Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Quality Care Transport, LTD.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

May 18, 2010

Jeffrey P. Scanlan, Co-owner
Dwight H. Whipp, Co-owner
Quality Care Transport, LTD.
30 South Sycamore Street
Springfield, Ohio 45505

Dear Messrs. Scanlan and Whipp:

Attached is our report on Medicaid reimbursements made to Quality Care Transport, LTD., Medicaid provider number 2369155, for the period July 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 $254,045 in findings plus $55,291.33 in interest accruals totaling $309,336.33 that are repayable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After May 18, 2010, additional interest will accrue at $55.68 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 Quality Care Transport, LTD.; 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

Mary Taylor, CPA
Auditor of State

cc: Barry P. Reich, Statutory Agent
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 Quality Care Transport, LTD. (hereafter called the Provider), provider number 2369155, headquartered at 30 South Sycamore Street, Springfield, Ohio 45505. 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 $254,045 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] Additionally, we assessed accrued interest of $55,291.33 in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $309,336.33, which is repayable to ODJFS as of the release of this audit report. Additional interest of $55.68 per day will accrue after May 18, 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."

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 August 18, 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 July 1, 2004 through March 31, 2007. The audit period, originally planned to begin on April 1, 2004, was revised to exclude three months of paid services so as to comply with Ohio Revised Code § 5111.061 and ensure any identified overpayments could be collected. During the revised audit period, the Provider was reimbursed $1,123,740.14 for 66,776 services rendered on 17,391 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 exception tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations as follows:

- 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.
- Claims for transport services billed while the recipient was a hospital inpatient.
- 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.

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. We analyzed the claim data for the records identified. Based on this analysis, we determined that the likelihood for overpayments was minimal and further assessment was neither warranted nor cost effective. As such, no findings were taken.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we selected a statistically random sample of 149 RDOS for ambulance services and 156 RDOS for ambulette services. These samples were stratified by dollar amount paid. When performing our audit fieldwork, we requested and reviewed the Provider's supporting documentation for the sampled RDOS.

Our fieldwork was performed between August 2008 and November 2008 as well as September 2009 to October 2009.

RESULTS

We did not take any findings in our exception tests for the aforementioned reasons. However, we identified $254,045 in findings from our projected samples, the bases of which are discussed below.

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 149 ambulance RDOS (involving 472 services) identified 30 RDOS with a combination of 140 errors resulting in a projected overpayment of $19,029. 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
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> ***
>
> (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 132 errors:

- 62 services where the practitioner either did not sign the CMN or the practitioner's signature was illegible and was not accompanied with identifying information;
- 58 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;

- 8 services where the CMN supplied did not cover the date of service; and
- 4 services where the CMN was not dated by the attending practitioner.

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

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 6 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 5101:3-15-02 (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

***

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 two 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 and were used in calculating the projected findings.

Summary of Ambulance Sample Findings

We took exception with 30 of 149 RDOS (involving 92 of 472 services) from our stratified random sample of ambulance transportation services were projected across the Provider's population of ambulance paid recipient dates of service, excluding those already selected for exception testing. This resulted in a projected overpayment amount of $30,691 with a precision of plus or minus $10,473 (34.12 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 restated 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 $19,029. This allows us to say that we are 95 percent certain the population overpayment amount is at least $19,029. 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 156 ambulette RDOS (involving 704 services) identified 57 RDOS with a combination of 327 errors resulting in a projected overpayment of $235,016. 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:

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

***

(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 314 errors:

- 140 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;
- 76 services where the practitioner either did not sign the CMN or the practitioner's signature was illegible and was not accompanied with identifying information;
- 68 services where the CMN supplied did not cover the date of service;
- 16 services where the attending practitioner did not certify that the patient met the conditions for a covered transport services;
- 8 services where the CMN was not dated;
- 4 services where the CMN received lacked the medical condition to support the medical necessity of the transport; and
- 2 services where the Provider did not supply a CMN.

While certain services had more than one error, only one finding was made per service. The reimbursements for these services were disallowed and were used in calculating the projected findings.

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 five services where the Provider was over paid mileage for transports. In these instances, we determined that the Provider billed in excess of what its records supported. We therefore disallowed the reimbursement for the excess billed mileage and used this amount in calculating the projected finding.

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 4 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 with Missing or Incomplete Supporting Documentation

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

***

Additionally, Ohio Admin.Code 5101:3-1-17.2 (D) states in pertinent part:

***

(D) To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of

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

We identified two services where the Provider did not provide complete addresses for points of transport origin or destination. Additionally, we identified two ambulette services that lacked documentation (e.g., trip log) to support the services billed had actually been rendered. Therefore, the reimbursements for these four services were disallowed and were used in calculating the projected findings.

Summary of Ambulette Sample Findings

The overpayments identified for 57 of 156 RDOS (involving 212 of 704 services) from our stratified random sample of ambulette transportation services were projected across the Provider's total population of ambulette services. This resulted in a projected overpayment amount of $304,499 with a precision of plus or minus $82,793 (27.19 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 restated as a single tailed lower-limit using the lower limit of a 90 percent confidence interval (equivalent to the method used in Medicare audits), and a finding was made for $235,016. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $235,016. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Summary of Findings

A total of $254,045 in findings was identified. These findings result from the combination of our statistical sample projections of overpayments from ambulance services ($19,029) and from ambulette services ($235,016).

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.

Certificates of Medical Necessity Improperly Altered During Audit

Ohio Rev.Code § 2913.40 (D) states:

> (D) No person, having submitted a claim for or provided goods or services under the medical assistance program, shall do either of the following for a period of at least six years after a reimbursement pursuant to that claim, or a reimbursement for those goods or services, is received under the medical assistance program:

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which the claim was submitted, or for which reimbursement was received, by the person;

(2) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based for the person.

Ohio Rev.Code § 2921.12 Tampering with evidence, further states:

(A) No person, knowing that an official proceeding or investigation is in progress, or is about to be or likely to be instituted, shall do any of the following:

(1) Alter, destroy, conceal, or remove any record, document, or thing, with purpose to impair its value or availability as evidence in such proceeding or investigation;

(2) Make, present, or use any record, document, or thing, knowing it to be false and with purpose to mislead a public official who is or may be engaged in such proceeding or investigation, or with purpose to corrupt the outcome of any such proceeding or investigation.

(B) Whoever violates this section is guilty of tampering with evidence, a felony of the third degree.

Throughout this audit, the Provider repeatedly submitted documentation, most notably certificates of medical necessity (CMN), which had been altered in an attempt to repair deficiencies identified by our audit. The most common alteration noted was the addition of "90 days" to the box in section 9 for temporary CMNs. By adding 90 days, the Provider extended the period of time covered by the CMN from a single day to a three-month period. The second most common alteration was the addition of "unsteady gait" to section 8, which occurred on a large number of CMNs. Section 8 requires the ordering practitioner to indicate the diagnosis or patient's medical condition that would require transport by an ambulette or ambulance. Both of these changes surfaced after audit staff had pointed out that many CMNs were invalid, incomplete or did not cover billed dates of service.

We also noted instances where doctors' or nurses' names and signatures had been added to sections 11 and 12 where the ordering and signing practitioner are identified. Without this information, the CMN would be incomplete and invalid. These changes occurred in documents presented in response to our draft report of January 25, 2010. In a few cases the new signatures were dated, but most were not. Nevertheless, the alterations occurred several years after the services were rendered.

The Provider in responding to the draft report submitted altered CMNs for 102 services. The majority of these services (86) were ambulette services and the remaining 16 were for ambulance

services. More notably, the alterations for 32 of the ambulette services would have resulted in the service having been approved if not for the CMN alteration being detected.

The alterations, on the CMNs for the remaining 70 services, were not the deciding factor in determining whether the service was approved or rejected. In other words, the alterations did not impact whether the CMN was valid or whether it covered the service date in question. For example, a temporary CMN altered with the "90 days" added to the period of coverage in section 9 would not have its coverage affected for a service on the same date that the CMN was signed. In that particular case, the service date would still have been covered if section 9 had been blank.

As noted above, alterations to documents occurred throughout the audit. This occurred despite repeated cautions to the Provider by both Auditor of State and Attorney General personnel. Moreover, the transmittal letter for our draft report specifically cited the two provisions of the Ohio Revised Code cited above and again cautioned the Provider about altering documents.

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 345 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 $18,918.66 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.

Evidence of Third Party Insurance

Ohio Admin.Code 5101:3-1-08 states in pertinent part:

> ***

> (D) The medicaid program must be the last payer to receive and adjudicate the claim…ODJFS reimburses for covered services only after the provider takes reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing ODJFS…
>
> ***

During our testing of ambulance services, we found 30 services where the patient records indicated third party insurance coverage. In the majority of cases, however, no mention of third party coverage was made in the claims to ODJFS. Because Medicaid is considered the payer of last resort, the Provider should have sought reimbursement through the third party insurance prior to billing the Medicaid program.

In order to avoid future findings in this area, we recommend that the Provider review its procedures to ensure that recipients' third party insurance is fully determined and are billed prior to Medicaid, as it is the payer of last resort. Furthermore, claims billed to the Medicaid program should fully disclose the presence and applicability of third party insurance.

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.
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> ***

During the course of our audit, we identified 20 services 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. A majority 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.

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 20 drivers (10 ambulance drivers and 10 ambulette drivers) randomly selected from personnel lists furnished by the Provider to determine if required procedures were followed and required documentation was kept on file. Our results are as follows:

Issues with Driving Record Reviews

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

> Effective January 1, 2004, each ambulance driver must provide from the bureau of motor vehicles his/her driving record at the time of application for employment and annually thereafter. The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment. Persons having six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulance driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

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

> Each ambulette driver must provide from the bureau of motor vehicles his/her driving record at the time of application for employment and annually thereafter. The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment. Persons having six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

Of the 10 ambulance drivers tested for compliance, 4 were hired after January 1, 2004 and were therefore required to provide a BMV record check prior to being hired. All 10, however, were required to comply with Ohio Admin.Code 5101:3-15-02(C)(3)(a)(vi) by providing annual driving record reviews. Our review of personnel records found no evidence of individual BMV or equivalent driving record reviews for the 4 drivers hired after January 1, 2004, nor was there evidence that the driving records were provided annually for each of the 10 individual drivers.

According to the Provider, its insurance company now conducts annual driving record reviews but only notifies the Provider if violations are found for a particular driver. It also conducts reviews for all new hires and upon request of the Provider. Otherwise, the insurance company provides a general notification that there were no issues found with any of the ambulance drivers. The Provider did not furnish proof of such general notifications from its insurance company during the audit period and further acknowledged that there was no BMV driving record review conducted in 2004.

Further, during the course of the audit period, the Provider employed one ambulette driver who had six points on his driving record, making him ineligible to drive an ambulette. No findings were taken for this driver because none of the services provided by this driver in our sample were during the period in which he had six points on his driving record.

PROVIDER'S RESPONSE

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on January 25, 2010. The Provider was afforded 10 business days from the receipt of the draft report to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. The Provider requested an extension to respond and supply additional documentation. An extension was granted to the Provider and additional documentation was accepted through March 26, 2010. After reviewing the additional documentation, findings were adjusted where appropriate.

APPENDIX I

Summary of Sample Record Analysis for Quality Care Transport, LTD.
For the period July 1, 2004 through March 31, 2007
Ambulance Sample Population – Provider Number 2369155

Description	Audit Period [July 1, 2004 - March 31, 2007]
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	***$214,956.59***
Number of Population Recipient Dates of Service	**1,321**
Number of Population Services Provided	**4,118**
Amount Paid for Services Sampled	***$29,134.72***
Number of Recipient Dates of Service Sampled	***149***
Number of Services Sampled	***472***
Estimated Overpayment using Point Estimate	***$30,691***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $10,473 (34.12%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/- $8,789 (28.64%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits) corrected for skewness[5]	***$19,029***

[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.*

APPENDIX II

Summary of Sample Record Analysis for Quality Care Transport, LTD.
For the period July 1, 2004 through March 31, 2007
Ambulette Sample Population – Provider Number 2369155

Description	Audit Period [July 1, 2004 - March 31, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulette services excluding exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$862,018.64***
Number of Population Recipient Dates of Service	**15,725**
Number of Population Services Provided	**61,694**
Amount Paid for Services Sampled	***$11,674.88***
Number of Recipient Dates of Service Sampled	***156***
Number of Services Sampled	***704***
Estimated Overpayment using Point Estimate	***$304,499***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $82,793 (27.19%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/- $69,482 (22.82%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$235,016***

Mary Taylor, CPA
Auditor of State

QUALITY CARE TRANSPORT, LTD.

CLARK 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 18, 2010

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