Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Hocking Valley Health Professionals, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

April 16, 2009

Gary Cook, Chief Executive Officer
Pickaway Plains / Health Pro Ambulance Service, Inc.
1950 Stoneridge Drive
Circleville, Ohio 43113

Dear Mr. Cook:

Attached is our report on Medicaid reimbursements made to Hocking Valley Health Professionals, Inc., Medicaid provider number 0686548, for the period July 1, 2003 to June 30, 2006. 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 $119,403.18 in findings. However, during the course of the audit, Hocking Valley Health Professionals, Inc. repaid $578.61, leaving $118,824.57 in overpayments plus $24,272.77 in interest accruals totaling $143,097.34 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 April 16, 2009, additional interest will accrue at $26.04 per day until repayment occurs. Interest is calculated pursuant to Ohio Administrative Code Section 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 / Health Pro Ambulance Service, Inc.; the former owners of Hocking Valley Health Professionals, Inc.; the Director and Legal Divisions of ODJFS; the Ohio Attorney General; Health and Human Services/Office of Inspector General; and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

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

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: Pickaway Plains / Health Pro Ambulance Service, Inc.
Former owners of Hocking Valley Health Professionals, Inc.
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
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 Hocking Valley Health Professionals, Inc. (hereafter called the Provider), provider number 0686548, which was formerly headquartered at 15047 First Street, Carbon Hill, Ohio 43111. In July 2007, the provider was purchased by and merged with Pickaway Plains Ambulance Service, Inc. to become Pickaway Plains / Health Pro Ambulance Service, Inc. The headquarters was changed to 1950 Stoneridge Drive, Circleville, Ohio 43113 and the 0686548 provider number was voluntarily terminated in April 2008. 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 §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 $119,403.18 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] During the course of the audit, however, the Provider repaid $578.61 leaving $118,824.57 in overpayments. Additionally, we assessed accrued interest of $24,272.77, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $143,097.34, which is repayable to ODJFS as of the release of this audit report. Additional interest of $26.04 per day will accrue after April 16, 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

[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).*

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

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

PURPOSE, SCOPE, AND METHODOLOGY

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

Following a notification letter, we held an entrance conference at the Provider's headquarters on August 28, 2007, 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 July 1, 2003 through June 30, 2006. The Provider was reimbursed $919,880 for 23,457 services rendered on 7,432 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]

[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.*

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.
- Potential duplicate claims for ambulance transport services for the same recipient, on the same date of service, for the same procedure codes, procedure code modifiers and units billed to both the Medicaid and Medicare programs as the primary insurer.
- Ambulance services billed to Medicaid that are potentially covered by Medicare for dually eligible recipients.
- Claims where both ambulance and ambulette services were billed for the same patient on the same day.
- Potential duplicate payments where payments were made for the same recipient on the same date of service with the same procedure code and modifier.
- Payments made for services to deceased patients for dates of service after the date of death.

Our exception test was negative for payments made for services to deceased patients after their date of death. However, we identified potentially incorrect reimbursements for the remaining exception tests. 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 184 RDOS and one for ambulette services consisting of 163 RDOS. The total results were then projected across the entire population to determine the total findings.

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

Our fieldwork was primarily performed between August 2007 and September 2008.

RESULTS

We identified findings of $6,201.66 for services in our exception testing. Additionally, we identified findings from our samples that when projected total $113,201.52. Together, our findings from our exception testing and projected samples total $119,403.18, the bases of which are discussed below. During the course of the audit, however, the Provider repaid ODJFS a total of $578.61 for identified overpayments in our exception testing leaving a net repayment due of $118,824.57.

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, duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs as the primary insurer, ambulance services billed to Medicaid that are potentially covered by Medicare for dually eligible recipients, claims where both ambulance and ambulette services were billed for the same patient on the same day, and duplicate payments. 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:

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

We initially identified 180 services for trips exceeding 50 one-way miles. Our analysis revealed eight 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 98 errors that resulted in findings:

- 30 services where the certificate of medical necessity or CMN, which certifies the basis for the necessity of the transport, was completed by an unauthorized practitioner per the Ohio Admin.Code; or the requisite credentials were not listed for the person signing the CMN; or no attending practitioner was identified for instances when an authorized proxy signed the CMN;
- 15 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 12 services where either the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 12 services where the CMN supplied did not cover the date of service;
- 9 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 and did not have a date of first transport; or the CMN was signed by the practitioner more than 180 days after the service was rendered;

- 6 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 4 services where the Provider did not supply a CMN; and
- 2 services where the Provider did not indicate the full name of the Medicaid-covered point of transport nor did it provide a corresponding address or vehicle identification.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $4,942.16 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:

> ***
>
> (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.
>
> ***
>
> (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…

***

(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 162 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 11 payments for the same service as was paid by Medicare, resulting in an overpayment. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare.

Findings totaling $578.61 were made on the amount paid by the Medicaid program as primary payer for the identified duplicate covered services. During the course of the audit, however, the Provider repaid the identified overpayment to ODJFS. Therefore, no amount remains due from this exception test.

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.
>
> ***

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 patients 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 29 ambulance transport services, and requested supporting documentation showing proper billing to and reimbursement by Medicaid.

Based on our review of records and the Provider's response, we identified four services where the Provider did not supply supporting documentation explaining why Medicaid should have been billed in place of Medicare. Findings totaling $239.22 were made on the amount reimbursed to the Provider for the errors listed above.

Same Day Services for Both Ambulance and Ambulette

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 service actually performed…
>
> ***

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 initially identified 33 services where the Provider billed for both an ambulance and an ambulette service for the same patient on the same day. Based on our review of records, we identified the following 34 errors that resulted in findings:

- 8 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 8 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 6 services where the Provider did not indicate the full name of the Medicaid covered point of transport nor did it provide a corresponding address or vehicle identification;
- 6 attendant services that were not appropriately documented;
- 2 services where the CMN supplied did not cover the date of service;
- 2 services where either the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information; and
- 2 services where the CMN was not dated by the attending practitioner and did not have a date of first transport.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $235.37 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Payments

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

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

We identified 308 services where the Provider appeared to have billed for more than one transport for the same recipient on the same date of service. Based on our review of records, we identified the following seven errors that resulted in findings:

- Two services where the number of miles billed exceeded the amount supported in the Provider's documentation;
- Two services where there was insufficient documentation to verify the services occurred which could indicate services not rendered or potentially duplicate billed services;
- One service where the Provider did not indicate the full name of the Medicaid covered point of transport nor did it provide a corresponding address or vehicle identification;
- One service where the Provider billed a base transportation code instead of the appropriate mileage code; and

- One service lacked documentation (e.g., trip log) to support that the service billed had actually been rendered.

Findings totaling $206.30 were made on the amount reimbursed to the Provider for the errors listed above.

Summary of Exception Testing

Total combined findings of $6,201.66 resulted from our exception tests, which included 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, claims where both ambulance and ambulette services were billed for the same patient on the same day, and duplicate payments. During the course of the audit, however, the Provider repaid $578.61 in identified exception test overpayments to ODJFS, leaving a net $5,623.05 in exception overpayments due. Some of the more common errors denoted during our exception testing included transportation services with an unauthorized or missing practitioner on the CMN, missing medical condition on the CMN, patient not certified as meeting conditions for covered transport, CMN does not cover date of service, and CMN not signed or an illegible signature was not accompanied with identifying information.

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.

The findings were then projected across the total sampled populations, resulting in a total finding of $113,201.52.

Ambulance Services Sample – Detailed Results

Our stratified random sample of 184 ambulance RDOS (involving 585 services) identified 34 RDOS (108 services) with a combination of 206 errors resulting in a projected population overpayment of $19,472.52. 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…

***

(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

***

(c) 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 144 errors:

- 44 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 33 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code; or the requisite credentials were not listed for the person signing the CMN; or no attending practitioner was identified for instances when an authorized proxy signed the CMN;
- 22 services where the CMN was not dated by the attending practitioner and did not have a date of first transport; or the CMN was signed by the practitioner more than 180 days after the service was rendered;
- 18 services where either the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 13 services where the CMN supplied did not cover the date of service;

- 8 services where the patient was transported by ambulance; however, the Provider submitted an ambulette CMN; and
- 6 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.

Patient Not Certified as Meeting Conditions for Covered Transport

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

> (A) (1) Covered land ambulance services:
>
> ***
>
> (2) Criteria for coverage
>
> 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 in this paragraph.
>
> (i) The patient's condition at the time of the transport is the determining factor in whether medical necessity is met, or not.
>
> ***
>
> (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.

***

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

***

(4) Practitioner certification form

***

(c) 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.

***

Our review of the Provider's documentation identified 54 instances where the attending practitioner did not certify that the patient met the conditions for a covered transport on the CMN (i.e., did not certify the patient was non-ambulatory and unable to use an ambulette; requires continuous medical supervision, or the patient requires oxygen administration during the transport). Therefore, the reimbursements for these services were disallowed and this amount was used 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

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 five services lacked documentation (e.g., trip log) to support the service billed had actually been rendered. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Incorrectly Billed Mileage

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

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

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

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

We identified three services where the Provider over billed mileage for transports. We determined the Provider billed in excess of what its records supported. We therefore disallowed the reimbursement for the excessively billed mileage and used this amount in calculating the projected finding.

Summary of Ambulance Sample Findings

The overpayments identified for 34 of 184 RDOS (involving 108 of 585 services) from our stratified random sample of ambulance transportation services were projected across the Provider's sub-population of ambulance paid recipient dates of service, excluding those already selected for 100 percent review. This resulted in a projected overpayment amount of $33,768 with a precision of plus or minus $10,904 (32.29 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 $19,472.52. This allows us to say that we are 95 percent certain the population overpayment amount is at least $19,472.52. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Ambulette Services Sample – Detailed Results

Our stratified random sample of 163 ambulette RDOS (involving 662 services) identified 77 RDOS (315 services) with a combination of 769 errors resulting in a projected population overpayment of $93,729. 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.

Incomplete Point of Transport and Vehicle Information

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

> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department . . .
>
> (2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .
>
> (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and
>
> ***

We identified 191 services where the Provider did not indicate the full name of the Medicaid covered point of transport nor did it provide a corresponding address or vehicle identification.

[5] *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.*

Note, for all but four services, there were other errors associated with the service where the supporting documentation lacked complete point of transport and vehicle information. We therefore disallowed the reimbursement for these four services and used this amount in calculating the projected finding.

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:

***

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

***

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

***

(4) Practitioner certification form

(a) The attending practitioner, or a hospital discharge planner or a registered nurse acting under the orders of the attending practitioner in accordance with paragraph (E)(4)(b) of this rule, must complete a "Practitioner Certification Form" for all medical transportation services…

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

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

(c) Medical condition

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

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

***

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

(a) The ambulette services must be medically necessary…

***

During our review of the documentation submitted by the Provider, we found numerous errors with the practitioner certification form (i.e., CMN), which certifies the basis for the necessity of the transport. Based on our review, we took findings due to the following 369 errors:

- 168 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code; or the requisite credentials were not listed for the person signing the CMN; or no attending practitioner was identified for instances when an authorized proxy signed the CMN;
- 110 services where either the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 52 services where the CMN was not dated by the attending practitioner and did not have a date of first transport; or the CMN was signed by the practitioner more than 180 days after the service was rendered;
- 15 services where the Provider did not supply a CMN;
- 8 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN;
- 8 services where the CMN supplied did not cover the date of service; and
- 8 services where the CMN received lacked the medical condition to support the medical necessity of the 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 and used this amount in calculating the projected finding.

Patient Not Certified as Meeting Conditions for Covered Transport

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

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

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

> (B) Ambulette services coverage and limitations
>
> ***
>
> (2) Covered ambulette transports:

> Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements in this paragraph are met.
>
> (a) The ambulette services must be medically necessary as specified below:
>
> (i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code;
> (ii) The attending has certified that the individual does not require ambulance services; the individual cannot be transported by automobile, bus, or other standard mode of transportation because the individual must be transported in a wheel chair; and the individual is physically able to be safely transported in a wheelchair.
>
> ***

Our review of the Provider's documentation identified 154 instances where the attending practitioner did not certify that the patient met the conditions for a covered transport on the CMN (e.g., did not certify the patient was non-ambulatory or that the patient needed a wheelchair). Therefore, the reimbursements for these services were disallowed and the amount used in calculating the projected finding.

Transports Greater than 50 Miles without Justification

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

> 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.

We identified 24 mileage services for trips exceeding 50 miles (one-way) 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) and used this amount in calculating the projected finding.

Transportation Services Lacking Supporting Documentation

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 21services 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.

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 10 services where the Provider over billed 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 excessively billed mileage and used this amount in calculating the projected finding.

Summary of Ambulette Sample Findings

The overpayments identified for 77 of 163 RDOS (involving 315 of 662 services) from our stratified random sample of ambulette transportation services were projected across the Provider's sub-population of ambulette paid recipient dates of service, excluding those already selected for 100 percent review. This resulted in a projected overpayment amount of $110,337

with a precision of plus or minus $16,607 (15.05 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 $93,729. This allows us to say that we are 95 percent certain the population overpayment amount is at least $93,729. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Summary of Findings

A total of $119,403.18 in findings was identified. These findings result from the combination of our exception testing ($6,201.66) and our statistical sample projections ($113,201.52). During the course of the audit, however, the Provider repaid ODJFS a total of $578.61 for identified overpayments in our exception testing leaving a net repayment due of $118,824.57. For those services selected in our exception testing and samples, we reviewed all corresponding records in their entirety (i.e., 100 percent review).

Matters for Attention

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

Incomplete Patient Certification on Ambulette CMNs

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

> Covered ambulette transports
>
> Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements are met.
>
> (a) The ambulette services must be medically necessary as specified below:
>
> (i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code; and
>
> (ii) The attending practitioner has certified that the individual does not require ambulance services: the individual does not use passenger vehicles as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code as transport to non-

> Medicaid services.; and the individual is physically able to be safely transported in a wheelchair.
>
> ***

During the course of our audit, we identified 8 services in our exception tests, 154 services in our ambulette sample and 18 services in our ambulance sample[5] where the attending practitioner did not certify that an ambulance was not required on the ambulette CMN supplied by the Provider, per the Ohio Admin.Code. Nearly all of these services occurred in conjunction with other errors, including those related to the CMN.

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

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

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…
>
> ***

Based on our testing, in addition to the 4 ambulance services identified in our exception test that were provided to dually eligible recipients, we found 315 services 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 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 $19,413.21 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.

[5] *Ambulances were used as ambulettes with appropriate U3 modifiers.*

Incomplete Supporting Documentation for Ambulette Services

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

> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department . . .
>
> (2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .
>
> > (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and

***

Our review identified numerous instances where the supporting documentation for ambulette transports did not include all the required elements, particularly vehicle identification, full name of Medicaid service provider which is one of the covered points of transport, and Medicaid patient number. Without this information, it becomes problematic to determine whether the service is covered by Medicaid.

In order to avoid potential future findings in this area, we recommend that the Provider review its procedures to ensure all required elements of documentation for ambulette services are consistently captured.

Incomplete Documentation of Need for Ambulette Services by Ambulance

Ohio Admin.Code 5101:3-15-05(A)(3) states:

> The rendering transportation provider has documented that its ambulette vehicles were unavailable and has documented referral attempts to a competing transportation provider or the rendering transportation provider has documented that delaying, deferring or missing the transport to or from the medicaid covered service would jeopardize the patient's health or cause excessive patient waiting time.

Our review did not find documentation to show that the Provider was in compliance with this requirement. We recommend that the Provider implement procedures to ensure the necessary documentation is obtained when using an ambulance as an ambulette.

PROVIDER'S RESPONSE

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on March 27, 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.

On April 1, 2009, the original owners of Hocking Valley Health Professionals, Inc. (a.k.a., Health Pro Ambulance) contacted us via telephone and indicated that they disagreed with some of the findings in the report and would be supplying us with a response but indicated they would not provide specific refuting evidence as they were no longer owners of the records or had easy access to them**.** They further indicated that they had previously provided all the documentation they felt was responsive during the course of the audit.

Their written response, which was received on April 2, 2009, expressed several concerns about our report, but they furnished no additional documentation to substantiate services billed. The concerns raised by the former owners centered on five basic issues as follows: (1) they believed that they had been led to expect minimal findings; (2) that they were told overpayments should not be paid back until the report was issued resulting in the incurring of interest charges; (3) that certificates of medical necessity (CMN) are extremely difficult to get completed by medical practitioners so substitutions need to be accepted; (4) they were concerned that our ambulance sample included occasions when the ambulance provided an ambulette service at a reduced price; and (5) they felt the findings were excessive because the majority of errors identified involved documentation issues and the majority of services were in fact provided.

First, in regards to the question of minimal findings, both the previous and current owners of Hocking Valley Health Professionals Inc. were told that the audit was multi-phased. The original owners dealt with the initial phase which included an entrance conference and site visit, our exception tests, and a pilot sample of one-way trips over 50 miles. They were told at the entrance conference and subsequently in follow-up communication that statistical samples of non-exception test ambulance and ambulette services would be done. Final results would not be known until after the samples were completed. In fact, the majority of the overpayment findings ($113,999.18) came from the statistical samples done in the final phase of the audit.

Secondly, during the course of the audit, the original owners and the subsequent owners were told to repay Medicaid for identified overpaid services that they agreed were overpaid. They were also told to immediately bill Medicare for potentially covered services that had been billed to Medicaid instead. During the initial phase of the audit, when services potentially covered by Medicare were being reviewed, some discussions were conducted with the original owners about what documentation was necessary to verify repayment to Medicaid. However, it appears the original owners were told to wait to repay some potential findings (those related to Medicare eligible services) to Medicaid because the overpayments at the time were preliminary and had

not been reviewed; therefore, they were not finalized at that point in the audit. Regardless, final findings related to Medicare eligibility were only $239.22.

Thirdly, the former owners also raised concerns about the difficulty in getting CMNs from the appropriate practitioners. While it may be difficult sometimes to get them filled out, CMNs are required by the Ohio Admin.Code and are similar to prescriptions for drugs – you have to have one in order for the service to be billable to ODJFS. In nearly all cases, a non-emergency transport is not billable to the Medicaid program without a proper CMN to support the service.

Fourthly, the former owners also raised a concern that the ambulance sample could be distorted by the inclusion of certain ambulance services paid at a reduced rate because of being used to provide ambulette transports. The statistical sample of ambulance services that was taken, however, was stratified by the amount paid per RDOS. Consequently, the ambulance services paid at a reduced fee were lumped together with similar paid services both in the population and the sample and therefore would not distort the projection results.

Finally, while the services may have been rendered, without a practitioner's certification of medical need or other requisite supporting documentation, the services are not reimbursable per the rules of the Medicaid program. Once the report is issued, ODJFS will make final determination regarding the findings and issue a proposed adjudication order. The Provider can at that point negotiate for a settlement with ODJFS or request a formal hearing per Chapter 119 of the Ohio Rev.Code to appeal the findings.

We discussed the former owners' concerns denoted in their letter and our subsequent response on April 8, 2009. Based on this discussion, we made changes to the audit report where appropriate. A copy of the former owners' April 2, 2009 response is presented in Appendix III. Patient and AOS employee names have been redacted for privacy reasons.

APPENDIX I

Summary of Sample Record Analysis for Hocking Valley Health Professionals, Inc.
For the period July 1, 2003 through June 30, 2006
Ambulance Sample Population – Provider Number 0686548

Description	Audit Period [July 1, 2003 – June 30, 2006]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulance services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$288,252.66***
Number of Population Recipient Dates of Service	***1,889***
Number of Population Services Provided	***5,071***
Amount Paid for Services Sampled	***$38,880.92***
Number of Recipient Dates of Service Sampled	***184***
Number of Services Sampled	***585***
Estimated Overpayment using Point Estimate	***$33,768***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $10,904 (32.29%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-14,297 (42.34%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits) corrected for skewness[6]	***$19,472.52***

[6] *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.*

APPENDIX II

Summary of Sample Record Analysis for Hocking Valley Health Professionals, Inc.
For the period July 1, 2003 through June 30, 2006
Ambulette Sample Population – Provider Numbers 0686548

	Audit Period [July 1, 2003 – June 30, 2006]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$222,261.79***
Number of Population Recipient Dates of Service	***3,955***
Number of Population Services Provided	***14,642***
Amount Paid for Services Sampled	***13,374.54***
Number of Recipient Dates of Service Sampled	***163***
Number of Services Sampled	***662***
Estimated Overpayment using Point Estimate	***$110,337***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $19,789 (17.93%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-16,607 (15.05%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$93,729***

APPENDIX III
Provider Response

April 2, 2009

Dear Jeff Castle:

We originally received audit info around Sept. 2006. We returned documentation on all that around Dec. 2006. During that period I talked with [redacted] a number of times via phone. I asked her specifically about refunding any money for problems I had identified, she adamantly said, no, do not refund anything until the audit is over. This was on recorded lines, but has since expired and erased.

We were told we would have the onsite visit in August 2007, which was a month after the company had changed hands. John & I were present for that visit, which was 2 days with [redacted] and 2 other auditors. We pulled additional documents at that time. All 3 auditors were reassuring that everything looked good, we had everything in good order.

There was no other information or contact, until [redacted] contacted the new owners for more documentation to be pulled, sometime in 2008. I don't know the exact number of services involved in this addition. The company had moved the office and we had no easy access of the paperwork, since we no longer were involved in the company. Of the resulting drafts, [redacted] gave me a chance to answer on 5 or 6 of the services, and recommended that I refund on what I identified as overpayments. That is the 603.49 that Health Pro refunded in 2008. He reassured me that everything looked good, the audit was not producing any large number of "bad" results, we were probably looking at a minimal repayment amount.

On Mar. 31, 2009, we were contacted by Gary Cook that he had received audit findings totaling 144,000. of repayment, including 24,430.63 in interest accruals. Had we known ANY interest was going to accrue, we definitely would have repaid money right at the beginning of the audit. There was no mention of any interest in any of the paperwork at the beginning of the audit. The ORC was mentioned regarding rules and regulations to follow as to documentation of services, and our company did our best to get the documentation as timely and totally as possible.

We then contacted Jeff Castle, and were emailed the audit report in full.

At this time, we are out of the state until the first week of May. We do not have instant access to the records, or the ability to produce additional documents within the specified 10days. The only thing we have is a copy of our initial reply to the 76 pages of services that we first received in 2006. I was able to cross reference some of the services with those 76 pages, but it appears that most of the findings are from the second group of service documentation requested in 2008, that was given by Gary Cook.

In reviewing it, we are seeing a number of CMN problems, such as "Unauthorized. Practitiononer on CMN, Ineligible signer/missing credentials, no attending practitioner ID'd. Unsigned or signer not traceable. CMN not dated/not signed with 180 days of 1st date of transport. CMN does not cover DOS. CMN missing medical condition. No medical necessity. Patient not certified. Section 7 criteria 3rd box not checked. (Bedconfined, wheelchair confined, unable to….etc. A number of our patients were repetitive transports due to chronic illness, such as CRD, dialysis transports, etc.

In the "Ambulance Sample" report starting with [redacted] that is 18 pages, the total findings were 6169.26, with another number underneath, 163.56. The amount allowed on these services was 13,374.54. I reviewed each service that had findings, up to page 13 of the 18. Of those services there were approx. 50 from the paperwork requested by [redacted], and one or none from my original documentation back in 2006. Of these, one recipient's

services stands out to me, 11 services for [redacted]. She was a CRD patient for a number of years. These 11 services were all covered by one CMN, which had some of the problems listed in the beginning of this paragraph. The CMN covers an amount of time for which it was used, but we also had perfectly correct CMNs that covered other times of transport for her. These 11 services amounted to 1201.63 in findings for this 18 page portion of the audit. It seems excessive to use these 11 services as part of the stratified amount adding up to 119,000. (I hope I'm explaining this correctly)

In the draft, there is information regarding issues with CMNs. The draft states some ORC info, which says the CMN must be signed by MD, DO, Podiatrist or APN. The CMN itself asks who is the attending practitioner, discharge planner or RN, and under the signature line it states, "MD, DO, RN, APN, LSW, etc. These are pretty close to the exact words on the CMN. The form was revised July, 2003. It is sometimes extremely hard to get the physician to sign, so we used the LSW, RN, Discharge planner, etc., which the CMN states is appropriate. They also balked at signing more than one form. A number of times, we would be given a "Transfer Form" that the hospital or nursing home used, that the practitioner would sign in place of a CMN. If the signature or credentials are illegible, we cannot change that. We do get used to certain signatures that we see over and over. I believe these are some of the CMN findings that aren't specific, as stated above.

In the draft for "Transports greater than 50 miles, there were 11 pages totaling findings from 17 claims of 4942.16. Of these 17 services, 14 were in the new sample from 2008, and 3 were in my sample from 2006. That is, I explained those in my documentation of the original 76 pages, and the others were from the second sampling by [redacted]. Of the 3 services that I originally answered, the one for 4/23/04 [redacted], I agreed that Mcaid needed repaid. For [redacted] (11/18/05), I agreed Medicaid needed repaid. The other for 5/18/06 [redacted], my response was that Medicaid was billed correctly. Again, it seems that most of the findings are from the second samplings, of which we did not see anything except the page of 5 or 6 services that [redacted] let us review.

In the draft "Ambulance Sample" beginning with [redacted], 22 pages, totaling findings of 7,260.94, with 24.88 repaid by provider, there are a number of "U3" trips, ambulette by ambulance. These are services not done by choice but out of necessity to provide timely service to the patient. Due to the small population spread over a large geography there were times when we used an ambulance to transport an ambulete patient, but billed the trip as an ambulete by squad. This was a large waste of resources, but we did the services, as necessary, but not to excess. The CMNs were probably completed with the idea of a wheelchair van as the transport vehicle We don't believe these amounts should be used in the stratified amount to come up with the 119,000.

In closing we feel that the total amount of the proposed findings is excessive and out of line for the type of errors found. Throughout our years of our operation we would refund Medicaid as we found overpayments internally, however we feel that it is unreasonable take back payments due to CMN errors when the trips were done in the best interest of the patient, along with the company operating in a fashion that we thought was in line with Medicaid. We would like to be able to reach a mutually agreeable figure for the findings and submit payment without the need to continue on to a hearing. We can be reached at our email of thejohnsonsofcarbonhill@hotmail.com and by phone @ [redacted].

Sincerely,

Cathy and John Johnson

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Mary Taylor, CPA
Auditor of State

July 22, 2009

David Espinoza
Senior Attorney, Office of Legal Services
Ohio Department of Job and Family Services
30 E. Broad St., 31st Floor
Columbus, OH 43215-3414

RE: Adjusted Audit Findings for Hocking Valley Health Professionals, Inc. AOS/MCA-09-006C

Dear Mr. Espinoza:

Per your request, we have reviewed the additional documentation provided by Hocking Valley Health Professionals, Inc. (Medicaid provider number 0686548) subsequent to the issuance of the audit report on April 16, 2009. This information was accompanied by a letter dated May 26, 2009, from the Provider's counsel summarizing the reasons why the Provider felt certain overpayments identified in the audit report were not justified and should be reversed.

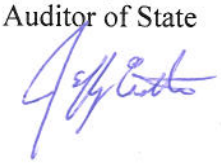
Based on our detailed review of the additional documentation and explanations provided, our net total findings prior to interest were reduced from $118,824.57 to $104,423.36, a reduction of $14,401.21 (12.1 percent). This reduction resulted from a $12,369 decrease in projected findings from our sample of ambulette services and a $2,032.21 decrease in projected findings from our sample of ambulance services. 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 $21,330.97 as of the date of our report release. Additional interest will accrue at the rate of $22.89 per day. Therefore, the adjusted total repayment due to the Ohio Department of Job and Family Services is $125,754.33 as of the date of the report release.

88 E. Broad St. / Fifth Floor / Columbus, OH 43215-3506
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

If you have any questions or need any additional information, please don't hesitate to contact me at (614) 466-7894.

Sincerely,

Mary Taylor, CPA
Auditor of State



Jeffrey Castle, Chief Auditor
Medicaid/Contract Audit Section

cc: Kris M. Dawley, Schottenstein, Zox and Dunn, Co., LPA
Chris Carson, OFMS, Bureau Chief, Bureau of Audit, ODJFS
Jane Young, Office of Ohio Health Plans, ODJFS
Rachel Jones, Chief, SURS, OFMS, Bureau of Audit, ODJFS
Henry Appel, Senior Assistant Attorney General, Ohio Attorney General's Office
Robert Hinkle, Chief Deputy Auditor, AOS
Karen Huey, Chief Legal Counsel, AOS
Norman Hofmann, Assistant Chief Auditor, Medicaid/Contract Audit Section, AOS

Mary Taylor, CPA
Auditor of State

HOCKING VALLEY HEALTH PROFESSIONALS, INC.

HOCKING COUNTY

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

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
APRIL 16, 2009

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