Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to MedCorp, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

August 24, 2010

J. Jeffrey Lowenstein, Vice-President of Legal
MedCorp, Inc.
745 MedCorp Drive
P.O. Box 80700
Toledo, Ohio 43608

Dear Mr. Lowenstein:

Attached is our report on Medicaid reimbursements made to MedCorp, Inc., Medicaid provider number 0236266, for the period April 1, 2004 to March 31, 2007. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). We identified $1,412,202.09 in findings plus $329,023.74 in interest accruals totaling $1,741,225.83 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 August 24, 2010, additional interest will accrue at $309.52 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 MedCorp, Inc.; 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 Norman Hofmann, Interim Chief Auditor of the Medicaid/Contract Audit Section, at (614) 728-7164 or toll free at (800) 282-0370.

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: 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 MedCorp, Inc. (hereafter called the Provider), provider number 0236266, headquartered at 745 MedCorp Drive, Toledo, Ohio 43608. 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 wheelchairs.

We performed our audit in accordance with Ohio Rev.Code §117.10 and our letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified $1,412,202.09 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] Additionally, we assessed accrued interest of $329,023.74 in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $1,741,225.83, which is repayable to ODJFS as of the release of this audit report. Additional interest of $309.52 per day will accrue after August 24, 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 business transactions. The provider will maintain such records for a period of six years from the

[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).*

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 October 7, 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 claims) for which the Provider rendered services to Medicaid patients and received payment during the period of April 1, 2004 through March 31, 2007. The Provider was reimbursed $10,483,536.85 for 477,737 services rendered on 130,993 recipient dates of service. A recipient date of service (RDOS) is defined as all services received by a particular recipient on a specific date.

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

Prior to beginning our fieldwork, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. The following tests resulted in potential overpayments:

[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.*

- Ambulance services billed to Medicaid that were potentially covered by Medicare for dually eligible recipients.
- Claims for transport services billed while the recipient was a hospital inpatient.
- Potential duplicate claims - payments made for the same recipient on the same date of service, for the same procedure codes and procedure code modifiers, and for the same dollar amount but on a different claim.
- Potential duplicate claims for ambulance transport services billed to the Medicaid program as the primary insurer under provider number 0236266, and then also billed to the Medicare program as the primary insurer under another of MedCorp, Inc.'s provider numbers (0721026 - independent laboratory services).
- Potential duplicate claims for transportation services billed by MedCorp, Inc. under provider number 0236266 and its sister company, MedCorp EMS South, LLC., under provider number 2613130.
- Payments made for services to deceased recipients for dates of service after the date of death.

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

To facilitate an accurate and timely audit of the Provider's remaining medical services, we selected a statistically random sample of 199 RDOS for ambulance services[4] and 181 RDOS for ambulette services. These samples were stratified by dollar amount paid.

When performing our audit fieldwork, we requested the Provider's supporting documentation for the sampled RDOS and all potentially inappropriate service code combination claims identified by our exception analyses.

Our fieldwork was performed primarily between October 2008 and August 2009. To meet the requirements set forth in Ohio Rev.Code § 5111.061 and to enable ODJFS to ultimately seek recovery, the Provider was officially notified of the identified overpayments on June 26, 2009. An initial exit conference was held on August 11, 2009, to discuss the identified findings. Following the conference, additional documentation was supplied by the Provider and reviewed through February 2010.

RESULTS

We identified findings of $16,696.09 for services in our exception testing. Additionally, we identified $1,395,506 in findings from our samples. Together, our findings from our exception testing and samples total $1,412,202.09, the bases of which are discussed below.

[4] The ambulance sample was drawn from non-emergency services that did not involve third-party payments.

Results of Exception Testing

We conducted a detailed review of records for those services identified by our exception tests. The results of our review are as follows.

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

Ohio Admin.Code 5101:3-1-05 states in pertinent part:

> ***
>
> (C) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.
>
> ***

We identified ambulance transport services that were provided to dually eligible recipients (persons who are eligible to receive benefits through Medicaid and are also eligible to receive benefits through Medicare Part B for ambulance transportation services). We removed the services rendered to the dually eligible patients from the remaining ambulance exception reports, the ambulance sample, and the sampled ambulance population to avoid double impact. We sent the Provider an exception report detailing those services potentially covered by Medicare that were still within 18 months of their date of service. The letter notified the Provider of our potential findings for the ambulance transport services in question, and requested supporting documentation showing proper billing to and reimbursement by Medicaid.

Based on our review of records and the Provider's response, we identified 107 services covered by Medicare where the Provider did not supply supporting substantive documentation explaining why Medicaid should have been billed as the primary payer. Further, we identified the following 132 errors that also resulted in findings:

- 66 services where the Provider did not supply a Certificate of Medical Necessity (CMN), also called a practitioner certification form, which certifies the basis for the medical necessity of the transport;
- 16 services where the CMN was not signed or signed with an illegible signature and was not accompanied with identifying information;
- 14 services lacked a patient condition assessment form documenting the level of service needed and provided;
- 11 services with potential third-party insurance where the Provider did not furnish evidence of a denial for coverage or the service was paid in duplicate by third-party insurance;

- 6 services where the number of miles paid exceeded the amount supported in the Provider's documentation;
- 6 services where an ambulance was used as an ambulette but the Provider billed an ambulance service without using the requisite U3 modifier to reduce the rate charged;
- 4 services for which the trip documentation indicated that the recipient was ambulatory;
- 4 services where the CMN submitted does not cover the date of service;
- 2 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code;
- 2 services where the transport destination was specifically not covered per Medicaid rule (i.e.. the recipient between the ages of 21 and 65 was transported to a psychiatric hospital for inpatient services); and
- 1 service where the Provider billed for the use of an extra attendant without the requisite supporting documentation.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $6,338.38 were made on the amount reimbursed to the Provider for the errors listed above.

Cross-Provider, Cross-System Duplicate Claims for Ambulance Services

Ohio Admin.Code 5101:3-1-05 states in pertinent part:

> ***
>
> (A) Definitions.
>
> (1) "Medicare" is a federally financed program of hospital insurance (part A) and supplemental medical insurance (also called SMI and/or part B) for aged and disabled persons.
>
> ***
>
> (6) "Dual Eligibles or Dually Eligible Consumers" are individuals who are entitled to medicare hospital insurance and/or SMI and are eligible for medicaid to pay some form of medicare cost sharing…
>
> (7) "Medicare Crossover Claim" means any claim that has been submitted to the Ohio department of job and family services (ODJFS) for medicare cost sharing payments after the claim has been adjudicated and paid by the medicare central processor, medicare carrier/intermediary or the medicare managed care plan and the medicare central processor or medicare carrier/intermediary has determined the deductible, coinsurance and/or co-payment amounts. Claims denied by the medicare carrier/intermediary or the medicare managed care plan are not considered medicare crossover claims…

> ***
>
> (B) Medicare crossover process.
>
> (1) The medicare program determines the portion of medicare cost sharing, if any, due to the provider based on medicare's business rules…
>
> ***
>
> (3) For medicare crossover claims, the total sum of the payments made by ODJFS, medicare and/or all other third party payers is considered payment in full…
>
> (b) If payment (other than the cost sharing amounts) is inadvertently received from both medicare and medicaid for the same service, the ODJFS claims adjustment unit must be notified in accordance with the provisions set forth in rule 5101:3-1-19.8 of the Administrative Code.
>
> ***

Furthermore, Ohio Admin.Code 5101:3-1-17.2 states in pertinent part that by signing an agreement to provide Medicaid services, a provider certifies and agrees to:

> ***
>
> (A) To ... submit claims only for services actually performed...
>
> ***

Finally, Ohio Admin.Code 5101:3-15-03(A)(2)(j) states,

> Ambulance services to all eligible medicare patient are to be billed to medicare. If the patient has medicare coverage, the department will reimburse only part-B co-insurance and deductible amounts.
>
> ***

Our exception test identified potential duplicate claims for ambulance transport services billed to the Medicaid program as the primary insurer under provider number 0236266, and then also billed to the Medicare program as the primary insurer under another of MedCorp, Inc.'s provider numbers (0721026 - independent laboratory services). We identified these services by matching claims where provider number 0236266 billed these services to Medicaid as the primary payer with claims where provider number 0721026 received Medicaid payments for Medicare

copayments; thus indicating that a claim was submitted to Medicare for the same service in duplicate.

Medicaid paid the Medicare co-insurance and deductible amounts for services billed to Medicare in addition to those where Medicaid was billed directly and paid as primary insurer. The matching was done by recipient, date of service, procedure code and procedure code modifier.

Thus, Medicaid was billed and made payment for 91 of the same services as were paid by Medicare, resulting in an overpayment. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare.

Findings totaling $3,702.29 were made on the amount reimbursed to the Provider for the errors listed above.

Transportation Services Billed for Hospital Inpatients

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

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

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

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

Our initial claims analysis identified transportation services where the Provider appeared to have billed for an ambulette transport while the patient was a hospital inpatient. Based on our review of records, we identified the following 214 errors that resulted in findings:

- 180 services where the Provider did not supply a CMN;

- 20 services where the number of miles paid exceeded the amount supported in the Provider's documentation;
- 4 services lacked documentation (e.g., trip report) to support that the service billed had actually been rendered;
- 4 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 2 services for trips exceeding 50 miles (one-way) that lacked documentation to justify the transport to be out of the patient's community;
- 2 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code; and
- 2 services for a cancelled trip where the Provider lacked the requisite supporting documentation in order to bill.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $3,583.86 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Payments

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part that by signing an agreement to provide Medicaid services, a provider certifies and agrees to:

> ***
>
> (A) To ... submit claims only for services actually performed...
>
> ***

We initially identified services where the Provider appeared to have billed for more than one transport for the same recipient on the same date of service, for the same procedure codes and procedure code modifiers, and for the same dollar amount but on a different claim. Based on our review of records, we identified the following 133 errors that resulted in findings:

- 65 services where the Provider did not supply a CMN;
- 60 services lacking supporting documentation which could indicate services not rendered or potentially duplicate billed service;
- 2 services where the number of miles paid exceeded the amount supported in the Provider's documentation;
- 2 services for trips exceeding 50 miles (one-way) that lacked documentation to justify the transport to be out of the patient's community;
- 2 services where the CMN was not signed or signed with an illegible signature and was not accompanied with identifying information; and
- 2 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $2,448.35 were made on the amount reimbursed to the Provider for the errors listed above.

Cross-Provider Duplicates

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:

> ***
>
> (B) To ... submit claims only for services actually performed...
>
> ***

We initially identified services where the Provider appeared to have billed duplicate claims for transportation services billed by MedCorp, Inc. under provider number 0236266 and its sister company, MedCorp EMS South, LLC., under provider number 2613130. Based on our review of records, we identified the following 20 errors that resulted in findings:

- 13 services where the Provider billed for a transport in duplicate with a transport billed by MedCorp EMS South, LLC.;
- 5 services where the number of miles paid exceeded the amount supported in the Provider's documentation; and
- 2 services where the Provider did not supply a CMN.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $592.12 were made on the amount reimbursed to the MedCorp, Inc. (provider number 0236266) for the errors listed above.

Services Billed for Deceased Recipients

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 service actually performed…
>
> ***

Additionally, Ohio Admin.Code 5101:3-15-03(A)(2)(i) states in pertinent part:

> Under the Medicaid program services to individuals who are deceased are not covered…
>
> ***

Our initial claims analysis identified 10 services where the transports appeared to have occurred after the recipient's date of death. Our analysis revealed that the date of death was incorrect for all 10 services; however, the Provider lacked the necessary supporting documentation for 2 of the services. Therefore, a finding totaling $31.09 was made on the amount reimbursed to the Provider for these services.

Summary of Exception Testing

Total combined findings of $16,696.09 resulted from our exception tests.

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 199 ambulance RDOS (involving 665 services) identified 83 RDOS with a combination of 219 errors resulting in a projected overpayment of $314,484. 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.

Incorrectly Billed Mileage

Ohio Admin.Code 5101:3-15-01(A)(14) states in pertinent part:

> ***

> "Loaded mileage" is defined as the number of miles a patient is transported in the ambulance or ambulette to or from a Medicaid covered service….

Ohio Admin.Code 5101:3-1-17.2 states in pertinent part that by signing an agreement to provide Medicaid services, a provider certifies and agrees to:

> ***
>
> (A) To ... submit claims only for services actually performed...
>
> ***

We identified 82 services where the Provider overbilled mileage for transports. In these instances, we determined the Provider billed in excess of what its records supported. We therefore disallowed the reimbursement for the excessively billed mileage and used this amount in calculating the projected findings.

Issues with Certificates of Medical Necessity

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

> ***
>
> (E) Documentation requirements
>
> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if documentation specified is not maintained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.
>
> ***
>
> (2) Records which must be maintained include…
>
> ***
>
> (b) The original "practitioner certification form", completed by the attending practitioner documenting the medical necessity of the transport, in accordance with this rule; and…
>
> ***
>
> (4) Practitioner certification form

***

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

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

A hospital discharge planner with a written order from the attending practitioner, may write the practitioner's name on the ordering line of the practitioner certification form, sign his or her own full name on the signature line and enter the date of signature…

(c) The practitioner certification form must state the specific medical conditions related to the ambulatory status of the patient which contraindicate transportation by any other means on the date of the transport, and use the correct form which specifies the mode of medical transportation (ambulance or ambulette) the patient will require. The attending practitioner must clearly specify the condition of the patient which renders transport by ambulance or ambulette medically necessary.

(d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission.

***

During our review of the documentation submitted by the Provider, we found errors with the practitioner certification form (i.e., CMN), which certifies the medical necessity and the type of transport required. Based on our review, we took findings due to the following 78 errors:

- 50 services where the Provider did not supply a CMN;
- 14 services where an ambulance was used as an ambulette but the Provider billed an ambulance service without using the requisite U3 modifier to reduce the rate charged;
- 10 services where either the CMN was not signed or the practitioner's signature on the CMN was illegible and was not accompanied with identifying information;
- 2 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code; and
- 2 services where the patient was transported by ambulance and the Provider billed for an ambulance service; however, an ambulette CMN was supplied as support.

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 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 50 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)(2)(a) states:

> A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), Medicaid patient number, full name of driver, vehicle identification, full name of the Medicaid covered service provider which is one of the Medicaid covered point(s) of transport, pick-up and drop-off times, complete

> Medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and

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

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

We identified five ambulance services that lacked any documentation (e.g., trip log) to support the services billed had actually been rendered. Therefore, the reimbursements for these services were disallowed and this amount was used in calculating the projected findings.

Non-Covered Transports to Psychiatric Hospital

Ohio Admin.Code 5101:3-15-03 states:

> (I) Transportation to and from psychiatric hospitals
>
> (1) Covered transportation services include the ambulance or ambulette transport of medicaid patients to and from public and private psychiatric hospitals for inpatient psychiatric hospital services only when the patient is age twenty-one and younger, or sixty-five and older, and the inpatient psychiatric services are eligible for reimbursement by medicaid in accordance the Chapter 5101:3-2 of the Administrative Code.
>
> (2) Psychiatric hospital is defined as a hospital that is eligible to participate in the medicaid program only for the provision of inpatient psychiatric services.

We identified four services where an adult between the ages of 21 and 65 was transported to a psychiatric hospital. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Summary of Ambulance Sample Findings

We took exception with 83 of 199 RDOS (involving 172 of 665 services) from our stratified random sample of ambulance transportation services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $1,969,059 with a 95 percent certainty that the actual correct payment amount fell within the range of $1,812,102 to $2,126,017 (+/- 7.97 percent). We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($1,969,059) from the amount paid to the

Provider for this population ($2,283,543), which resulted in a finding of $314,484. 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 181 ambulette RDOS (involving 738 services) identified 104 RDOS with a combination of 371 errors resulting in a projected overpayment of $1,081,022. There were services that had more than one error; however, only one finding was made per service. The bases for these errors are presented below.

Issues with Certificates of Medical Necessity

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

> ***
>
> (E) Documentation requirements
>
> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if documentation specified is not maintained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.
>
> ***
>
> (2) Records which must be maintained include…
>
> ***
>
> (b) The original "practitioner certification form", completed by the attending practitioner documenting the medical necessity of the transport, in accordance with this rule; and…
>
> ***
>
> (4) Practitioner certification form
>
> ***
>
> (d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be

> obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission.

During our review of the documentation submitted by the Provider, we found errors with the practitioner certification form (i.e., CMN), which certifies the medical necessity and the type of transport required. Based on our review, we took findings for the following 198 errors:

- 184 services where the Provider did not supply a CMN;
- 8 services where either the CMN was not signed or the practitioner's signature on the CMN was illegible and was not accompanied with identifying information;
- 4 services where the signature on the CMN was not dated; and
- 2 services where the CMN was not obtained by the Provider before billing for reimbursement.

While certain services had more than one error, only one finding was made per service. Therefore, the reimbursements for these services were disallowed and this amount was 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….

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:

> ***
>
> (C) To ... submit claims only for services actually performed...
>
> ***

We identified 85 services where the Provider over billed 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 excessively 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 77 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)(2)(a) states:

> A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), Medicaid patient number, full name of driver, vehicle identification, full name of the Medicaid covered service provider which is one of the Medicaid covered point(s) of transport, pick-up and drop-off times, complete Medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and

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

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

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

Issues with Driver and Attendant Qualifications

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

> Each driver and each attendant must have a current card issued and signed by a certified trainer as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certificate or EMT certification. A copy of both sides of the card must be maintained by the provider and provided upon request to the department or their designee. All current employees must provide their current card (not a copy) for inspection upon request to ODJFS or its designee. Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or its designee.

During our review of documentation submitted by the Provider for 22 ambulette drivers, the Provider was unable to furnish proof that 2 drivers had the requisite CPR and first aid certifications; however, only 1 of these drivers rendered services that appeared in our sample. The one driver lacked a current, valid first aid certification during a portion of the audit period. We therefore disallowed the reimbursement for six services conducted by this driver during the time in which he lacked the required certification and used this amount in calculating the projected finding.

Summary of Ambulette Sample Findings

The overpayments identified for 104 of 181 RDOS (involving 303 of 738 services) from our stratified random sample of ambulette transportation services were projected across the Provider's total population of paid recipient dates of service. This resulted in a projected overpayment amount of $1,856,755 with a precision of plus or minus $603,883 (32.52 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 re-stated 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[5] and a final adjusted lower limit finding was made for $1,081,022. This allows us to say that we are 95 percent certain the population overpayment amount is at least $1,081,022. A detailed summary of our statistical sample and projection results is presented in Appendix II.

[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.*

Summary of Findings

A total of $1,412,202.09 in findings was identified. These findings result from the combination of our exception testing ($16,696.09), our statistical sample projection of ambulance services ($314,484), and of our statistical sample projection of ambulette services ($1,081,022).

Some of the more significant errors denoted during our record review included services with missing, incomplete or invalid CMNs; overbilled mileage; services billed in duplicate; services billed to the wrong program as primary payer; and transports greater than 50 miles without the requisite justification.

Matters for Attention

Although the following matters did not result in monetary findings during the current audit, we are bringing them to the attention of the Provider as areas of non-compliance as they could result in future findings. We are also bringing these issues to the attention of ODJFS as the state single agency responsible for the Medicaid program in Ohio, ODJFS is well positioned to educate providers and improve system controls to curtail these issues.

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

Ohio Admin.Code 5101:3-1-05 (c) states in pertinent part:

> ***
>
> (C)…for individuals who are eligible under both medicare and medicaid or who are qualified medicare beneficiaries described in this rule, medicaid pays the medicare deductible and coinsurance amounts…The department will not pay for any service payable by, but not billed to, medicare.…

Based on our testing, we found 3,405 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 paid $95,868.16 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.

Issues Tying Permits to Transporting Vehicles

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

> Federal, state and local laws and regulations
>
> Providers of air ambulance, ambulance and ambulette services must operate in accordance with all applicable local, state, and federal laws and regulations, including any applicable requirements developed by the Ohio medical transportation board as provided in Chapter 4765. of the Revised Code or applicable requirements developed for transportation in accordance Chapter 4766. of the Revised Code.

Ohio Admin.Code 5101:3-15-02(B)(1) states in pertinent part:

> Certification Requirements
>
> All providers of ground ambulance services must be certified under and participating in Medicare. All Ohio providers of ground ambulance services must be licensed in accordance with Chapter 4766. of the Revised Code and comply with all specifications of Chapter 4766. of the Revised Code, unless the provider is exempt from licensure as specified in section 4766.09 of the Revised Code…

Additionally, Ohio Rev.Code Section 4766.07(A) states in pertinent part:

> Except as otherwise provided by rule of the Ohio medical transportation board, each emergency medical service organization, nonemergency medical service organization, and air medical service organization subject to licensure under this chapter shall possess a valid permit for each ambulance, ambulette, rotorcraft air ambulance, fixed wing air ambulance, and nontransport vehicle it owns or leases that is or will be used by the licensee to perform the services permitted by the license…

During the course of the audit, the Provider used pseudo unit numbers to identify the vehicles that performed transport services. The Provider indicated these numbers are assigned based on station and crew and are transferred from one vehicle to another on an as needed basis. For example, if one vehicle is inoperable on a given day, the unit number is reassigned to another vehicle to perform transport services. A station may have 20 pseudo unit numbers and 25 vehicles to provide service. According to the Ohio Medical Transportation Board, this is not a common practice among transportation providers.

The Provider was able to produce permits by VIN number and stated that they were for all of its vehicles; however, the Provider's trip documentation only includes the pseudo unit number. The trip documentation does not include the VIN number or the permit number. Further, the Provider did not furnish a "crosswalk" between the VIN numbers/permit numbers and the pseudo unit numbers. Therefore, we could not verify whether a transport was in fact performed by a permitted vehicle.

Issues with the Completion of the Certificate of Medical Necessity

Ohio Admin.Code 5101:3-15-02(E)(4)(a) states in part:

> 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…
>
> ***

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.
>
> ***

Despite Medicaid rules requiring the attending practitioner or proxy to complete the CMN form, it was the standard practice of the Provider to complete and pre-print a majority of the information on the CMN for the signature of the attending medical practitioner or authorized proxy for both ambulance and ambulette transports. It was also the standard practice of the Provider not to fill in the box on the ambulette CMN, certifying that an ambulance service was not needed, even though this is required per the Ohio Administrative Code. The Provider indicated that all questions asked prior to completion of the CMN supported the use of an ambulette, not an ambulance; and therefore, filling in this box was unnecessary.

We discussed these noncompliance errors with ODJFS officials who indicated they would not support a monetary finding on these issues alone. Consequently, no finding was taken for the Provider completing the CMN form as long as an attending practitioner or authorized proxy signed it. Also, no finding was taken for ambulette CMNs that did not state that an ambulance

was not required. To date, we have not issued findings nor questioned costs in these areas. However, we feel the inconsistency between administrative rule and application cannot remain. We therefore recommend that ODJFS revisit these rules and either revise the requirements or enforce them.

Incomplete Documentation of Need for Ambulette Services by Ambulance

Ohio Admin.Code 5101:3-15-05(A)(3) states:

> The rendering transportation provider has documented that its ambulette vehicles were unavailable and has documented referral attempts to a competing transportation provider or the rendering transportation provider has documented that delaying, deferring or missing the transport to or from the medicaid covered service would jeopardize the patient's health or cause excessive patient waiting time.

Our review did not find documentation to show that the Provider was in compliance with this requirement. We recommend that the Provider implement procedures to ensure the necessary documentation is obtained when using an ambulance as an ambulette.

Other Observations

We reviewed the Provider's employee files and other documentation maintained to determine if the Provider complied with driver requirements per the Ohio Administrative Code. The results, as follows, did not result in monetary findings, but could in the future. 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 56 drivers (34 ambulance drivers and 22 ambulette drivers) randomly selected from a list of 950 drivers to determine if required procedures were followed and required documentation was kept on file. The list includes drivers employed by both MedCorp, Inc. and MedCorp EMS South, LLC., since the providers share personnel. Our results are as follows:

Lack of 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.

Our review of 56 driver personnel files found no documentation to show that any of the 34 ambulance drivers had annual BMV driving record reviews. We also found no evidence to show that 2 ambulette drivers had submitted a BMV record at the time of application for employment.

Lack of Driver's Licenses

Ohio Admin.Code 5101:3-15-02 (B)(2) states in pertinent part:

> Driver and attendant qualifications
>
> Providers of ambulance services must maintain on file records verifying that drivers and attendants meet the following requirements on the date of the transportation service:
>
> (a) Each individual who functions primarily as an ambulance driver complies with local, state and federal laws and regulations.
>
> (b) Qualifications of each ambulance driver meets the specifications set forth in Chapters 4765. and 4766. of the Ohio Revised Code; and
>
> (c) Each ambulance attendant must have a current emergency medical technician (EMT) certification card issued by the division of emergency medical services (EMS) under the Ohio department of public safety; and
>
> ***

Ohio Admin.Code 5101:3-15-02(E)(2) states in pertinent part:

> 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. All records and documentation required by this rule must be retained in accordance with rules 5101:3-1-17.2 and 5101:3-1-27 of the Administrative Code.
>
> ***
>
> (d) Copies of the pilot's/driver's/attendant's certification or licensure, which must be current at the time of transport, in accordance with paragraph (D)(2) of this rule for air ambulance, paragraph (B)(2) of this rule for ambulance and paragraph (C)(3) of this rule for ambulette.
>
> ***

Further, Ohio Admin.Code 5101:3-15-02 (C)(3)(a)(viii) states:

> Each ambulette driver must have a valid driver's license and be 18 years or older.

Our review of 56 driver personnel files found no evidence of a driver's license for 1 ambulance driver and 1 ambulette driver.

Lack of CPR and First Aid Certifications

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

> Each driver and each attendant must have a current card issued and signed by a certified trainer as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certificate or EMT certification. A copy of both sides of the card must be maintained by the provider and provided upon request to the department or their designee. All current employees must provide their current card (not a copy) for inspection upon request to ODJFS or its designee. Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or its designee.

Our review of 22 ambulette driver personnel files found no evidence of a CPR and first aid certification for 1 driver, while another driver lacked a first aid certification only.

Lack of Medical Statements

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

> ***

> (iv) Each ambulette driver and each attendant must provide a signed statement from a licensed physician declaring that they do not have a medical condition, a physical condition, including a vision impairment (not corrected), and a hearing impairment (not corrected), or mental condition which could interfere with safe driving, safe passenger assistance, the provision of emergency treatment activity, or could jeopardize the health or welfare of patients being transported.
>
> ***
>
> (v) Each ambulette driver must undergo testing for alcohol and controlled substances by a laboratory certified for such testing under CLIA and be determined to be drug and alcohol free…
>
> ***

Our review of 22 ambulette driver personnel files found no evidence of a signed and dated medical statement for 4 drivers indicating that they were fit to drive or provide passenger assistance.

Lack of Alcohol and Drug Screening Following Accidents

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

> Repeat drug and alcohol testing must be performed at a minimum whenever the driver has been involved in a motor vehicle accident for which he/she was the driver; and

Our review of 22 ambulette driver personnel files found no evidence that drug and alcohol screening was conducted for 3 drivers and there were no results documented for 1 driver.

PROVIDER'S RESPONSE

Detailed lists of services for which we took findings were first mailed to the Provider on June 26, 2009. A conference was held on August 11, 2009 to discuss the preliminary findings and to receive documentation from the Provider that aimed to substantiate the services for which we took findings. Subsequent to this meeting, additional information was requested in order to complete the audit. We reviewed the information that was received through June 2010; however, not all information requested was furnished.

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on July 21, 2010. The Provider was afforded 10 business days from the receipt of the draft report to formally respond in to the audit report. The Provider requested an extension to respond. An extension was granted to the Provider and additional documentation was accepted through August 16, 2010. After reviewing the additional documentation, findings were adjusted where appropriate.

A formal response was received from the Provider on August 17, 2010 and is presented in Appendix III.

APPENDIX I

Summary of Sample Record Analysis for MedCorp, Inc.
For the period April 1, 2004 through March 31, 2007
Ambulance Sample Population – Provider Number 0236266

Description	Audit Period [Oct. 1, 2004 – March 31, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulance services excluding exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$2,283,543***
Number of Population Recipient Dates of Service	***13,941***
Number of Population Services Provided	***42,932***
Amount Paid for Services Sampled	***$60,996***
Number of Recipient Dates of Service Sampled	***199***
Number of Services Sampled	***665***
Projected Correct Population Payment Amount	***$1,969,059***
Upper-limit Correct Population Payment Estimate at 95% Confidence Level	***$2,126,017***
Lower-limit Correct Population Payment Estimate at 95% Confidence Level	***$1,812,102***
Precision of Estimated Correct Population Payment Amount at 95% Confidence Level	***$156,957 (+/-7.97 %)***
Projected Overpayment Amount = Total Medicaid Amount Paid – Projected Correct Population Payment Amount	***$314,484***

APPENDIX II

Summary of Sample Record Analysis for MedCorp, Inc.
For the period April 1, 2004 through March 31, 2007
Ambulette Sample Population – Provider Number 0236266

Description	Audit Period [Oct. 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	***$2,345,273.86***
Number of Population Recipient Dates of Service	***106,948***
Number of Population Services Provided	***410,399***
Amount Paid for Services Sampled	***$24,104.89***
Number of Recipient Dates of Service Sampled	***181***
Number of Services Sampled	***738***
Estimated Overpayment using Point Estimate	***$1,856,755***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $603,883 (32.52%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-775,426 (41.77%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits) corrected for skewness[6]	***$1,081,022***

[6] *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 III: Provider's Response

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August 17, 2010

Norman Hofmann
Health Care and Contract Audit Section
88 East Broad Street, 5th Floor
Columbus, OH 43215

Re: Medicaid Audit of Medcorp, Inc.

Dear Mr. Hofmann:

On behalf of Medcorp Inc. ("Medcorp"), I am submitting the provider's response to the draft audit report issued July 22, 2010. In addition to this response letter, Medcorp also has submitted additional documentation to address many of the exceptions taken.

Medcorp is an Ohio corporation which provides medical transportation services throughout Ohio including to Medicaid recipients residing in nursing homes and receiving home care services. The Auditor conducted a stratified audit of Medicaid claims paid to Medcorp for services provided between October 1, 2004, and March 31, 2007 (the 'Audit Period"). The majority of the audited claims were for transportation services provided to nursing home residents.

According to the audit report, during the Audit Period, Medcorp submitted claims for 477,737 Medicaid services rendered on 130,993 recipient dates of service and was reimbursed $10,483,536.85 for those services. The Auditor conducted its audit by first performing "exception tests" on certain readily identifiable claims, and then by statistically sampling the remaining claims, as explained below.

A. EXCEPTION TESTING

The Auditor conducted "Exception Testing" of the following six categories of claims, where it reviewed 100 percent of the claims in each category. This Exception Testing resulted in an overpayment finding of $17,095.71:

APPENDIX III: Provider's Response

Exception Testing Category	Amount Disallowed
Ambulance Services Billed to Medicaid Potentially Cover by Medicare	$6,733.92
Cross-Provider, Cross-System Duplicate Claims of Ambulance Services	$3,702.29
Transportation Services Billed for Hospital Inpatients	$3,583.86
Duplicate Payments	$2,448.35
Cross-Provider Duplicates	$596.20
Services Billed for Deceased Recipients	$31.09
TOTAL	$17,095.71

First, it must be pointed out that for three of these categories (transporting hospital inpatients, duplicate payments, and billing for deceased recipients) no findings were made for the stated exception. In other words, Medcorp refuted 100% of those exceptions. Medcorp did not submit any duplicate claims, it did not bill for transporting patients who were hospital inpatients at the time of the transport, and it did not bill for patients who were deceased. Instead, the Auditor found some other reason to deny the claims, such as an insufficient certificate of medical necessity ("CMN") or excess mileage. But since these alternative reasons essentially are the same review conducted on the samples, this tactic raises questions about the validity of the sampling process conducted in this audit.

With regard to the Medicare cross-over claims, Medcorp only billed Medicaid when it knew the service was not covered by Medicare. For example Medicare does not cover ambulette transports, nor does it cover an ambulance transport from a nursing facility to a physician's office. Under those circumstances Medicaid was billed as primary.

Medcorp disputes all of these exception findings and believes it has documentation to support each claim.

B. STATISTICAL SAMPLE TESTING AND EXTRAPOLATION

After the exception testing was conducted the audit report indicates that the exception tested claims were removed from the universe and that the remaining claims were stratified into ambulance claims and ambulette claims. The Auditor then randomly sampled 199 ambulance resident dates of services (involving 665 Medicaid claims) and 181 ambulette resident dates of service (involving 738 Medicaid claims) and made findings based on a review of these samples. This review resulted in the following categories of disallowances, and projected overpayments of $314,484 for Medcorp's ambulance claims and $1,081,022 for Medcorp's ambulette claims:

APPENDIX III: Provider's Response

Ambulance Samples	$314,484.00
Incorrectly Billed Mileage	
Issues with CMN	
Transports Greater Than 50 Miles	
Lacking Supporting Documentation	
Non-covered Transport to Psychiatric Hospital	
Ambulette Samples	$1,081,022.00
Issues with CMNs	
Incorrectly Billed Mileage	
Transports Greater Than 50 Miles	
Lacking Supporting Documentation	
Issues with Driver and Attendant Qualifications	

Medcorp disputes each of these findings as well. These findings are based solely on a perceived insufficiency in the documentation maintained by Medcorp. There is no question that the transports in question were made. Medcorp believes the documentation it provided, including CMNs, run logs, and its employee files, substantially documents each claim. Additional documentation also was provided separately.

C. STATISTICAL SAMPLING

Medcorp strongly objects to the statistical sampling used in this audit. The Exception Testing of 100 percent of the claims in certain categories combined with a stratified audit and statistical sampling of claims in other categories creates a great potential for flawed audit findings. This flaw becomes evident when claims for the same resident are subject to both the Exception Testing and the Statistical Sampling. Furthermore, the size of the statistical sample was too small to provide adequate assurance that the audit results are accurate or valid, and the overpayment estimate therefore has a very strong potential to be flawed. This conclusion is evident in the very wide precision levels (sampling error) calculated at the 90% and 95% confidence intervals (see pages 27 and 28 of the audit report), which strongly suggests that a larger sample size is required.

D. ADMINISTRATIVE APPEAL

Finally, as a Medicaid provider Medcorp is entitled to an administrative hearing pursuant to R.C. Chapter 119 to contest these findings once they are finalized. The Department of Job and Family Services, or any other agency acting on its behalf, is

APPENDIX III: Provider's Response

barred by Ohio law from taking any action against Medcorp until certain administrative remedies have been exhausted, including the issuance of a proposed adjudication order and a 30-day notice of the right to request a hearing. Medcorp intends to exercise its right to administrative review and accordingly requests such a hearing with this response.

Sincerely,

J. Randall Richards
Attorney at Law

JRR/kdj

Mary Taylor, CPA
Auditor of State

MEDCORP INC.

LUCAS 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
AUGUST 24, 2010

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