PHYCISIANS AMBULANCE SERVICE, INC.
DBA PHYSICIANS MEDICAL TRANSPORT TEAM
CUYAHOGA COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2012 THROUGH DECEMBER 31, 2014

Dave Yost • Auditor of State

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PHYSICIANS AMBULANCE SERVICE, INC.
DBA PHYSICIANS MEDICAL TRANSPORT TEAM
CUYAHOGA COUNTY

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

Ronald C. Hess, President/Chief Executive Officer
Physicians Ambulance Service, Inc., DBA Physicians Medical Transport Team
4495 Cranwood Parkway
Cleveland, Ohio 44128

RE: *Medicaid Provider Number 2234933*

Dear Mr. Hess:

We examined your (the Provider'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, 2012 through December 31, 2014. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid. In addition, we determined if the services were authorized in certificates of medical necessity (CMNs). We also reviewed personnel records to verify that driver qualifications were met and verified vehicle licensure with the Ohio Department of Public Safety, Division of Emergency Medical Services (EMS Board) (formerly Ohio Medical Transportation Board). 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 attestation standards established by the American Institute of Certified Public Accountants 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 Adverse Opinion on Medicaid Services

Our examination found material non-compliance with service documentation, service authorization requirements and driver qualification requirements. 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.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to service documentation, service authorization and driver qualifications for the period of January 1, 2012 through December 31, 2014.

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 January 1, 2012 and December 31, 2014 in the amount of $107,120.99. This finding plus interest in the amount of $2,546.69 totaling $109,667.68 is due and payable to the ODM upon its adoption and 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

July 21, 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 regulations 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 within 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 patients confined to a wheelchair may be eligible to receive non-emergency medical transportation services. Qualifying wheelchair van services must be certified as medically necessary indicating that the individual must be accompanied by a mobility-related assistive device and that transportation by standard passenger vehicle or common carrier is precluded or contraindicated. The necessity of a transportation service rendered on a fee-for-service basis must by certified by a practitioner holding a current license or certification to practice in a professional capacity. *See* Ohio Admin. Code §§ 5160-15-21, 5160-15-22, and 5160-15-27

During the examination period, the Provider received total reimbursement of $734,703.21 for 32,881 services. Of these services, 6,076 were ambulance or specialty care transports for which the Provider was paid $342,368.40 and 26,805 were wheelchair van services for which the Provider was paid $392,334.81.

We noted that the Provider did business during the examination period under the name Physicians Medical Transport Team although this is not a registered name in Ohio. The Provider also operates offices in three additional Ohio cities: Akron, Ashland and North Ridgeville.

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 wheelchair van (ambulette) services, that the Provider rendered to Medicaid patients and received payment during the period of January 1, 2012 through December 31, 2014. These 26,805 wheelchair van services included 13,408 non-emergency wheelchair van transport services (procedure code A0130) and 13,397 mileage codes (procedure code S0209). The wheelchair van services were rendered on 7,606 recipient dates of service (RDOS). A recipient date of service is defined as all services for a given recipient on a specific date of service.

We received the Provider's paid claims history from ODM's Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed any voids, services paid at zero, services with third party payments and services with Medicare co-payments.

From this population we extracted all transports and corresponding mileage code where a nursing facility modifier was used prior to January 1, 2014. Transports of nursing facility residents were not directly reimbursable during the portion of the examination period prior to this date. This resulted in an exception test of 78 services – 39 transports each with corresponding mileage.

Purpose, Scope, and Methodology (Continued)

From the remaining subpopulation we selected a simple random sample using RDOS as the sampling unit to facilitate a timely and efficient examination of the Provider's services as permitted Ohio Admin. Code § 5160-1-27(B)(1). We then obtained the detailed services for the 214 RDOS selected. This resulted in a sample size of 751 services (376 transport codes and 375 mileage codes).

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. During fieldwork we reviewed personnel records and service documentation. We sent a missing records list and a final request for information to the Provider and we reviewed all documents received for compliance.

Results

We examined 78 wheelchair van transportation services (39 transports and 39 mileage codes) in our exception test of transports billed with a nursing facility modifier prior to January 1, 2014 and found 69 errors. After we sent the notification of our intent to perform the compliance examination, the Provider submitted repayment of $159.32 for six transports included in the exception test. We completed our examination of all services selected for the exception test and incorporated the repayment of these six transports. As a result, we identified $591.08 as an overpayment.

We also examined 751 wheelchair van transportation services (376 transports and 375 mileage codes) in our statistical sample and identified 599 errors. We took exception with 209 of 751 statistically sampled recipient services (76 of 214 RDOS) from a random sample of the Provider's population of paid services (which excluded services in the exception test.) Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $284,708, with a 95 percent certainty that the actual correct payment amount fell within the range of $259,206 to $310,211 (+/- 8.96 percent.) We then calculated findings by subtracting the correct population amount ($284,708) from the amount paid to the Provider for this population ($391,237.91), which resulted in a finding of $106,529.91. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

While certain services had more than one error, only one finding was made per service. The basis for our findings is described below in more detail.

On January 19, 2016 the Provider completed an ambulette questionnaire and stated that, since February, 2011, it has been aware of the requirements that in order for an ambulette transport to be covered by Medicaid, the transport must be in an ambulette, licensed and approved as such by OMTB and that a certificate of medical necessity must be on file for the individual being transported. The Provider further stated it maintained all records and documents necessary to substantiate transportation services.

A. Certificate of Medical Necessity

All transportation providers are required by Ohio Admin. Code § 5101:3-15-02(E)(2)[2] 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. In addition, providers must obtain the completed, signed and dated CMN prior to billing the transport and CMN forms are not transferable from one transportation provider to another. *See* Ohio Admin. Code § 5101:3-15-02(E)(4)

Exception Test

Our review of the CMNs to support the exception test identified 20 transports lacking a CMN to cover the transport and two transports in which each CMN reflected "weakness" as the medical condition and was signed by a registered nurse with no attending practitioner identified. The Provider submitted repayment for six of the transports lacking a CMN. The remaining 16 errors are included in the overpayment amount of $591.08.

Statistical Sample

Our review of the CMNs to support the statistical sample identified the following errors:

- 58 transports in which the CMN did not certify the recipient met any criteria for medical necessity, did not include a medical condition, was not signed by an authorized practitioner, did not include the name of the Provider and/or included the name of a different transportation provider;
- 7 transports in which there was no CMN to cover the transport; and
- 2 transports for same recipient in which the CMN was for ambulance transport and it identified a different transportation provider.

These 67 errors were used in the overall projection of $106,529.91.

In addition, we noted CMNs for 149 transports (three in the exception test and 146 in the statistical sample) that included a medical condition and were signed by an authorized practitioner but were not complete. While these CMNs indicated that at least one criterion was met, they did not consistently indicate that the recipient met all of the criteria. Per Ohio Admin. Code § 5101:3-15-03(B)(2), ambulette services are covered only when the individual has been determined and certified by the attending practitioner to be non-ambulatory at the time of transport and does not require ambulance services; the individual does not use passenger vehicles as transport to non-Medicaid services; and the individual is physically able to be safely transported in a wheelchair.

After receipt of the final request for information, the Provider submitted numerous additional CMNs, some of which contradicted previously supplied CMNs for the same recipient and date of service. We used the most compliant CMN provided for our testing. The Provider's procedures result in multiple CMNs being obtained for the same recipient covering the same time frame. The focus appears to be on obtaining multiple CMNs rather than ensuring a valid CMN is on-file for each transport. This practice, which results in an administrative burden for the Provider and the attending practitioners, may be contributing to the material non-compliance identified in this examination.

[2] 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)

Recommendation:

The Provider should establish a system to obtain the required CMNs for any services rendered on a fee-for-service basis, ensure they are completed by an authorized attending practitioner, and to review those CMNs to ensure they are complete prior to submitting a bill to Medicaid for the transport. 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 the mileage, 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)

Exception Test

We tested to determine if the Provider had the required supporting documentation and identified six transports in which there was no service documentation to support the transport and 17 transports in which the miles billed exceeded the documented miles. The Provider submitted repayment for four of the services with no supporting documentation and two of the services with mileage errors.

The remaining 17 errors are included in the overpayment of $591.08.

We also noted three instances in which the documentation lacked the name of the Medicaid service provider but we were able to match it to the name on documentation to a different transport. We found four additional instances without the name of the Medicaid provider but we were able to identify the provider through an internet search of the address. As result, we determined it is likely one point of transport was to a Medicaid covered service. Accordingly, we considered the seven errors to be non-compliant but did not identify a corresponding overpayment.

Statistical Sample

We reviewed the trip documentation to support the transports and corresponding mileage codes and identified three transports in which there was no documentation to support the transport and four transports in which the miles billed exceeded the documented miles.

These seven errors were used in the overall projection of $106,529.91.

We also noted 69 instances of incomplete documentation in which the pick-up and drop-off times and/or address of the Medicaid covered service provider was missing and seven instances in which the mileage was not documented but the mileage billed was the same as the mileage documented and billed for the other leg of the round trip transport.

In addition, the trip documentation did not always include the name of the Medicaid covered service provider. In 152 such instances we matched the name to documentation for a different service using the address listed. We noted an additional 74 instances in which the name of the Medicaid covered service provider was not included and we could not match it to other documentation. We haphazardly selected 20 of the 74 instances and performed an internet search of the addresses. In all 20 instances the address was that of a medical service provider. Accordingly, we determined it is likely one point of transport was to a Medicaid covered service and considered the total of 226 errors to be non-compliant but did not identify any corresponding overpayment.

B. Trip Documentation (Continued)

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Admin. Code § 5160-15-27. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate 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. 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) or proof of insurance from insurance carrier, and complete passenger assistance training. In addition, each driver must provide copy of BMV driving record on annual basis. *See* Ohio Admin. Code § 5101:3-15-02(C)(3). Each driver must also maintain a valid drivers' license.

We haphazardly selected 12 drivers from the Provider's trip documentation for testing. From the Provider's employee roster, we determined that six of the 12 drivers tested were hired during the examination period and we applied the applicable hiring requirements. We found the following errors for hiring requirements:

- 1 driver had no documentation of a criminal background check and 2 drivers did not have the background checked completed within 60 days of hire;
- 1 driver did not have a signed physician statement;
- 3 drivers lacked an alcohol test and 2 drivers did not have the test completed within 60 days of hire;
- 1 driver lacked a controlled substance test and 1 driver did not have the test within 60 days of hire;
- 1 driver lacked passenger assistance training; and
- 1 driver did not have a copy of BMV driving record and the driver was not on the Provider's insurance record.

In addition, we tested all 12 drivers for the required annual requirements and noted four drivers with lapses in first aid ranging from approximately two to four months and the same four drivers had lapses in CPR ranging from approximately one to four months.

Due to the errors noted, two drivers were ineligible during the entire examination period and four drivers were ineligible until all hiring requirements were met and/or during lapses in certifications.

Exception Test

Our review of the documentation identified one transport by an ineligible driver. This one error is included in the overpayment of $591.08.

C. Driver Qualifications (Continued)

Statistical Sample

Our review of the documentation identified 44 transports by an ineligible driver and one transport in which the name of the driver was illegible. These 45 errors were used in the overall projection of $106,529.91.

We also noted one driver who met all hiring and annual requirements although the alcohol test was approximately one year late. We determined this driver was non-compliant but eligible to render services. We found 25 services rendered by this driver in the statistical sample.

Recommendation:

The Provider should develop and implement a system to ensure that all drivers complete all requirements prior to rendering transportation services. In addition, the Provider should ensure that those requirements which involve renewal of certifications are also met and that supporting documentation is maintained. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

D. Vehicle Licensure

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 licensing records from the EMS Board through the Provider's annual renewal date of March 30, 2014.

Exception Test

Our review of the documentation identified two transports in a wheelchair van prior to the vehicle being licensed by the EMS Board. These two errors are included in the overpayment of $591.08.

Statistical Sample

We identified no errors.

Recommendation:

We recommend the Provider use only licensed vehicles to render services. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

E. Covered Services

According to Ohio Admin. Code § 5101:3-15-02.8, medical transportation services were not directly reimbursed for recipients residing in a nursing facility. This limitation, which went into effect on July 31, 2009, ended on December 31, 2013.

For all services modified with "N" indicating one point of transport was a nursing facility, we cross checked the date of service to additional paid services in the MITS system. If there was payment on the same date as the transport to a nursing facility, we concluded the recipient was a resident of the nursing facility.

E. Covered Services (Continued)

Exception Test

Our review of the documentation identified seven transports for a nursing facility resident. The Provider submitted repayment for one of these transports. The remaining six errors are included in the overpayment of $591.08.

F. Billing Codes

According to Ohio Admin. Code § 5101:3-15-05(B)(1)(c), in order to receive reimbursement for ambulette services provided in an ambulance, a provider must bill the "basic life support, non-emergency (BLS non-emergency)" code and the code for the loaded land ambulance mileage. In addition, both codes must be modified with U3 to indicate an ambulette service by an ambulance.

Exception Test

Our review of the documentation identified four wheelchair van transports provided in an ambulance that were billed with the ambulette codes and no U3 modifier.

Statistical Sample

Our review of the documentation identified seven wheelchair van transports provided in an ambulance that were billed with the ambulette codes and no U3 modifier.

We determined that these 11 errors did not result in an overpayment by the Medicaid program.

Recommendation

The Provider should review its billing procedures and ensure the correct code and modifiers are billed. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Provider Response:

The Provider submitted an official response to the results of this examination which is presented in **Appendix II**. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Conclusion:

Our process includes offering the Provider an opportunity to participate in an exit conference to discuss the preliminary results of the examination. The Provider declined to participate in an exit conference. While we received an official response from this Provider, no basis for the disagreement with the results was contained in the Provider's response.

APPENDIX I

Summary of Statistical Sample Analysis

POPULATION
The population from which this subpopulation and sample was taken is all paid Medicaid services, less services examined in the exception test, net of any adjustments where the service was performed and payment was made by ODM during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from MITS. This system contains all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLING UNIT
The sampling unit was a recipient date of service (RDOS).

SAMPLE DESIGN
We used a random sampling approach.

Description	Analysis
Number of Population RDOS	7,572
Number of Population RDOS Sampled	214
Number of Population RDOS Sampled with Errors	76
Number of Population Services Provided	26,727
Number of Population Services Sampled	751
Number of Population Services Sampled with Errors	209
Total Medicaid Amount Paid for Population	$391,237.91
Amount Paid for Population Services Sampled	$10,969.56
Projected Correct Population Payment Amount	$284,708
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$310,211
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$259,206
Projected Overpayment Amount (Amount Paid for Population Services Sampled minus Projected Correct Population Payment Amount)	$106,529.91
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	$25,502 (+/-8.96%)

Source: AOS analysis of MITS information and the Provider's medical records

APPENDIX II

Geoffrey E Webster, President
Attorney at Law

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gewebster@gewebster.com

September 7, 2016

Via Fedex Tracking #777169124911
Kristi Erlewine, Chief Auditor
Medicaid/Contract Audit Section.
Auditor of State
88 East Broad Street, Ninth Floor
Columbus, Ohio 43215-3506

Re: Physicians Ambulance Service, Inc.
Medicaid Provider # 2234933

Dear Ms. Erlewine:

My client and I have had an opportunity to review your letter of August 25th and the Summary Reports forwarded with the Cover Letter. Your letter requested my client either request an exit conference or submit an "official response" to the Report as amended by the review of the additional records supplied.

Physicians Ambulance Service, Inc. disagrees with the findings, interpretations of the documents reviewed and the methodology utilized in the "audit" to project to the universe of the claims paid.

I do not see that an exit conference has an adequate likelihood of productive result to warrant the expense. It is clear the Auditor's Office is firm in its position the audit report is an accurate representation of my client's performance in the delivery of Medicaid covered transportation services. It is clear my client strongly disagrees with that position.

My client disagrees any sum is due and owing and disagrees that an audit was done in the manner required by applicable standards governing audits of this nature. I presume the Auditor's Office will process the report and deliver it to the Department of Medicaid for further processing. My client does not waive any right, power or privilege at law or in equity regarding the claims made and reserves the right to assert all defenses and rights at any subsequent administrative hearing, including, without limitation, the rights to a citizen when the State takes action that is not substantially justified.

Sincerely,

Geoffrey E. Webster

GEW/ss
Enclosure

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PHYSICIANS AMBULANCE SERVICE

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
SEPTEMBER 22, 2016

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