



Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

*Audit of Medicaid Reimbursements Made to
Brookeside Ambulette*

A Compliance Audit by the:

**Fraud and Investigative Audit Group
Health Care and Contract Audit Section**



Mary Taylor, CPA

Auditor of State

June 15, 2007

Mr. Howard Schnable
Owner
Brookeside Ambulette
255 Gradolph Street
Toledo, Ohio 43612

Dear Mr. Schnable:

Attached is our report on Medicaid reimbursements made to Brookeside Ambulette, Medicaid Provider Number 0963159, for the period July 1, 2002 through June 30, 2005. We identified \$592,355.15 in findings plus \$83,680.31 in interest accruals that are repayable to ODJFS. After June 15, 2007, additional interest will accrue at \$133.89 a day until repayment occurs. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). The specific procedures employed during this audit are described in the scope and methodology section of this report. Interest is calculated pursuant to Ohio Administrative Code Section 5101:3-1-25(C)(3).

We are issuing this report to the Ohio Department of Job and Family Services because as the state agency charged with administering Ohio's Medicaid program, the Department 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 the ODJFS' Legal Office at (614) 466-4605. To facilitate repayment, a "provider remittance form" is located at the back of this report.

Copies of this report are being sent to Brookeside Ambulette, the Ohio Attorney General, the Ohio Medical Transportation Board, and the Director and Legal Division of the Ohio Department of Job and Family Services. In addition, copies are available on the Auditor's web site (www.auditor.state.oh.us).

Mr. Howard Schnable
June 15, 2007
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Questions regarding this report should be directed to Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858, or toll free at (800) 282-0370.

Sincerely,

A handwritten signature in black ink that reads "Mary Taylor". The signature is written in a cursive, flowing style.

Mary Taylor, CPA
Auditor of State

cc: Brookeside Ambulette
Ohio Attorney General
Ohio Medical Transportation Board
Director, Ohio Department of Job and Family Services
Legal, Ohio Department of Job and Family Services

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
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
PC	Ambulette Practitioner Certification Form (Certificate of Medical Necessity JFS 03452)

SUMMARY OF RESULTS

The Auditor of State performed an audit of Brookeside Ambulette (hereafter called the Provider), Provider #0963159, doing business at 255 Gradolph Street, Toledo, Ohio, 43612. Within the Medicaid program, the Provider is listed as an ambulette service provider. An ambulette is defined as a vehicle that is designed to transport individuals sitting in wheelchairs.

We performed our audit in accordance with Ohio Rev. Code § 117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of the audit, we identified \$592,355.15 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest¹ of \$83,680.31 are repayable to ODJFS. Additional interest of \$133.89 per day will accrue after June 15, 2007 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. The fundamental concept of 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.

Ohio Admin.Code § 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

In addition, Ohio Admin.Code § 5101:3-1-29(A) states in part: "...In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

¹ Ohio Admin.Code § 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Adm.Code 5101:3-1-25(C) further defines the "date payment was made", which in the Provider's case was September 28, 2005, the latest payment date in the random sample used for analysis.

² See Ohio Admin.Code § 5101:3-1-01(A) and (A)(6).

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.”

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 place of business on January 11, 2006, to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of July 1, 2002 through June 30, 2005. The Provider was reimbursed \$1,281,671.45 (excluding Medicare crossovers) for 85,268 services rendered on 21,951 recipient dates of service. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the Ohio Medicaid Providers Handbook 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, 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 field work, 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. These included tests for:

- Potentially duplicate payments to identify whether payments were 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.
- Payments made for services to deceased patients for dates of service after the date of death.

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.

- Potentially inappropriate service code combinations on claims.

The exception tests for duplicate payments and for services to deceased patients identified potentially incorrect reimbursements. When performing our audit field work, we requested the Provider's supporting documentation for these areas and for all potentially inappropriate service code combination claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a statistically random sample of 166 recipient dates of service, containing a total of 634 services.

Our work was performed between December 2005 and September 2006.

FINDINGS We identified and projected findings of \$580,845.00 for the services in the sampled population. Additionally, we identified findings of \$11,510.15 for services in our exception testing. Together, our findings totaled \$592,355.15. The bases for our results are discussed below.

Unsupported Services in Sample

During our review of randomly selected patients' transportation records, we found findings for: lack of certification for medical necessity, lack of documentation for transportation services, transport of ambulatory patients, incomplete street addresses on transport documentation, billing for canceled trips, and incorrectly billed units of mileage.

Some recipient dates of service with a finding had more than one deficiency, thus causing the total number of deficiencies to be more than the 634 services sampled. Only one finding was identified per service, however. Findings from our sample were projected to the sub-population of services remaining after removal of Medicare cross-over payments and services in our exception testing for 100 percent review. The projected overpayment finding from our sample was \$580,845.00. The bases for this finding are given below.

Lack of Certification for Medical Necessity

Ohio Admin.Code § 5101:3-15-03(B)(2)(a) states in pertinent part:

“...ambulette services are covered only when...medically necessary...”

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

(E) Documentation requirements

- (1) Providers of air ambulance and ambulette services must maintain records which fully describe the extent of services provided.
- (2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule.

- (b) The original practitioner certification form, completed by the attending practitioner, documenting the medical necessity of the transport, in accordance with this rule;

In our review of trip documentation, we identified the following issues with respect to the practitioner certification (PC) forms for the sampled services. There were 206 services (32 percent of the sampled services) where the PC was incomplete and did not support that the recipient was non-ambulatory and 78 services, or 12 percent, where the Provider could not produce a PC at all. The reimbursements to the Provider for these 284 services were included in calculating the finding for the sampled population.

Lack of Documentation for Transportation Services

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

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

We determined that 43 services, or seven percent, lacked documentation to support the service billed had been rendered. The reimbursements to the Provider for these 43 services were included in calculating the finding for the sampled population.

Transport of Ambulatory Patients

Ohio Admin.Code § 5101:3-15-03 (B) states in pertinent part:

- (2) Covered ambulette transports:

Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements in this paragraph 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;

Additionally, Ohio Admin.Code § 5101:3-15-01(A)(20) states in part:

“Nonambulatory”...is defined as those permanently or temporarily disabling conditions which preclude transportation in motor vehicle(s) or motor carriers as defined in section 4919.75 of the Revised Code that are not modified or created for transporting a person with a disabling condition. . . .

We identified 24 (four percent) services where the practitioner certifications (PCs) stated the recipient was ambulatory and thus not eligible for ambulette transport. The reimbursements to the Provider for these 24 services were included in calculating the finding for the sampled population.

Incomplete Street Addresses on Trip Documentation

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

(2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .

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

Our review identified 61 services, or (10 percent), where the Provider’s transport records did not contain a complete address or the name of the Medicaid-covered service. Without this

information, we were not able to verify the service was eligible for Medicaid reimbursement. Thus, the reimbursements to the Provider for these 61 services were included in calculating the findings for the sampled population.

Certification Forms Signed by Persons with Incorrect Practitioner Designation

Ohio Admin.Code § 5101:3-15-01(A)(6) states in pertinent part:

“Attending practitioner” is defined as the practitioner (i.e., primary care practitioner or specialist) who provides care and treatment to the patient on an ongoing basis and who can certify the medical necessity for the transport. . . .Practitioners must hold a valid and current license or certification to practice as at least one of the following:

- (a) A doctor of medicine
- (b) A doctor of osteopathy
- (c) A doctor of podiatric medicine
- (d) An advance practice nurse (APN).

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

(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. . . .

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. . . .

From our sample of 634 services, we identified 40 services, or six percent, that had PCs signed by a person with an improper professional designation, such as a physical therapist, or the person’s professional designation was not stated. The reimbursements to the Provider for these 40 services were included in calculating the finding for the sampled population.

Billing for Canceled Trips

Ohio Admin.Code § 5101:3-15-03(L) states in pertinent part:

Transport of an individual to a Medicaid covered service that was cancelled or unavailable may be reimbursed if:

- (2) The transportation provider had no prior notice of the unavailability or cancellation from the Medicaid covered service provider or the individual.
- (3) The medical transportation provider obtained written documentation...from the Medicaid covered service provider before billing the department for transport. The written documentation must include:
 - (a) A business name, address, and phone number of the Medicaid covered service provider.
 - (b) The date and time of the cancelled or unavailable service.
 - (c) A description of the reason(s) for the cancellation or unavailability of the service.
 - (d) A statement indicating that the Medicaid covered service provider was unable to notify the Medicaid transportation provider or the individual of the cancellation or unavailability of the service prior to the arrival at the destination, and
 - (e) The printed name and signature of the business/office manager or nurse.
- (4) For reimbursement, the medical transportation provider must use modifier U6, service unavailable/canceled; for both the base rate and loaded mileage procedure codes.
- (5) The reason for the cancellation or unavailability of the service did not occur is due to the action or inaction of the individual being transported or the medical transportation provider.

During the audit period, the Provider billed six transportation services, or one percent of our sample, for which documentation showed the recipient canceled the trip at the point of pick-up, did not answer the door, or was otherwise unavailable. The Provider stated they were unaware that cancellations could not be billed or that the Ohio Administrative Code had documentation requirements for certain allowable circumstances. Because recipient files lacked documentation to support billing for the canceled trips, we identified findings for these six services. The reimbursements for these six services were included in calculating the findings for the sampled population.

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....

In reviewing the Provider’s trip documentation, we compared mileage from the drivers’ trip logs with mileage units billed. We found four instances where a total of eight more miles were billed than was documented in the trip logs. Findings were made on the amount reimbursed to the Provider for the overstated miles. These findings were included in calculating the findings for the sampled population.

Summary of Sample Findings

Table 1
Summary of Deficiencies

Deficiency	Number of Deficiencies
Address is Incomplete (street number and/or name)	61
Patient is Ambulatory	24
Canceled Trip	6
Missing Practitioner Certification Form	78
Practitioner Certification Form Not Completed	206
No Documentation This Date of Service	43
Incorrect Practitioner Designation Completing Practitioner Certification Form	40
Incorrectly Billed Mileage Units	4
Total Deficiencies	462

Note: Some services had more than one deficiency.

The overpayments identified for 95 of 166 recipient dates of service (involving 333 of 634 services) from our stratified statistical random sample were projected across the Provider’s total population of paid recipient dates of service. This resulted in a projected overpayment amount of \$663,794 with a precision of plus or minus \$99,012 (14.92 percent) at the 95 percent confidence level. Since this projection did not meet criteria that 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 method used in Medicare audits), and a finding was made for \$580,845. This allows us to say that we are 95 percent certain that the population overpayment amount is at least \$580,845. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Results of Exception Testing

Our exception testing consisted of a 100 percent review of all services identified by our duplicate or other tests as having potential findings. These services included duplicate payments, transports over 50 miles, transportation services billed for patients while they were hospital inpatients, and services billed for a deceased recipient.

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...

Our testing identified 63 recipients, representing 485 services, where it appeared the Provider billed and was paid twice for identical services on the same date of service. Upon review of documentation supplied by the Provider, we found 178 services were properly documented.

However, of the remaining 307 services, we identified various issues which resulted in findings. (Note: some services had multiple issues):

- 160 undocumented, or dublicately billed, services
- 177 services with incomplete physician certifications of medical necessity
- 33 services where no physician certification found
- 46 services with physician certifications signed by someone having an incorrect professional designation
- 10 services provided to ambulatory recipients
- 20 services billed for canceled trips
- 4 services with an incomplete address
- 2 services where physician certifications were not dated

Findings were made on the amount reimbursed to the Provider for the services listed above for a total of \$5,608.29.

Transports Over Fifty Miles

Ohio Admin.Code § 5101:3-15-03(H) states:

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.

The Provider billed transports for 26 recipients, covering 150 services, with trips greater than 50 miles. The Provider did not have documentation explaining why the trips were outside the recipient's community. Based on the Provider's trip documentation, we either made findings for the miles exceeding 50 or for the entire trip if the Provider could not produce appropriate trip documentation.

Findings for transports over 50 miles totaled \$4,508.18.

Transportation Services Billed for Hospital Inpatients

Ohio Admin.Code § 5101:3-15-03(E) states in part:

The following services are not covered:

(1)Unloaded transports (i.e., no Medicaid patient in the vehicle);

We performed a match of the Provider's services against services billed by hospitals to determine if Brookeside billed for transporting the patients while they were hospital inpatients. Our match showed 83 instances were this occurred.

We requested documentation from the Provider for these 83 transportation services. Our review showed that for 65 services, the Provider had either documented the patient was not home, the trip was cancelled, or that the patient was in the hospital. Thus, we identified a finding for \$1,370.07, which is the total reimbursed to the Provider for these 65 services.

Services Billed for Deceased Recipient

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 service actually performed...

During our exception testing, we determined the Provider billed Medicaid for one service rendered after a recipient's date of death. A finding was made for the \$23.61 reimbursement received for this service.

Summary of Exception Testing

Total combined findings of \$11,510.15 resulted from our 100 percent exception testing, which included \$5,608.29 in findings for duplicate payments; \$4,508.18 in findings for trips over 50 miles; \$1,370.07 in findings for transportation services billed while recipients were hospitalized, and \$23.61 billed for a deceased recipient.

Summary of Findings

A total of \$592,355.15 in findings was identified. These findings result from the combination of our statistical sample results (\$580,845.00) and our 100 percent exception testing results (\$11,510.15).

Other Observations

We reviewed employee files and other documentation maintained by the Provider to determine if the records supported the Provider's compliance with driver and vehicle requirements per the Ohio Administrative Code.

The results, as follows, did not result in monetary findings because we were not able to tie each deficiency to a specific service in our sample and/or the Provider was in the process of taking corrective action. However, failure to comply with applicable regulations could place patients in harms way, and/or jeopardize the Provider's status with the Medicaid program.

Vehicle Documentation and Inspection

We requested documentation of the Provider's vehicle inspection and safety data. The results of our review are as follows.

Lack of Adequate Vehicle Inspection

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

- (a) Each provider must conduct daily inspection and testing of the hydraulic lift or access ramp prior to transporting any wheelchair bound patient; and
- (b) Each provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum that the following was performed: the

daily inspection and testing of the wheelchair restraints, wheelchair lifts and/or access ramps, the lights, the windshield wipers/washers, the emergency equipment, mirrors, and the brakes...

We reviewed the Provider's daily inspection sheets and found dates and odometer readings were sporadically recorded. The documentation did not show that inspections were done daily, as the dates and odometer readings were not consecutive.

Additionally, the elements required per the Ohio Administrative Code were not the items documented by the Provider. The Provider's daily inspection sheets list the following five items to be checked:

1. Oil
2. Transmission Fluid
3. Coolant
4. Brake Fluid
5. Fueled up at end of day

However, these items do not include the seven items required to inspected daily by Ohio Admin.Code § 5101:3-15-02(C)(2)(b). According to the Provider, their drivers check the wheelchair lifts daily, but it is not documented.

The Provider explained that a new checklist has been created to address the items required to be monitored. However, this new form provides for the daily check of only the wheelchair restraints and lift ramps. The lights, mirrors, windshield wipers/washers, brakes are in weekly check categories and the emergency equipment is in a monthly check category. All seven of the required checks are specified to be performed on a daily basis.

Lack of Annual Independent Vehicle Safety Checks

Ohio Admin.Code § 5101:3-15-02(C)(2)(c) states:

- (c) Each provider must provide evidence that at least an annual vehicle inspection was completed on each vehicle by the Ohio state highway patrol safety inspection unit, or a certified mechanic, and the vehicle has been determined to be in good working condition.

During the audit period, the Provider had dispatch locations in Toledo, Bryan, and Defiance. The City of Toledo has an annual vehicle licensing inspection which the Provider used in lieu of the annual highway patrol or certified mechanic's safety inspection. However, it does not appear any annual safety inspection was done for the Bryan or Defiance branches of the business which are now closed.

Required Documentation Lacking for Drivers

Based on the Provider's record keeping and transport documentation, we could not match a particular driver for a service tested by our audit with their personnel files. However, we did review the employment files of 17 of 75 drivers for documentation of required items. What we found during our review is discussed below.

We discussed our results with the Provider's representatives during the course of the audit. The Provider submitted a response which discussed these items. However, in their response, the Provider did not indicate what caused these problems or that periodic monitoring/quality control would be performed.

Lack of Required Training

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

(a)(ii)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. . . . Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or their designee.

(a)(vii)Each ambulette driver and each attendant must have completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.

Our review of 17 of the 75 (22 percent) driver personnel files for evidence of required CPR/EMT and passenger assistance training found that:

- Eleven, or 65 percent, did not have CPR certificates or an alternate EMT certificate.
- Eight, or 47 percent, did not have documentation of passenger assistance training.

The Provider's first response included a form to be included in each employee's personnel file as a check-off list of necessary items. This form includes acknowledgement that the employee has CPR/Basic First Aid and Special Needs Training. In addition, the Provider is now maintaining a

master list of employee CPR and first aid training. We performed a review of personnel files for current drivers, and found the Provider is now monitoring CPR certificates.

Lack of Driver Criminal Background Checks

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

Each ambulette driver and each attendant must submit himself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been convicted of or pleaded guilty to violations cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the Revised Code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply.

Our review of employee personnel files showed 12 of 17 files, or 71 percent, did not contain evidence of having criminal background checks. Four of the 12 had City of Toledo licenses, which the Provider claimed includes a background check as part of the city's licensing procedures. We asked the Provider to obtain verification from the City that background check procedures are intrinsic to the licensing process; however, we never received such assurance.

The Provider's first response included a form to be included in each employee's personnel file as a check-off list of necessary items. This form includes acknowledgement that the employee has had fingerprinting for a background check.

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...

We did not find medical statements for 11 (65 percent) employees or drug screen results for three (18 percent) employees, in the Provider's personnel files.

The Provider's first response included a form to be included in each employee's personnel file as a check-off list of necessary items. This form includes acknowledgement of a physical/drug screen. The Provider should ensure that results are kept on file to show whether the physical and drug screen are in-fact taken and passed.

Inconsistent Annual Review of Driving Record

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 employee personnel files found five employees, or 29 percent, where no driving record results were noted. We noted the Provider is currently requesting annual driving record checks for ambulette drivers from its insurance company. In addition to checking driving records for new employees, per their first response, the Provider now sends a list of current drivers to its insurance company annually.

Improper Modifiers

Ohio Admin.Code § 5101:3-15-03(D)(1) states:

Modifiers for the point of transport is a two-position modifier that is constructed from the following values. The first position alphabetic value is used to report the origin or "from" service. The second position alphabetic value is used for the destination or "to" of service.

Even though the non-use of modifiers on the billings from the Provider did not cause findings, we noted trips where the modifiers for the base rate billing code and mileage billing code were not the same. Additionally, we found 71 services which were billed unmodified.

Ohio Administrative Code requires the use of modifiers and without the modifier, the billing will not show whether the transport was for a Medicaid covered service.

The Provider's first response noted that accurate trip modifiers are an issue being addressed.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on September 20, 2006. Prior to the draft, the Provider was given an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently supplied additional documentation that was used to adjust our findings. Additionally, the Provider submitted written comments of corrections in progress at that time.

During the field review, the Provider stated all present files were being audited for accuracy and corrections were being made when possible. They also stressed the importance of accurate documentation to all departments, and education will be ongoing for all employees. The Provider also claimed to be working daily to improve the billing process for Medicaid and all transportation customers. Processes will be updated continually to reflect new changes in the Medicaid rules.

On November 21, 2006, the Provider received an exit conference and stated they agreed with the facts of the audit issues and the Provider stated they would submit a response by December 1, 2006 pertaining to reform measures to prevent recurrence of the matters discussed in this report. On November 29, 2006, we received a telephone call from the Provider's attorney stating he would submit a response on December 4, 2006. Subsequently, we were told that a response would not be forthcoming until December 15, 2006.

On February 8, 2007, we received a written "plan of correction" from the Provider's new counsel. This plan was not accompanied by any additional documentation; so no further adjustments were made to our findings. The "plan of correction" furnished by Provider's counsel addressed each area of audit finding. A copy of the written "plan of correction" appears below.



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February 8, 2007

Via Hand-Delivery

Cynthia Callendar
Director of Fraud and Investigative Audit Group
Auditor of State
38 East Broad Street
Columbus, Ohio 43215

**Re: Brookeside Ambulette
Medicaid Provider No. 0963159**

Dear Director Callendar:

This law firm and the undersigned represent Brookeside Ambulette ("Brookeside"), 255
Gracolph Street, Toledo, Ohio 43612.

In September 2006, the Auditor of State conducted an audit of Brookeside. The audit involved
Medicaid reimbursements made to Brookeside for the period July 1, 2002, through June 30,
2005. A draft report was issued in which Brookeside allegedly received excess Medicaid
reimbursement. In order to minimize the potential of receiving excess Medicaid payments in the
future, Brookeside was requested to prepare a Plan of Correction. This letter shall serve as
Brookeside's Plan of Correction. PLEASE NOTE the submission of this Plan of Correction does
not constitute an admission as to the accuracy of the draft audit, and this submission does not and
should not be considered as an admission against interest in any pending or future action, claim,
demand, or liability made against Brookeside.

The draft audit listed 11 areas of alleged concern. The 11 areas will be mentioned separately
with a Plan of Correction offered for each area. The 11 areas are as follows:

1. Lack of Certification for Medical Necessity

The allegation is the practitioner certification forms were incomplete and did not support
services rendered. In order to address this concern, an individual has been designated to
maintain all provider certification forms. The provider certification forms will be

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Cynthia Callendar
February 8, 2007
Page 2

reviewed for accuracy and completeness prior to client transportation. The review will involve both temporary and permanent practitioner certification forms. The original practitioner certification forms will be maintained in each client record, and all client records will be kept in the billing department.

2. Lack of Documentation for Transportation Services

The allegation is there was a lack of documentation to support the service billed. As mentioned, an individual has been designated to maintain practitioner certification documentation. This individual has been charged with updating and amending, if necessary, the documentation. In addition, a supervisor in the dispatching department has been charged with the responsibility of verifying the accuracy of the driver's trip log. This review will occur monthly.

Our response for this area applies to Areas 5, 7, 9 and 10, too.

3. Transport of Ambulatory Patients

The allegation is physician certifications stated the recipient was ambulatory and thus not eligible for ambulette transportation. A transportation log of who not to transport has been developed. This particular "do not transport" log is maintained and updated by Brookeside's billing department.

4. Incomplete Street Addresses on Trip Documentation

The allegation is Brookeside's transport logs did not contain a complete address or name of Medicaid-covered service. In respect to those individuals who are eligible to receive Medicaid services, a transport log, as described earlier, has been developed. The transport log lists each provider's name and address. The transport log is maintained by the Dispatcher.

5. Persons with Incorrect Practitioner Designation Signed PCs

The allegation is practitioner certification forms were signed by a person with an improper professional designation. In order to ensure this situation does not present itself again, an individual has been designated to review the accuracy and completeness of each practitioner certification form. Each practitioner certification form is maintained in each client record, and all client records are kept in the billing department.

6. Billing for Cancelled Trips

The allegation is Brookeside billed for transportation services when the recipient cancelled the trip at the point of pick up, did not answer the door, or was otherwise unavailable. Unless the provider of care cancels the trip, Brookeside will make a good

XXXXXX

Cynthia Callendar
February 8, 2007
Page 3

faith effort not to bill Medicaid for cancelled trips. A billing representative has been charged with the responsibility of ensuring proper billing.

7. Incorrectly Billed Mileage

The allegation is the drivers' trip logs showing mileage units which did not correspond with miles billed. A dispatcher or their designee has been charged with the responsibility of reviewing each driver's trip log to ensure appropriate billing. The miles on the trip log will serve as the basis for miles billed.

8. Duplicate Payments

The allegation is Brookside was paid twice for identical services on the same date of service. In order to ensure this allegation does not occur again, each ODHS form 6870 will be reviewed for accuracy and completeness prior to submission of claim. If it is determined a Medicaid overpayment has been made, the Medicaid overpayment will be returned soon thereafter on form 6870.

9. Transports Over 50 Miles

Billing miles was based upon Brookside's Medicaid provider address, and not on Brookside's local office site. In order to ensure appropriate billing, the dispatcher is now required to fill out a form showing why a transport in excess of 50 miles is necessary. Information from the recipient's attending physician will accompany the transport form.

10. Transportation Services Billed for Hospital In-Patients

The allegation is Brookside billed for transporting patients while they were hospital in-patients. This allegation occurred when a trip had been cancelled. See answer to Item 6, above.

11. Services Billed for Deceased Recipient

This allegation involved a unique set of circumstances. Services were provided to a live recipient, but the recipient died soon thereafter while Brookside was waiting for the practitioner certification form to be completed. Any suggestion that Brookside billed for services provided to a recipient who had died prior to the service date is incorrect.

All the foregoing corrective actions have been initiated and are being reviewed to see if further refinement is necessary. While no Medicaid provider is perfect, Brookside is making a good faith attempt to ensure appropriate and proper billing in the future.

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APPENDIX I

Summary of Sample Record Analysis for Brookside Ambulette Population
For the period July 1, 2002 through June 30, 2005

Description	Audit Period July 1, 2002 – June 30, 2005
Type of Examination	Simple Random Sample
Description of Sub-Population Sampled	All paid services net of any adjustments, excluding duplicates, exceptions, and Medicare Cross-over payments
Total Medicaid Amount Paid For Sub-Population Sampled	\$1,268,900.51
Number of Population Recipient Dates of Service	21,893
Number of Population Services Provided	85,187
Amount Paid for Services Sampled	\$9,439.42
Number of Recipient Dates of Service Sampled	166
Number of Services Sampled	634
Estimated Overpayment using Point Estimate	\$663,794
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	+/- \$99,012 (14.92%)
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	+/- \$82,950 (12.50%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits).	\$580,845.00

PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
PO Box 714856
Columbus, OH 43271-4856

1. Provider Name and Address:

Brookeside Ambulette

255 Gradolph Street

Toledo, Ohio 43612

2. Provider Number:

0963159

3. Review Period:

**July 1, 2002 through
June 30, 2005**

4. AOS Finding Amount (including accrued interest):

\$676,035.46

5. Interest "as of" Date:

June 15, 2007

6. Date Payment Mailed:

7. Additional Interest Owed:

**(Calculated by multiplying \$133.89 by the difference in
days between #5 and #6)**

8. Total Amount Repaid:

(Sum of # 4 and #7)



Mary Taylor, CPA
Auditor of State

August 26, 2008

Mr. Christopher Carson
Asst. Bureau Chief, Bureau of Audit/ORAA
Ohio Department of Job and Family Services
4020 East 5th Avenue
P.O. Box 1618
Columbus, Ohio 43216-1618

RE: Adjusted Audit Findings for Brookside Ambulette AOS/HCCA-07-005C

Dear Mr. Carson:

During the discovery phase of the initial 119 hearing on the audit findings in our June 2007 report on Brookside Ambulette (AOS/HCCA-07-005C), Brookside Ambulette (hereafter referred to as the Provider) produced a voluminous amount of additional documentation purporting to substantiate many of the services on which findings had been taken. After an initial review of documentation submitted by the Provider, a mutual agreement was reached by respective counsels that the initial presumptive adjudication order would be rescinded; thus permitting Auditor of State staff time to thoroughly review the newly submitted documentation and adjust findings as appropriate. The Ohio Department of Job and Family Services would then issue a new updated presumptive adjudication order with the adjusted finding amount. We have completed our review of the additional documentation submitted by the Provider and have summarized the results below.

Our total findings were reduced from \$592,355.15 to \$582,271.05, a reduction of \$10,084.10 (1.7 percent). This reduction resulted from a \$9,435 decrease in the projected findings from our statistical sample and a \$649.10 decrease in findings from our 100 percent exception testing. This reduction in findings plus a change in the method of interest calculation required by Ohio Administrative Code Section 5101:3-1-25 also resulted in a reduction in accrued interest from \$83,680.31 to \$79,763.16 as of June 15, 2007. Additional interest will accrue at \$127.62 per day until repayment occurs.

Christopher Carson

August 26, 2008

Page 2

If you have any questions or need any additional information, please don't hesitate to contact me at (614) 728-7164.

Sincerely,

Mary Taylor, CPA
Auditor of State



Norman Hofmann, Assistant Chief Auditor
Medicaid/Contract Audit Section

cc: Howard Schnable, Owner, Brookside Ambulette
David Espinoza, Senior Attorney, Office of Legal Services, ODJFS
Kevin Jones, Program Integrity Manager, Office of Ohio Health Plans, ODJFS
Rachel Jackson, Chief, SURS, ORRA, Bureau of Audit, ODJFS
Henry Appel, Senior Assistant Attorney General, Ohio Attorney General's Office
Robert Hinkle, Chief Deputy Auditor, AOS
Jeffrey Castle, Chief Auditor, Medicaid/Contract Audit Section, AOS



Mary Taylor, CPA
Auditor of State

BROOKESIDE AMBULETTE

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
JUNE 15, 2007**