Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Life Ambulance Service, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

May 21, 2009

Michael C. Pistole, Owner
Life Ambulance Service, Inc.
1643 Offnere Street
Portsmouth, Ohio 45662

Dear Mr. Pistole:

Attached is our report on Medicaid reimbursements made to Life Ambulance Service, Inc., Medicaid provider number 0595771 and 2468137, for the period April 1, 2003 to March 31, 2006. 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 $352,663.83 in findings plus $81,779.36 in interest accruals totaling $434,443.19 that is repayable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After May 21, 2009, additional interest will accrue at $77.30 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 Life Ambulance Service, Inc.; the Director and Legal Divisions of ODJFS; the Ohio Attorney General; Health and Human Services/Office of Inspector General, and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

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Questions regarding this report should be directed to Jeffrey Castle, Chief Auditor of the Medicaid/Contract Audit Section, at (614) 466-7894 or toll free at (800) 282-0370.

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: Life Ambulance Service, Inc.
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Ohio Attorney General
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 Life Ambulance Service, Inc., headquartered at 1643 Offnere Street, Portsmouth, Ohio 45662. In addition to auditing provider number 0595771 (assigned to Life Ambulance Service, Inc.), we also audited provider number 2468137 under the same ownership. This provider number was assigned to a sister company, Life Emergency Medical Services, Inc., which ceased operations in January 2006 and transferred its property to Life Ambulance Service, Inc.

Life Ambulance Service, Inc., (hereafter called the Provider) is listed as an ambulance and ambulette service provider within the Medicaid program. Ambulances are defined as vehicles designed to transport individuals in a supine position, while ambulettes are 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 $352,663.83 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] Additionally, we assessed accrued interest of $81,779.36, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $434,443.19, which is repayable to ODJFS as of the release of this audit report. Additional interest of $77.30 per day will accrue after May 21, 2009, 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,

[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).*

or medical practices; and that constitute an over utilization 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 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 23, 2007, 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) for which the Provider rendered services to Medicaid patients and received payment during the period of April 1, 2003 through March 31, 2006. The Provider was reimbursed $4,792,648 of which $4,303,439 was for provider number 0595771 and $489,209 was for provider number 2468137. The total reimbursement of nearly $4.8 million was for 120,638 services rendered on 34,885 recipient dates of service. A recipient date of service (RDOS) is defined as all services received by a particular recipient on a specific date.

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

[3] *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by*

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. These included tests for the following exceptions:

- Potential duplicate payments where 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.
- Claims for ambulette transport services billed while the recipient was a hospital inpatient.
- Potential duplicate claims for ambulance transport services for the same recipient, on the same date of service, for the same procedure codes and procedure code modifiers billed to both the Medicaid and Medicare programs as the primary insurer.
- Payments made for services to deceased patients for dates of service after the date of death.
- Claims reimbursed with one-way mileage greater than 50 miles.
- Ambulance services billed to Medicaid that are potentially covered by Medicare for dually eligible recipients.
- Ambulance base codes and attendant codes billed for more than one unit.

From our exception testing we identified potentially incorrect reimbursements for duplicate payments, ambulette services billed while the recipient was a hospital inpatient, duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs, ambulance base codes and attendant codes billed for more than one unit, services to deceased patients, and ambulance services billed to Medicaid potentially covered by Medicare (for dually eligible recipients). Our exception testing also identified numerous one-way trips greater than 50 miles. Because of their relative high number, however, we felt we could obtain a good representation of one-way trips over 50 miles by leaving them in the remaining population of claims for our statistical sample. 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 remaining 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 two statistically random pilot samples of 100 RDOS that were stratified based on whether the trips contained one-way mileage of greater than 50 miles. One sample was for ambulette services and the other was for ambulance services. The total results were then projected across the entire population to determine the total findings.

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.

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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.

Our fieldwork was primarily performed between October 2007 and July 2008.

RESULTS

We identified findings of $82,932.83 for services in our exception testing. Additionally, we identified findings from our samples that when projected total $269,731. Together, our findings from our exception testing and projected samples total $352,663.83, the bases of which are discussed below.

Results of Exception Testing

We performed exception testing on the Provider's paid claims for the following issues: ambulance services billed to Medicaid potentially covered by Medicare (for dually eligible recipients), duplicate payments, ambulance base codes and attendant codes billed for more than one unit, duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs, ambulette services billed while the recipient was a hospital inpatient, and services to deceased patients. All of these tests identified possible overpayments. Therefore, when performing our audit fieldwork, we reviewed all available documentation for claims identified by our exception testing (i.e., 100 percent review). 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.
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> ***

We identified ambulance transports 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 samples, and the ambulance sample populations to avoid double impact.

We originally identified 18,985 services where the Provider billed Medicaid for a transport where the recipient was also listed as having Medicare Part B coverage. We sent the Provider a letter and an exception report detailing those services potentially covered by Medicare. Based on further information, we backed out services with modifiers "P," "ND," or "DN" as these services are not covered by Medicare except under special circumstances. In addition, we excluded services where we determined that Medicaid had already paid the deductible or coinsurance on a Medicare claim.

After backing out these services, there remained 996 services for which we requested documentation from the Provider to substantiate why Medicaid was billed in place of Medicare. Based on a review of the documentation, there were 950 services billed directly to Medicaid as the primary insurer rather than Medicare.

Based on our review of records and the Provider's written response, we identified 768 services covered by Medicare where the Provider acknowledged the finding or did not provide supporting substantive documentation explaining why Medicaid should have been billed as the primary payer. In addition, we also identified the following 922 errors that resulted in findings:

- 456 services lacking supporting trip documentation;
- 240 services where the Provider either agreed that reimbursement should be made to Medicaid or noted that it made reimbursement for the service in question; however, it did not submit substantive documentation of the repayment;
- 170 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 necessity of the transport;
- 22 services where the patient was transported by ambulance; however, the Provider submitted an ambulette CMN;
- 9 services where the Provider billed for an ambulance transport when the patient was transported by ambulette with an ambulette CMN;
- 8 services where the documentation indicates that the patient was ambulatory;
- 7 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 6 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 2 services for which the Provider submitted conflicting trip documentation; and
- 2 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $46,927.41 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...

(B) To ascertain and recoup any third-party resource(s) available to the consumer prior to billing the department. The department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in division-level designation 5101:3 of the Administrative Code.

***

We identified 1,345 services where the Provider appeared to have billed for more than one transport for the same recipient on the same date of service. Based on our review of records, we identified the following 326 errors that resulted in findings.

- 181 services lacking supporting documentation which could indicate services not rendered or potentially duplicate billed services;
- 45 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 43 services where the Provider either did not supply a CMN or the CMN supplied did not cover the date of service;
- 14 services where the number of units (e.g., miles) billed exceeded the amount supported in the Provider's documentation;
- 13 services where the Provider billed the wrong procedure code for the service provided;
- 10 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN;
- 7 services where the documentation in support of the transport did not contain a complete address of the pick-up and/or drop-off location;
- 6 services for cancelled trips where the Provider lacked the requisite supporting documentation in order to bill;
- 5 services where the CMN supplied was incomplete; and
- 2 services where there was third party insurance coverage which was not billed prior to billing Medicaid.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $20,171.45 were made on the amount reimbursed to the Provider for the errors listed above.

Ambulance Base Codes and Attendant Codes Billed for More Than One Unit

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

(A) To…submit claims only for services actually performed…

***

(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.

Further, Ohio Admin.Code 5101:3-15-01, Medical Transportation Services, Definitions, states in pertinent part:

***

(A)(5) "Attendant" is defined as an individual employed by the transportation provider separate from the basic crew of the ambulance or ambulette vehicle who…is present to aid in the transfer of Medicaid covered patients…

We originally identified 606 services where the Provider billed more than one unit for a transportation base code or an attendant code where only one unit is normally billed. Note, of these services, 38 were already included in our exception test for duplicate payments and were therefore excluded from this test. We then matched these services with their corresponding claims and reviewed all 1,705 services comprising these claims.

We reviewed the Provider's documentation and identified 17 services where the Provider inappropriately billed in excess of one unit for a transportation base code. Further, we identified 88 attendant services that were not appropriately documented and 6 attendant services that were actually rendered by another provider. Based on our review of records for the remaining services, we identified the following 188 errors that resulted in findings:

- 57 services where the Provider either did not supply a CMN or the CMN supplied did not cover the date of service;
- 45 services lacking documentation to support the transport or the corresponding mileage;
- 20 services where the Provider used an incorrect modifier which did not always result in a finding; [4]
- 18 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 15 services where the CMN supplied was incomplete;
- 10 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN;
- 6 services for trips exceeding 50 miles (one-way) that lacked documentation to justify the transport to be out of the patient's community;

[4] *Findings were only made in those cases that the Provider failed to properly modify the service when multiple passengers were transported.*

- 6 services for cancelled trips where the Provider lacked the requisite supporting documentation in order to bill;
- 6 services where the number of units (e.g., miles) billed exceeded the amount supported in the Provider's documentation; and
- 5 services where the Provider incorrectly coded the service resulting in an overpayment.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $10,867.54 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Claims for Ambulance Services Paid for by Both Medicaid and Medicare

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 208 services where the Provider billed both Medicaid and Medicare as the primary payer for the same patient and service. We identified these services by matching claims where Medicaid paid the Medicare co-insurance and deductible amounts with those where Medicaid was billed directly and paid as primary insurer. Additionally, this match identified several instances where Medicare appeared to have been double-billed, resulting in duplicate co-insurance and deductible payments by Medicaid. The matching was done by recipient, date of service, procedure code and procedure code modifier. Therefore, Medicaid made two payments for the same service resulting in an overpayment. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare.

Findings totaling $4,531.85 were made on the amount paid by the Medicaid program as primary payer for the identified duplicate covered services.

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 26 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 determined that the Provider actually billed for four ambulette transports while the patient was residing in a hospital. For the remaining services, we identified the following 12 errors that resulted in findings:

- 8 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN;
- 2 services where the number of miles billed exceeded the amount supported in the Provider's documentation; and
- 2 services for trips exceeding 50 miles (one-way) that lacked documentation to justify the transport to be out of the patient's community.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $307.90 were made on the amount reimbursed to the Provider 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 six services where the transports appeared to have occurred after the recipient's date of death. Our analysis revealed that the Provider billed for two services after the recipient's date of death. For the remaining four services the date of death was incorrect, however, the Provider lacked the necessary supporting documentation for two of the services. Therefore, a finding totaling $126.68 was made on the amount reimbursed to the Provider for these services.

Summary of Exception Testing

Total combined findings of $82,932.83 resulted from our exception tests, which included ambulance services billed to Medicaid that were potentially covered by Medicare (for dually eligible recipients), duplicate payments, ambulance base codes and attendant codes billed for more than one unit, duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs, ambulette services billed while the recipient was a hospital inpatient, and services to deceased patients. Some of the more common errors denoted during our exception testing included transportation services and mileage lacking supporting documentation; services with missing, incomplete or invalid CMNs; attending practitioners not certifying that the patient met the conditions for a covered transport; excessive mileage billed; and services with incorrect codes and modifiers.

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 pilot samples that were stratified based on whether the trips contained one-way mileage of greater than 50 miles. 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.

During our review of sampled records, we identified findings which can be attributed to several issues including but not limited to missing or incomplete CMNs, transports greater than 50 miles without justification, services lacking supporting documentation, and patient not certified as meeting conditions for covered transport. As was the case with our exception tests, there were services in our samples that had more than one error; however, only one finding was made per service.

The findings were then projected across the total sampled populations, resulting in a total finding of $269,731.

Ambulance Services Sample – Detailed Results

Our stratified random sample of 100 ambulance RDOS (involving 340 services) identified 21 RDOS with a combination of 38 errors resulting in a projected population overpayment of $112,290. 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 obtained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.
>
> ***
>
> (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the Medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and

(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

***

(c) Medical Condition

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.

***

We determined that 12 services were not supported by a properly completed CMN. More specifically, 8 services lacked any CMN, while the remaining 4 services lacked a properly completed CMN. Without a properly completed CMN, we could not determine the medical necessity of the transportation service. We therefore disallowed the reimbursement for these services 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 12 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 5101:3-1-17.2 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 eight services lacked documentation (e.g., trip log) to support the service billed had actually been rendered. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

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 two services where the Provider over billed mileage for transports. In both instances, we determined the Provider billed in excess of what its records supported and the Provider's billed mileage was greater than that listed on independent map engines. We therefore disallowed the reimbursement for the excessively billed mileage and used this amount in calculating the projected finding.

Non-Covered Transport 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 two 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.

Incomplete Point of Transport Information

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

> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department . . .
>
> (2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .
>
> (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and
>
> ***

We identified two services where the Provider did not indicate the name of the Medicaid covered point of transport nor did it provide a corresponding address. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Summary of Ambulance Sample Findings

The overpayments identified for 21 of 100 RDOS (involving 38 of 340 services) from our stratified random sample of ambulance transportation services were projected across the Provider's total population of paid recipient dates of service. This resulted in a projected overpayment amount of $237,684 with a precision of plus or minus $135,012 (56.8 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 $112,290. This allows us to say that we are 95 percent certain the population overpayment amount is at least $112,290. 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 100 ambulette RDOS (involving 354 services) identified 31 RDOS with a combination of 103 errors resulting in a projected population overpayment of $157,441. The bases for these errors are presented below.

Transportation Services Lacking Supporting Documentation

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.

[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.*

We determined that 64 services lacked documentation (e.g., trip log) to support the service billed had actually been rendered. The amounts reimbursed for these services were used in calculating the projected finding.

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.

***

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

(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

***

(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.

During our review of the documentation submitted by the Provider, we found numerous errors with the practitioner certification form (i.e., CMN), which certifies the basis for the necessity of the transport. Based on our review, we took findings due to the following 12 errors:

- 6 services where the CMN was incomplete in that the date of transport was missing;
- 4 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN; and
- 2 services where the CMN was not signed by the practitioner or an authorized proxy.

While certain CMNs had more than one error, only one finding was made per CMN. The amounts reimbursed for these services were used in calculating the projected finding.

Patient Not Certified as Meeting Conditions for Covered Transport

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

> (B) Ambulette services coverage and limitations
>
> ***
>
> (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;
>
> (ii) The attending has certified that the individual does not require ambulance services; the individual cannot be transported by automobile, bus, or other standard mode of transportation because the individual must be transported in a wheel chair; and the individual is physically able to be safely transported in a wheelchair.
>
> ***

Additionally, Ohio Admin.Code 5101:3-15-01 states in pertinent part:

> (A) The following definitions are applicable to this chapter
>
> ***
>
> (20) "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. . . .

Our review of the Provider's documentation identified eight instances where the attending practitioner did not certify that the patient met the conditions for a covered transport on the CMN (e.g., did not certify the patient was non-ambulatory or that the patient needed a wheelchair). Therefore, the reimbursements for these services were disallowed and the amount 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 12 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.

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:

***

(D) To ... submit claims only for services actually performed...

***

We identified five 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 verified the Provider's mileage documentation with independent map engines. We therefore disallowed the reimbursement for the excessively billed mileage and used this amount in calculating the projected finding.

Billing for Canceled Trips

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

***

(L) 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.

***

(5) The reason for the cancellation or unavailability of the service did not occur due to the action or inaction of the individual being transported or the medical transportation provider.

Our review of the Provider's documentation identified two transportation services where the patient canceled the trip at the point of pick-up, did not answer the door, or was otherwise unavailable to be transported. Since the patient was not transported, these services were not eligible for reimbursement. The amounts reimbursed for these services were used in calculating the projected finding.

Summary of Ambulette Sample Findings

The overpayments identified for 31 of 100 RDOS (involving 91 of 354 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 $236,542 with a precision of plus or minus $94,254 (39.85 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), and a finding was made for $157,441. This allows us to say that we are 95 percent certain the population overpayment amount is at least $157,441. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Summary of Findings

A total of $352,663.83 in findings was identified. These findings result from the combination of our exception testing ($82,932.83) and our statistical sample projections ($269,731). For those services selected in our exception testing and samples, we reviewed all corresponding records in their entirety (i.e., 100 percent review).

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.

Incomplete Patient Certification on Ambulette CMNs

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

Covered ambulette transports

> Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements are met.
>
> (a) The ambulette services must be medically necessary as specified below:
> (i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code; and
> (ii) The attending practitioner has certified that the individual does not require ambulance services: the individual does not use passenger vehicles as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code as transport to non-Medicaid services.; and the individual is physically able to be safely transported in a wheelchair.
>
> ***

During the course of our audit, we identified 101 services in our exception tests and 30 services in our ambulette sample where the attending practitioner did not certify that an ambulance was not required on the ambulette CMN supplied by the Provider, per the Ohio Admin.Code. A majority of these services occurred in conjunction with other errors, including those related to the CMN. To certify that an ambulance is not needed, practitioners must only check a box on the ambulette CMN (Box 3 of Section 7 of the ambulette CMN).

In order to avoid potential future findings in this area, we recommend that the Provider review its procedures to ensure that ambulette CMNs used to support services billed are completed in their entirety.

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

Ohio Admin.Code 5101:3-1-05 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, in addition to the 749 ambulance services identified in our exception test that were provided to dually eligible recipients, we found 196 services paid for by Medicaid that were potentially covered by Medicare Part B. With Medicare Part B reimbursement, Medicaid would have been the secondary payor, 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 $11,025.48 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 payor of last resort.

PROVIDER'S RESPONSE

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on March 20, 2009. The Provider was afforded 10 business days from the receipt of the draft report to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. The Provider requested an extension to respond and supply additional documentation. An extension was granted until April 23, 2009, at which time additional documentation was received from the Provider. After reviewing the additional documentation, findings and adjustments were made where appropriate.

APPENDIX I

Summary of Sample Record Analysis for Life Ambulance Service, Inc.
For the period April 1, 2003 through March 31, 2006
Ambulance Sample Population – Provider Numbers 0595771 and 2468137

Description	Audit Period [April 1, 2003 – March 31, 2006]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid non-emergency ambulance services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$2,542,028.96***
Number of Population Recipient Dates of Service	***13,182***
Number of Population Services Provided	***44,473***
Amount Paid for Services Sampled	***$23,061.05***
Number of Recipient Dates of Service Sampled	***100***
Number of Services Sampled	***340***
Estimated Overpayment using Point Estimate	***$237,684***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $135,012 (56.80%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-113,306 (47.67%)***
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]	***$112,290***

[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 II

Summary of Sample Record Analysis for Life Ambulance Service, Inc.
For the period April 1, 2003 through March 31, 2006
Ambulette Sample Population – Provider Numbers 0595771 and 2468137

	Audit Period [April 1, 2003 – March 31, 2006]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulette services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$1,052,624.75***
Number of Population Recipient Dates of Service	***15,428***
Number of Population Services Provided	***59,352***
Amount Paid for Services Sampled	***$8,481.41***
Number of Recipient Dates of Service Sampled	***100***
Number of Services Sampled	***354***
Estimated Overpayment using Point Estimate	***$236,542***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $94,254 (39.85%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-79,101 (33.44%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$157,441***

Mary Taylor, CPA
Auditor of State

June 29, 2009

Michael C. Pistole, Owner
Life Ambulance Service, Inc.
1643 Offnere Street
Portsmouth, Ohio 45662

RE: Adjusted Audit Findings for Life Ambulance Service, Inc. AOS/MCA-09-001C

Dear Mr. Pistole:

Subsequent to the issuance of the audit of Life Ambulance Service, Inc. (AOS/MCA-09-001C), questions arose as to whether sufficient notice was given to the provider regarding the identified overpayments during the audit to comply with Ohio Revised Code § 5111.061(A). While we feel this requirement is directory rather than mandatory, we decided to be conservative and revise the audit period to include only those months that clearly comply with the notification requirement outlined in Ohio Revised Code § 5111.061(A). Consequently, we are adjusting the audit period to July 1, 2003 to March 31, 2006.

In calculating the audit findings for the adjusted audit period, it was discovered that the results of the ambulance sample had been inadvertently sorted causing a mismatch between results and the associated strata and sample numbers. This resulted in an incorrect projection for the ambulance service population. We corrected this sorting error when adjusting the audit period and re-projecting the sample results. The revised finding amount for the ambulance service population is $216,256, as opposed to the previously reported amount of $112,290.

After removing paid service dates from the other tests in our audit prior to July 1, 2003, there was no change to the results of our exception testing and only a slight change to the results of our ambulette sample. The revised finding amount for the ambulette service population is $157,825, as opposed to the previously reported amount of $157,441. Attached are summaries of the revised ambulance and ambulette sample projections.

Our total findings therefore increased from $352,663.83 to $457,013.83, an increase of $104,350. Interest in the amount of $105,977.12 was calculated based on the revised finding amount as of the report issue date of May 21, 2009. Total findings due including interest are now $562.990.95. Additional interest will accrue at $100.17 per day until repayment occurs.

88 E. Broad St. / Fifth Floor / Columbus, OH 43215-3506
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If you have any questions or need any additional information, please don't hesitate to contact me at (614) 466-7894.

Sincerely,

Mary Taylor, CPA
Auditor of State

Jeffrey Castle, Chief Auditor
Medicaid Contract Audit Section

Attachments

cc: J. Randall Richards, Attorney at Law, Chester Willcox & Saxbe, LLP
Gene Meadows, Esquire, Life Ambulance Inc.
Chris Carson, Bureau Chief, Bureau of Audit, ODJFS
David Espinoza, Senior Attorney, Office of Legal Services, ODJFS
Jane Young, Office of Ohio Health Plans, ODJFS
Rachel Jones, Chief, SURS, OFMS, Bureau of Audit, ODJFS
Robert Hinkle, Chief Deputy Auditor, AOS
Karen Huey, Chief Legal Counsel, AOS
Norman Hofmann, Assistant Chief Auditor, Medicaid Contract Audit Section, AOS

Mary Taylor, CPA
Auditor of State

LIFE AMBULANCE SERVICE, INC.

SCIOTO COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
MAY 21, 2009

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