CITYWIDE INCORPORATED
HAMILTON COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2010 THROUGH DECEMBER 31,2012

Dave Yost · Auditor of State

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CITYWIDE, INCORPORATED
HAMILTON COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO NON-EMERGENCY MEDICAL TRANSPORTATION

LaTausha E. Hargrove, Owner
Citywide Incorporated
260 Northland Boulevard, Suite 209
Cincinnati, Ohio 45246

RE: *Medicaid Provider Number 3030295*

Dear Ms. Hargrove:

We examined your (the Provider's or Citywide's) compliance with specified Medicaid requirements for driver qualifications, service documentation, and service authorization related to the provision of non-emergency medical transportation services during the period of January 1, 2010 through December 31, 2012. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid and compared the elements contained in the documentation to the Medicaid rules. In addition, we determined if the services were authorized by certificates of medical necessity (CMNs) and reviewed personnel records to verify driver qualifications were met. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion and report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Disclaimer of Opinion

As described in the Compliance Examination Report, we were unable to gain assurance regarding the validity of documentation supporting the Provider's compliance with the specified Medicaid requirements. Issues with the Provider's documentation include multiple trip sheets to support the same transport; one CMN being used for multiple years for the same recipient; and the same CMN being used for multiple recipients. In addition, we were unable to identify the vehicles used in the transports and we found trips provided by drivers outside of their reported hire and termination dates. Also, we identified services for the same recipient on the same date as services paid by Ohio Medicaid to another transportation company. Furthermore, the Provider declined to submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable laws and regulations regarding Ohio Medicaid reimbursement; establishing and maintaining effective internal control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

Disclaimer of Opinion

Because of the matters described in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the compliance with the specified Medicaid requirements for the period of January 1, 2010 through December 31, 2012. Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We found the Provider was overpaid by Ohio Medicaid for services rendered between July 1, 2010 and December 31, 2012 in the amount of $688,292.32 (see Results section for period to recover overpayments). This finding plus interest in the amount of $72,379.12 totaling $760,671.44 is due and payable to ODM upon ODM's adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

This report is intended solely for the information and use of the ODM, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/Office of Inspector General, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

April 4, 2016

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are 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 § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulation that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. See Ohio Admin. Code § 5160-1-01(B) According to Ohio Admin. Code § 5160-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated with the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin. Code § 5160-1-17.2(E)

Some Ohio Medicaid recipients confined to a wheelchair may be eligible to receive transportation services provided by an ambulette provider. See Ohio Admin. Code § 5160-15-03(B)(2) An ambulette is a vehicle designed to transport wheelchair bound individuals. Qualifying ambulette services must be certified as medically necessary by an attending practitioner for individuals who are non-ambulatory, able to be safely transported in a wheelchair, and do not require an ambulance. "Attending practitioner" is defined as the primary care practitioner or specialist who provides care and treatment to the recipient on an ongoing basis and who can certify the medical necessity for the transport. An attending practitioner can be a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, or an advanced practice nurse. Ohio Admin. Code § 5160-15-01(A)(6)

The Provider was enrolled as a Medicaid provider on March 8, 2010. During the examination period, the Provider received reimbursement of $702,317.04 for 49,603 non-emergency services, including 24,821 non-emergency wheelchair van transport services (procedure code A0130) and 24,782 mileage services (procedure code S0209).

The owner of Citywide obtained some of its vehicles from another transportation company, C.G.G. Inc., which is no longer in business. The Auditor of State (AOS) issued a Medicaid compliance examination report on C.G.G. Inc. on May 13, 2014 with an examination period of January 1, 2009 through December 31, 2011. AOS found that none of the drivers employed by C.G.G. Inc. met the requirements to provide ambulette services and, because of this and additional non-compliance identified, AOS identified the entire Medicaid reimbursement to C.G.G. Inc. as an overpayment.

In addition to the common vehicles, we found that six of the nine Citywide drivers were also drivers for C.G.G. Inc., including the owner of C.G.G. Inc. In addition, we found common recipients served by both companies and selected as one of our exception tests, transports of the same recipients on the same day as transports paid by Ohio Medicaid to both C.G.G. Inc. and Citywide. In addition, we found CMNs in Citywide's documentation that identified C.G.G. Inc. as the transportation provider.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of non-emergency medical transportation services, specifically ambulette services, that the Provider rendered to Medicaid recipient and received payment during the period of July 1, 2010 to December 31, 2012.

Purpose, Scope, and Methodology (Continued)

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed any services that were marked as void and not paid, and services paid at zero.

We extracted all paid services for another provider, C.G.G. Inc., for calendar years 2010 and 2011 and summarized the services by recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. We also summarized all of Citywide's paid services by RDOS. A match was then performed between the Citywide RDOS summary file (12,184 RDOS) and the C.G.G. Inc. RDOS summary file (3,899 RDOS) using the recipient identification number and date of service as the match keys. A total of four matching RDOS were found. We then obtained the detailed services which resulted in an exception test of 10 services (five transport codes and five mileage codes) for recipients that were provided a service on the same date by both transportation companies (see Background section).

We removed the 10 services identified for the first exception test from Citywide's total paid services and then summarized the remaining detailed services by RDOS. We then extracted all RDOS with 10 or more services and matched these RDOS with detailed services by recipient identification number and date of service. This resulted in a total of 63 services (32 transports and 31 mileage codes) for a second exception test.

From the remaining population, we selected a simple random sample to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). A simple random sampling approach was used because of the moderate variability in the amount paid and the number of services provided per RDOS. An estimate of the population overpayment standard deviation was made using the standard deviation of the actual amount paid per claim and a conservative 50 percent error rate estimate. The sample size calculation was done with the RAT-STATS statistical software package[2].

After extracting all of the detailed services in the two exception tests, the remaining paid services were summarized by RDOS. We selected a random sample of RDOS and then obtained the detailed services for all of the selected RDOS. A total of 1,631 services were pulled for the 398 sampled RDOS.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. After conducting our review of the records initially submitted by the Provider, we sent a completed list of missing records to the Provider. The Provider submitted additional documentation which we reviewed for compliance.

Results

We reviewed personnel files and found the Provider had no drivers that met the driver qualifications during the examination period. In addition, we found material non-compliance with requirements for CMNs and trip documentation in the sample reviewed and both exception tests.

ODM may recover an overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made according to Ohio Rev. Code § 5164.57. Based on the non-compliance found in our testing, we identified $688,292.32, the amount reimbursed for all services paid on or after July 1, 2010, as an overpayment.

[2] RAT-STATS is a statistical software package created by the U. S. Department of Health and Human Services, Office of Inspector General (HHS/OIG) and is the primary statistical tool for OIG's Office of Audit Services.

Results (Continued)

While the results section presents all non-compliance identified, no overpayment was identified for services paid prior to July 1, 2010.

During our review of documentation submitted by the Provider, we became concerned as to the authenticity of the records submitted. We noted that we had received two trip sheets for the same transport for 12 separate transports. A comparison of these documents noted differences in the pick up times, drop off times, driver's name, odometer readings and total mileage. In addition, in reviewing CMNs we noted that the same CMN with changes to dates covered was used multiple times. We also noted nearly identical CMNs submitted with names of different recipients.

During our first on-site visit, we encountered delays in obtaining records from the Provider, and after receiving some initial records, we waited long periods of time before additional records were provided even though we had been assured the records were readily available. At the end of the day, when we inquired as to the delays, the Provider indicated the records were disorganized and the owner was trying to first organize them before submitting them. We assured her this was not necessary and asked that all of the records be provided.

We reviewed 1,631 services (816 transports and 815 mileage codes) in the statistical sample and found 797 errors in addition to the ineligible drivers.

We reviewed 10 services (five transports and five mileage codes) in the exception test for services provided by Citywide and C.G.G. Inc. on the same date and found five errors in addition to the ineligible drivers.

We reviewed 63 services (32 transports and 31 mileage codes) in the exception test of recipients with 10 or more services in one day and found 44 errors in addition to the ineligible drivers.

The basis for our finding is described below in more detail.

A. Certificate of Medical Necessity

All transportation providers are required by Ohio Admin. Code § 5101:3-15-02(E)(2)[3] to obtain a CMN that has been signed by an attending practitioner that documents the medical necessity of the transport. 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. Ambulette providers must obtain the completed, signed and dated CMN prior to billing the transport. The practitioner certification form is non-transferrable from one transportation provider to another. *See* Ohio Admin. Code § 5101:3-15-02(E)(4)

In our testing of CMNs, we found the same CMN used multiple times with dates of first transport and signature dates changed. In addition, we found the same CMN used for different recipients with the added change of recipient name and identifier. In these instances, we did not identify errors for the services covered by the earliest dated CMN. We identified all services associated with subsequent use(s) of the same CMN as an error.

[3] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013. These renumbering effects all rules noted in the Results section of this report.

A. Certificate of Medical Necessity (Continued)

Statistical Sample

Our review of the statistical sample of 816 transports (procedure code A0130) we identified the following errors:

- 189 services in which CMN was a copy of a previous CMN;
- 91 CMNs that were not valid as they were not signed by authorized practitioner, not one of the criteria for transport was met, there was no medical condition and/or the CMN was for another provider; and
- 10 services with no CMN to cover the date of service.

In 12 of the 91 CMNs that were not valid, the CMN indicated the transportation provider was C.G.G. Inc. In addition, we found 288 transports with incomplete CMNs as the CMNs did not indicate that all three criteria necessary for the transport to be a Medicaid covered service were met. We noted that for 81 of these 288 transports, the CMN indicated the patient was ambulatory.

Exception Test – Services provided by Citywide and C.G.G. Inc.

Our review of the five transports (procedure code A0130) in this exception test identified three incomplete CMNs and noted that, for all three services, the CMN indicated the patient was ambulatory.

Exception Test – Recipients with 10 or more services in one day

Our review of the 32 transports (procedure code A0130) in this exception test identified five transports in which the CMNs were not valid as they were not signed by an authorized practitioner. In addition, we found 22 transports in which the CMNs were not complete as they did not indicate that all three criteria necessary for the transport to be a Medicaid covered service were met.

Recommendation:

The Provider should establish a system to obtain the required CMNs and to review those CMNs to ensure they are complete prior to billing Medicaid for the transport. The Provider should ensure that it does not use CMNs transferred from another transportation provider. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Trip Documentation

Trip documentation records must describe the transport from the time of pick up to drop off, and include mileage, full name of attendant, full name of driver, vehicle identification, full name of the Medicaid covered service provider, and complete Medicaid covered point of transport addresses. This requirement is necessary to calculate the correct payment prior to billing Ohio Medicaid. See Ohio Admin. Code § 5101:3-15-02(E)(2)

Statistical Sample

We obtained trip documentation from the Provider and reviewed it for the required elements and to ensure that the transport was a covered Medicaid service. The Provider submitted multiple trip sheets for 12 transports in our statistical sample. In two of these 12 instances, the trip sheets included the same information.

B. Trip Documentation (Continued)

Statistical Sample (Continued)

In the other 10 instances, the trip sheets had different drivers, pick up times, drop off times, odometer readings, and/or total mileage. As we could not verify the validity of these trip documents, we noted all 12 instances as errors.

In addition to the 12 transports with two trip sheets, our review of the 816 transports in the statistical sample found these additional errors:

- 8 transports with no supporting trip documentation;
- 4 transports in which the trip documentation did not contain name of the Medicaid provider or it could not be determined that one point of the transport was a covered Medicaid service; and
- 140 transports in which mileage paid exceeded the mileage documented.

There were also 55 transports with incomplete documentation. The incomplete documentation did not consistently contain pick up time, drop off times, vehicle identification and/or complete addresses.

Exception Test – Services provided by Citywide and C.G.G. Inc.

Our review of five transports found two transports in which mileage paid exceeded the mileage documented.

As C.G.G. Inc. is no longer in business, we were unable to compare its trip documentation submitted to Citywide's documentation. The 2014 compliance examination of C.G.G. Inc. found, in a material number of instances, that the company lacked trip documentation to support services.

Exception Test – Recipients with 10 or more services in one day

Our review of 32 transports found eight transports with no supporting trip documentation and six transports in which mileage paid exceeded mileage documented. In addition, we found three transports with incomplete documentation as they did not include complete addresses, pick up time and/or drop off time.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with all Medicaid requirements. In addition, the Provider should implement a quality review process to ensure that documentation is complete prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Driver Qualifications

All ambulette drivers must pass a criminal background check and have a signed medical statement from a licensed physician declaring the individual does not have a medical, physical or mental condition or impairment which could jeopardize the health or welfare of patients being transported.

C. Driver Qualifications (Continued)

Also, each driver must undergo testing for alcohol and controlled substances by a certified laboratory and be determined to be drug free. Background checks, medical statements, and drug test results must be completed and documented before the driver begins providing ambulette services or within 60 days thereafter. Prior to employment, each driver must obtain first aid and Cardiopulmonary Resuscitation (CPR) certification (or have an Emergency Medical Technician certification), provide a copy of his/her driving record from the Bureau of Motor Vehicles (BMV), and complete passenger assistance training. *See* Ohio Admin. Code § 5101:3-15-02(C)(3). Each driver must also maintain a valid drivers' license.

There were nine individuals that we identified as drivers in our sample based on the Provider's trip documentation. There were 16 transports in the statistical sample in which no driver was identified. We selected all of the identified nine drivers to test for compliance with driver requirements. Hiring dates and application dates submitted by the Provider were initially used to test compliance; however, we noted transports outside of these dates, and so determined that the information submitted by the Provider was not reliable. We then performed our tests using the first date of service with the identified driver in our sample and exception tests.

Based on our review of personnel files and all documentation submitted by the Provider, we found the following errors:

- 1 driver had no criminal background check;
- 5 drivers did not have criminal background checks conducted by the Bureau of Criminal Investigation; however, all 5 did have background checks conducted by the City of Cincinnati and/or Hamilton County;
- 1 driver had no documentation of a valid driver's license and 2 drivers had a lapse ranging from 3 months to almost 1 year in which there was no documentation of a valid driver's license;
- 1 driver lacked a driving record and 2 drivers had lapses in their driving records ranging from 2 weeks to 6 months after the driver's first date of service;
- 8 drivers lacked the alcohol test;
- 1 driver had no controlled substance test and 1 driver had no controlled substance test until 6 months after first date of transport;
- 1 driver did not have first aid or CPR certification and 2 drivers had lapses in certification ranging from 5 to 10 months;
- 3 drivers had no physician statement and 1 driver had a 6 month lapse in obtaining the physician statement; and
- 5 drivers lacked passenger assistance training and the remaining 4 drivers had lapses in this training with 1 driver having lapse of 8 months and the remaining 3 completing the training after our examination period.

As a result of the pervasive non-compliance with driver requirements, we found that the Provider had no drivers that were eligible for Medicaid reimbursement.

Recommendation:

The Provider should develop and implement a system to ensure that all drivers complete required documentation prior to rendering services and maintain the necessary certifications and licensure while providing non-emergency transportation services. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

D. Vehicle Review

According to Ohio Admin. Code § 5101:3-15-02(A)(2), providers of ambulette services must operate in accordance with applicable requirements developed by the Ohio Medical Transportation Board in accordance with Chapter 4766 of the Ohio Rev. Code.

We obtained records from the State Board of Emergency Medical services (EMS Board) and confirmed that the Provider had one licensed vehicle in 2010 and three licensed vehicles in 2011 and 2012.

While some of the Provider's trip documentation did contain vehicle identification (number) we never received any documentation from the provider to identify which vehicle used which number. As a result, we were unable to verify that licensed vehicles were used for the transports in our sample.

Recommendation:

The Provider should develop and implement a system to ensure all vehicles are properly licensed prior to use and to identify which exact vehicle is being used in the transport. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Provider Response: A draft report was sent to the Provider on June 2, 2016, and the Provider was afforded an opportunity to respond to this examination report. The Provider declined an exit conference to discuss the draft examination report. The Provider also declined to submit an official response to the results noted above.

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CITYWIDE INCORPORATED

HAMILTON 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
JULY 19, 2016

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