Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Community Ambulance Service, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

May 26, 2009

Greg Beauchemin, President/CEO
Community Ambulance Service, Inc.
25400 West Eight Mile Road
Southfield, Michigan 48034

Dear Mr. Beauchemin:

Attached is our report on Medicaid reimbursements made to Community Ambulance Service, Inc. Medicaid provider number 0990594, for the period April 1, 2004 to March 31, 2007. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified $3,507.57 in findings. However, during the course of the audit, Community Ambulance Service, Inc. repaid $263.90, leaving $3,243.67 in overpayments plus $506.90 in interest accruals totaling $3,750.57 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 May 26, 2009, additional interest will accrue at $0.71 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 Community Ambulance Service, 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).

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

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: Community Ambulance Service, Inc.
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Ohio Attorney General
Health and Human Services/Office of Inspector General
Ohio Medical Transportation Board

TABLE OF CONTENTS

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 Community Ambulance Service, Inc. (hereafter called the Provider), provider number 0990594, headquartered at 952 Linden Avenue, Zanesville, Ohio 43701. Within the Medicaid program, the Provider is listed as an ambulance service provider, furnishing both ambulance and ambulette services. 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 $3,507.57 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 $263.90 leaving $3,243.67 in overpayments. Additionally, we assessed accrued interest of $506.90, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $3,750.57, which is repayable to ODJFS as of the release of this audit report. Additional interest of $0.71 per day will accrue after May 26, 2009, until repayment.

BACKGROUND

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

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called “providers”) render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the Ohio Medicaid Provider Handbook. A fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services.[2] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers’ compliance with reimbursement rules to ensure that services billed are properly documented and consistent with professional standards of care; medical necessity; and sound fiscal, business, or medical practices.

Ohio Admin.Code 5101:3-1-29(B)(2) states: “ ‘Waste and abuse’ are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization 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

[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).*

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 July 29, 2008, to discuss the purpose and scope of our audit. The scope of our audit was limited to claims (not involving Medicaid co-payments for Medicare) for which the Provider rendered services to Medicaid patients and received payment during the period of April 1, 2004 through March 31, 2007. The Provider was reimbursed $1,071,148.99 for 27,409 services rendered on 9,738 recipient dates of service. A recipient date of service (RDOS) is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code and the Ohio Administrative Code as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's paid claims history from ODJFS' Medicaid Management Information System (MMIS), which contains an electronic file of services billed to and paid by the Medicaid program. This claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[3]

Prior to beginning our fieldwork, we performed a series of computerized tests on the Provider's Medicaid payments 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.*

- Payments made for services to deceased recipients for dates of service after their date of death.
- Potential duplicate claims for ambulance transport services for the same recipient, on the same date of service, for the same procedure codes and procedure code modifiers billed to both the Medicaid and Medicare programs as the primary insurer.
- Potential duplicate services 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.
- Claims for ambulette transport services billed while the recipient was a hospital inpatient.

Our exception tests for deceased recipients being billed for services after their date of death and potential duplicate services were negative. However, we identified potentially incorrect reimbursements for ambulance services paid for by both the Medicaid and Medicare programs as the primary insurer and claims for ambulette transport services billed while the recipient was a hospital inpatient.

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

To facilitate an accurate and timely audit of the Provider's remaining medical services, we selected a statistically random sample of 176 RDOS for ambulance services and a statistically random sample of 147 RDOS for ambulette services. These samples were stratified by dollar amount paid.

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 July 2008 and October 2008.

RESULTS

We identified findings of $583.98 for services in our exception testing. Additionally, we identified $2,923.59 in actual findings from our samples. Together, our findings from our exception testing and samples total $3,507.57, the bases of which are discussed below.

Results of Exception Testing

We performed exception testing on the Provider's paid claims for the following two issues: ambulance services paid for by both the Medicaid and Medicare programs as the primary insurer and claims for ambulette transport services billed while the recipient was a hospital inpatient. The results of our review are as follows.

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 identified eight services where the Provider billed 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. Therefore, Medicaid made eight payments for the same service resulting in an overpayment. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare. Additionally, we identified a duplicate Medicare crossover payment where it appears the Provider billed Medicare twice for the same service and Medicaid was billed both times for the coinsurance/deductible. Findings totaling $397.12 were made on the amount paid by the Medicaid program as primary payer for the identified duplicate covered services and $48.04 for the duplicate Medicare crossover payment.

Transportation Services Billed for Hospital Inpatients

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

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

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

***

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

***

(E) Service Limitations

The following services are not covered:

(1) Unloaded transports (i.e., no Medicaid patient in the vehicle) …

***

We performed an analysis of the Provider's billed services to identify if there were transportation services billed for patients while they were hospital inpatients. Our analysis initially identified 36 services potentially billed for ambulette transports while the recipient was a hospital inpatient.

Our review determined that all 36 services were involved with actual transports. However, we took findings on four services because the patient was transported by ambulette; yet the Provider submitted an ambulance Certificate of Medical Necessity (CMN), which certifies the medical necessity and the type of transport required. Findings totaling $138.82 were made on the amount reimbursed to the Provider for the errors listed above.

Summary of Exception Testing

Total combined findings of $583.98 resulted from our exception tests, which included ambulance services paid for by both the Medicaid and Medicare programs as the primary insurer, ambulette services billed and provided with an ambulance CMN and a duplicate Medicare crossover payment.

Results of Statistical Samples

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

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

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

Ambulance Services Sample – Detailed Results

Our stratified random sample of 176 ambulance RDOS (involving 476 services) identified 10 RDOS (34 services) with a combination of 62 errors resulting in an actual overpayment of $2,331.56. There were services that had more than one error; however, only one finding was made per service. The bases for these errors are presented below.

Issues with Certificates of Medical Necessity

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

> ***
>
> (E) Documentation requirements
>
> (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) 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.

***

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.
>
> ***

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 medical necessity and the type of transport required. Based on our review, we took findings due to the following 58 errors:

- 24 services where either the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 20 services where the requisite credentials were not listed for the person signing the CMN; or no practitioner was identified for instances when an authorized proxy signed the CMN;
- 8 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 4 services where the CMN supplied did not cover the date of service; and
- 2 services where the Provider did not supply a CMN.

While certain CMNs had more than one error, only one finding was made per service. We therefore disallowed the reimbursement for these services and made a finding for $2,035.45.

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 identified four ambulance services that lacked documentation (e.g., trip log) to support the services billed had actually been rendered. We therefore disallowed the reimbursement for these services and made a finding for $296.11.

Summary of Ambulance Sample Findings

The overpayments identified for 10 of 176 RDOS (involving 34 of 476 services) from our stratified random sample of ambulance transportation services were not projected to the population of ambulance services. However, because of the large degree of sampling error and skewness obtained, the results did not meet our criteria for use. Therefore, the findings for the services in our ambulette sample were limited to the actual identified overpayment of $2,331.56. During the course of the audit, however, the Provider repaid $263.90 to ODJFS for some of the overpayments identified as part of the ambulance sample.

Ambulette Services Sample – Detailed Results

Our stratified random sample of 147 ambulette RDOS (involving 555 services) identified 13 RDOS (31 services) with a combination of 65 errors resulting in an actual overpayment of $592.03. 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 5101:3-15-03 (B)(2), Covered ambulette transports states in pertinent part:

> ***
>
> (a) The ambulette services must be medically necessary…
>
> ***

Additionally, 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...
>
> ***
>
> (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

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

***

(4) Practitioner certification form

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

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

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…

***

During our review of the documentation submitted by the Provider, we found numerous errors CMN and took findings due to the following 54 errors:

- 26 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 14 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code, the ordering practitioner's name and provider number are missing, or the requisite credentials were not listed for the person signing the CMN nor could they be determined;
- 10 services where an illegible signature for the ordering practitioner or proxy was not accompanied with identifying information; and
- 4 services where the CMN supplied did not cover the date of service.

While certain CMNs had more than one error, only one finding was made per service. The reimbursements for these services were disallowed.

Patients' Non-Ambulatory Status in Question

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

> ***
>
> (B) Ambulette services coverage and limitations
>
> ***
>
> (2) Covered ambulette transports
>
> Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements in this paragraph are met.
>
> (a) The ambulette services must be medically necessary as specified below:
>
> (i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code;
>
> ***

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

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

Our review of the Provider's documentation identified six services where the patients' non-ambulatory status was in question. In one case, the CMN indicated that the patient was

ambulatory; while in another case, the trip documentation indicated that the patient was ambulatory. The reimbursements for these services were disallowed.

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 five services lacked documentation (e.g., trip log) to support the service billed had actually been rendered. The reimbursements for these services were disallowed.

Summary of Ambulette Sample Findings

The overpayments identified for 13 of 147 RDOS (involving 31 of 555 services) from our stratified random sample of ambulette transportation services were projected to the population of ambulette services. However, because of the large degree of sampling error and skewness obtained, the results did not meet our criteria for use. Therefore, the findings for the services in our ambulette sample were limited to the actual identified overpayment of $592.03. During the course of the audit, however, the Provider repaid $51.30 to ODJFS for some of the overpayments identified as part of the ambulance sample.

Summary of Findings

A total of $3,507.57 in findings was identified. These findings result from the combination of our exception testing ($583.98) and the actual overpayments identified in our statistical samples of ambulance services ($2,331.56) and ambulette services ($592.03). During the course of the audit, however, the Provider repaid ODJFS a total of $263.90 for identified overpayments in both the ambulance and ambulette samples. For those services selected in our exception testing and samples, we reviewed all corresponding records presented 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 10 services in our ambulette sample 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. 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) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.
>
> ***

Based on our testing, we found 829 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 $30,623.43 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.

Incomplete Documentation and Miscoding 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.

In addition, Ohio Admin.Code 5101:3-15-05(B)(1)(c) states:

> For the total reimbursement, the provider must bill the "Basic life support, non emergency (BLS non-emergency)" code and the code for the loaded land ambulance mileage. Both codes must be modified with the appropriate Medicaid covered point of transport modifier and U3, ambulette service by ambulance vehicle, modifier (two modifiers in total).

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. Further, the Provider should review its billing practices to ensure it properly bills the correct procedure code and modifier 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 April 24, 2009. The Provider was afforded 10 business days from the receipt of the draft report to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. The Provider contacted the AOS and indicated it had reviewed the findings and contents of the draft audit report and had no additional information to submit. The Provider further indicated that it intended to remit the identified overpayments upon receipt of the publicly issued report.

Mary Taylor, CPA
Auditor of State

COMMUNITY AMBULANCE SERVICE, INC.

MUSKINGUM 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
MAY 26, 2009

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