambulance Service, Inc.
For the period January 1, 2003 to December 31, 2005
Ambulance Sample Population – Provider Number 0768941

Description	Audit Period [Jan 1, 2003 – Dec 31, 2005]
Type of Examination	Stratified Random Sample
Description of Subpopulation Sampled	All paid ambulance services net of any adjustments, less Medicare co-payments, exceptions, or Medicare Part B eligible ambulance service
Total Medicaid Amount Paid For Sub-Population Sampled	***$216,873.64***
Number of Population Recipient Dates of Service	***1,269***
Number of Population Services Provided	***3,402***
Amount Paid for Services Sampled	***$20,459.62***
Number of Recipient Dates of Service Sampled	***100***
Number of Services Sampled	***309***
Estimated Overpayment using Point Estimate	***$34,610***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $15,990 (46.20%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/- $13,419 (38.77)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$21,191***

APPENDIX II

Summary of Statistical Sample Analysis for Pickaway Plains Ambulance Service, Inc.
For the period January 1, 2003 to December 31, 2005
Ambulette Sample Population – Provider Number 0768941

Description	Audit Period [Jan 1, 2003 – Dec 31, 2005]
Type of Examination	Stratified Random Sample
Description of Subpopulation Sampled	All paid ambulette services net of any adjustments less any exceptions
Total Medicaid Amount Paid For Sub-Population Sampled	***$1,061,953.71***
Number of Population Recipient Dates of Service	***18,186***
Number of Population Services Provided	***70,913***
Amount Paid for Services Sampled	***$13,251.90***
Number of Recipient Dates of Service Sampled	***135***
Number of Services Sampled	***550***
Estimated Overpayment using Point Estimate	***$287,015***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/-$94,141 (32.80%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-$79,006 (27.53%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$208,009***

APPENDIX III

Summary of Statistical Sample Analysis for Pickaway Plains Ambulance Service, Inc.
For the period January 1, 2003 to December 31, 2005
Ambulance Sample Population – Provider Number 2169415

Description	Audit Period [Jan 1, 2003 – Dec 31, 2005]
Type of Examination	Stratified Random Sample
Description of Subpopulation Sampled	All paid ambulance services net of any adjustments less exceptions and Medicare co-payments
Total Medicaid Amount Paid For Sub-Population Sampled	***$262,635.65***
Number of Population Recipient Dates of Service	***1,724***
Number of Population Services Provided	***4,876***
Amount Paid for Services Sampled	***$25,115.54***
Number of Recipient Dates of Service Sampled	***131***
Number of Services Sampled	***420***
Estimated Overpayment using Point Estimate	***$58,844***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/-$20,888 (35.50%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-$17,530 (29.79%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$41,314***

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Mary Taylor, CPA
Auditor of State

January 20, 2009

Mr. Christopher Carson
Asst. Bureau Chief, Bureau of Audit/ORAA
Ohio Department of Job and Family Services
4020 East 5th Avenue
P.O. Box 1618
Columbus, OH 43216-1618

RE: Adjusted Audit Findings for Pickaway Plains Ambulance Service, Inc.
AOS/MCA-09-002C

Dear Mr. Carson:

During a quality review of workpapers prior to the issuance of the proposed adjudication order, some minor calculation errors were discovered in our final audit workpapers. We promptly notified ODJFS legal counsel and requested time to fully verify our workpapers and correct any miscalculations found. We would then provide ODJFS with the corrected finding and interest amounts; along with any adjustment needed to the summary of errors found in our exception and sample tests. It is our understanding that ODJFS would then issue a presumptive adjudication order with the adjusted finding amount. We have completed our review of our workpapers and have summarized the results below.

Our total findings were reduced from \$308,822.09 to \$307,422.09, a reduction of \$1,400 (0.45 percent). This reduction resulted entirely from a decrease in the projected findings from our statistical sample due to mathematical errors in the calculation of overpayments prior to projection. Except for two instances, where additional findings for unsupported mileage over 50 miles were taken on the ambulette sample for provider number 0768941; no change in the number or type of errors occurred. Applying the reduced finding amount to the standard interest calculations required by Ohio Admin.Code 5101:3-1-25(A) results in accrued interest of \$62,191.91 as of the date of our report release. Additional interest will accrue at the rate of \$67.38 per day.

Sincerely,

Mary Taylor, CPA
Auditor of State

Jeffrey Castle, Chief
Medicaid/Contract Audit Section

cc: David Espinoza, Senior Attorney, Office of Legal Services, ODJFS
Rachel Jackson, Chief, Surveillance and Utilization Review Section
Clyde Cook, President, Pickaway Plains Ambulance Service, Inc.

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Mary Taylor, CPA
Auditor of State

PICKAWAY PLAINS AMBULANCE SERVICE, INC.

PICKAWAY 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 7, 2008

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