Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Donald Martens & Sons Ambulance Service, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

February 2, 2010

Dean Martens, President
Donald Martens & Sons Ambulance Service, Inc.
6900 Lake Abrams Road
Middleburg Heights, OH 44130

Dear Mr. Martens:

Attached is our report on Medicaid reimbursements made to Donald Martens & Sons Ambulance Service, Inc., Medicaid provider number 0175993, for the period October 1, 2004 to September 30, 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 $70,427.55 in findings. However, during the course of the audit, Donald Martens and Sons Ambulance Services, Inc. repaid $210.47 leaving $70,217.08 in overpayments plus $11,296.29 in interest accruals totaling $81,513.37 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 February 2, 2010, additional interest will accrue at $15.39 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 Donald Martens and Sons Ambulance Services, Inc.; the Director and Legal Divisions of ODJFS; the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

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

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: Donald A. Martens, Sr., Statutory Agent
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Medicaid Fraud Control Unit, Ohio Attorney General
U. S. Department 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 Donald Martens & Sons Ambulance Service, Inc. (hereafter called the Provider), provider number 0175993, headquartered at 6900 Lake Abrams Rd., Middleburg Heights, Ohio 44130. Within the Medicaid program, the Provider is listed as an ambulance service provider, furnishing both ambulance and ambulette services. An ambulance is defined as a vehicle that is designed to transport individuals in a supine position, while an ambulette is designed to transport individuals sitting in a wheelchair.

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 $70,427.55 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 $210.47 leaving $70,217.08 in overpayments. Additionally, we assessed accrued interest of $11,296.29 in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $81,513.37, which is repayable to ODJFS as of the release of this audit report. Additional interest of $15.39 per day will accrue after February 2, 2010, 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."

[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).*

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 November 25, 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 or third-party insurance claims) for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 2004 through September 30, 2007. The Provider was reimbursed $2,555,995.88 for 133,197 services rendered on 38,519 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 to determine if reimbursements were made for potentially inappropriate services or service code combinations. Of these tests, the following resulted in potential overpayments:

- Ambulance services billed to Medicaid that were potentially covered by Medicare for dually eligible recipients.
- Claims billed for specialty care transport services.
- Claims for transport services billed while the recipient was a hospital inpatient.
- Potential duplicate claims where payments were made for the same recipient on the same date of service, and for the same procedure codes and procedure code modifiers.
- 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.
- Payments made for services to deceased recipients for dates of service after the date of death.

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 Provider's total 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 191 RDOS for ambulance services and 121 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 performed between November 2008 and February 2009.

RESULTS

We identified findings of $7,568.03 for services in our exception testing. Additionally, we identified $62,859.52 in findings from our samples. Together, our findings from our exception testing and samples total $70,427.55, the bases of which are discussed below. During the course of the audit, however, the Provider repaid $210.47 for identified overpayments in our exception testing leaving a net repayment due of $70,217.08.

Results of Exception Testing

Exception tests performed on the Provider's paid claims identified the following issues: ambulance services billed to Medicaid that were potentially covered by Medicare for dually eligible recipients, specialty care transports, claims for transport services billed while the recipient was a hospital inpatient, billing for duplicate payments, billing both Medicare and

Medicaid for the same service, and services billed for deceased recipients. Upon review of detailed records, our exception test for services billed for deceased recipients was negative. The results of our review of the remaining issues are as follows.

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 215 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 117 services covered by Medicare where the Provider did not supply supporting substantive documentation explaining why Medicaid should have been billed as the primary payer. Further, we identified the following 118 errors that also resulted in findings:

- 49 services where the Provider did not supply a CMN;
- 48 services lacked documentation (e.g., trip report) to support that the service billed had actually been rendered;
- 5 services where the incorrect code and/or modifier was used;
- 4 services where the CMN supplied did not cover the date of service;
- 4 services where the Provider transported the patient by ambulance, billed for an ambulance transport, but submitted an ambulette CMN for support;
- 4 services where the CMN was signed with an illegible signature and was not accompanied with identifying information;
- 2 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code; and

- 2 services where the CMN received lacked the medical condition to support the medical necessity of the transport.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $6,582.24 were made on the amount reimbursed to the Provider for the errors listed above. During the course of the audit, however, the Provider was in the process of repaying Medicaid for several of the identified overpayments. As of the point the audit was drafted, the Provider had repaid $210.47 of the identified overpayments to ODJFS, leaving an overpayment due of $6,371.77.

However, when questioned about Medicare eligibility, it appears that in 18 additional instances, the Provider was seeking to adjust ambulance services to lower level ambulette services with Medicaid, despite receiving Medicare denials. Thus, the documentation supported the level of service (ambulance) originally billed to Medicaid. Note: no overpayments were taken for these 18 services.

Specialty Care Transports

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 5101:3-15-01 (26) states in pertinent part:

> …"Specialty care transport services (SCT)" is defined as a level of interhospital services which is beyond the scope of the paramedic and must be furnished by one or more health professionals who are trained in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care or paramedic with additional training).

We initially identified 123 services where the Provider billed for specialty care transports. Although we found no instances of services not provided by required special care professionals, we identified the following 14 errors that resulted in findings:

- 10 services where the Provider did not supply a CMN;
- 2 services where the incorrect code and/or modifier was used; and

- 2 services where the Provider transported the patient by ambulance, billed for an ambulance transport, but submitted an ambulette CMN for support.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $631.40 were made on the amount reimbursed to the Provider for the errors listed above.

Transportation Services Billed for Hospital Inpatients

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

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

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

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

Our initial claims analysis identified 68 transportation services where the Provider appeared to have billed for an ambulette transport while the patient was a hospital inpatient. Based on our review of records, we identified the following 10 errors that resulted in findings:

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

There were services that had more than one error; however, only one finding was made per service. Findings totaling $138.45 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 initially identified 33 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 19 errors that resulted in findings:

- 9 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code;
- 9 services where the CMN was signed with an illegible signature and was not accompanied with identifying information; and
- 1 service lacking supporting documentation which could indicate services not rendered or potentially duplicate billed service.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $127.23 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Claims for Ambulance Services Paid 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 22 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 one payment 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. Additionally, two services lacked trip documentation to support the service was rendered.

Findings totaling $88.71 were made on the amount reimbursed to the Provider for the errors listed above.

Summary of Exception Testing

Total combined findings of $7,568.03 resulted from our exception tests. The Provider repaid $210.47 of this amount during the course of the audit, leaving an overpayment due of $7,357.56.

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 191 ambulance RDOS (involving 465 services) identified 17 RDOS with a combination of 74 errors resulting in a projected overpayment of $62,621. 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

***

(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) 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 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 65 errors:

- 23 services where the Provider did not supply a CMN;
- 10 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code;
- 10 services where the practitioner's signature on the CMN was illegible and was not accompanied with identifying information;
- 8 services where the signature of the practitioner signing the CMN is not dated;
- 8 services where the CMN supplied did not cover the date of service;
- 4 services where the CMN was not signed within 180 days of the first date of service; and
- 2 services where the attending practitioner did not certify that the patient met the conditions for a covered transport.

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

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. Therefore, the reimbursements for these services were disallowed.

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 overbilled mileage for transports. In these instances, we determined the Provider billed in excess of what its records supported. We therefore disallowed the reimbursement for the excessively billed mileage.

Transports Greater than 50 Miles without Justification

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

> ***

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

***

We identified two 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.

Summary of Ambulance Sample Findings

We took exception with 17 of 191 RDOS (involving 57 of 465 services) from our stratified random sample of ambulance transportation services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $586,344, with a 95 percent certainty that the actual correct payment amount fell within the range of $545,162 to $627,526 (+/- 7.02 percent). We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($586,344) from the amount paid to the Provider for this population ($648,965), which resulted in a finding of $62,621. 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 121 ambulette RDOS (involving 452 services) identified 5 RDOS with a combination of 28 errors resulting in an actual overpayment of $238.52. 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 5101:3-15-02 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

***

(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 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 for the following 18 errors:

- 8 services where the Provider did not supply a CMN;
- 4 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code;
- 4 services where the practitioner's signature on the CMN was illegible and was not accompanied with identifying information; and
- 2 services where the attending practitioner did not certify that the patient met the conditions for a covered transport services.

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

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 10 ambulette services that lacked documentation (e.g., trip log) to support the services billed had actually been rendered. Therefore, the reimbursements for these services were disallowed.

Summary of Ambulette Sample Findings

The overpayments identified for 5 of 121 RDOS (involving 16 of 452 services) from our stratified random sample of ambulette transportation services were not projected to the population of ambulette services. No projection was made because both the error rate and the overpayments identified fell below our criteria for projecting results of a sample. Therefore, the findings for the services in our ambulette sample were limited to the actual identified overpayment of $238.52.

Summary of Findings

A total of $70,427.55 in findings was identified. These findings result from the combination of our exception testing ($7,568.03), our statistical sample projection of ambulance services ($62,621), and of our statistical sample of ambulette services ($238.52). During the course of the audit, the Provider repaid a total of $210.47 in findings leaving a remaining finding amount of $70,217.08.

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.

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 626 services paid for by Medicaid that were potentially covered by Medicare Part B. With Medicare Part B reimbursement, Medicaid would have been the secondary payer, 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 could have paid as much as $30,706.93 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 payer of last resort.

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.

Other Observations

We reviewed the Provider's employee files and other documentation maintained to determine if the Provider complied with driver requirements per the Ohio Administrative Code. The results, as follows, did not result in monetary findings; however, failure to comply with applicable regulations could place patients in harm's way and jeopardize the Provider's status with the Medicaid program.

Required Documentation Lacking for Drivers

We reviewed the Provider's employment files for 28 drivers (21 ambulance drivers and 7 ambulette drivers) randomly selected from the list of 455 personnel (336 drivers) furnished by the Provider to determine if required procedures were followed and required documentation was kept on file. Our results are as follows:

Lack of Criminal Background Checks for Drivers

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

> ***
> (a)(iii)
> Each ambulette driver and each attendant must submit himself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been convicted of or pleaded guilty to violations cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the Revised Code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply.
>
> ***
>
> (b) A provider may employ an applicant on a temporary provisional basis pending the results of the required information set forth in paragraphs (C)(3)(a) (iii), (C)(3)(a)(iv) and (C)(3)(a)(v) of this rule if the following conditions are met . Providers who are in the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.
>
> > (i) The length of the temporary provisional period shall be sixty days or the period established by another state government agency or board with the authority under Ohio law to regulate providers of ambulette services, whichever is greater.

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

***

Our review of seven ambulette driver personnel files found four where there were no results of a criminal background check maintained on file; however, three of the files contained evidence that the Provider had paid for a criminal background check.

PROVIDER'S RESPONSE

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on August 21, 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 September 9, 2009, the Provider requested an extension to respond to our draft report and was granted a one-month extension. On October 13, 2009, the Provider submitted additional documentation, which we reviewed and made adjustments to the findings as appropriate.

APPENDIX I

Summary of Sample Record Analysis for Donald Martens & Sons Ambulance Service, Inc.
For the period October 1, 2004 through September 30, 2007
Ambulance Sample Population – Provider Number 0175993

Description	Audit Period [Oct. 1, 2004 – Sept. 30, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulance services excluding exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$648,965***
Number of Population Recipient Dates of Service	***6,036***
Number of Population Services Provided	***14,825***
Amount Paid for Services Sampled	***$37,272***
Number of Recipient Dates of Service Sampled	***191***
Number of Services Sampled	***465***
Projected Correct Population Payment Amount	***$586,344***
Upper-limit Correct Population Payment Estimate at 95% Confidence Level	***$627,526***
Lower-limit Correct Population Payment Estimate at 95% Confidence Level	***$545,162***
Precision of Estimated Correct Population Payment Amount at 95% Confidence Level	***$41,182 (+/- 7.02 %)***
Projected Overpayment Amount = Total Medicaid Amount Paid – Projected Correct Population Payment Amount	***$62,621***

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Mary Taylor, CPA
Auditor of State

DONALD MARTENS AND SONS AMBULANCE SERVICE, INC.

CUYAHOGA 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
FEBRUARY 2, 2010

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