



Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

*Audit of Medicaid Reimbursements Made to
Hometowne Transportation, LLC*

A Compliance Audit by the:

Medicaid/Contract Audit Section



Mary Taylor, CPA

Auditor of State

February 19, 2009

Jayne Barnes, Owner
Hometowne Transportation, LLC
7485 Colerain Ave Ste 1
Cincinnati, OH 45239

Dear Ms. Barnes:

Attached is our report on Medicaid reimbursements made to Hometowne Transportation, LLC, Medicaid provider number 2209747, 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 \$565,088.23 in findings plus \$119,767.74 in interest accruals totaling \$684,855.97 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 February 19, 2009, additional interest will accrue at \$123.85 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 Hometowne Transportation, LLC; the Director and Legal Divisions of ODJFS; the Ohio Attorney General; and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (www.auditor.state.oh.us).

Jayne Barnes
February 19, 2009
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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,

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: Hometowne Transportation, LLC
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Ohio Attorney 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 Hometowne Transportation, LLC (hereafter called the Provider), 2209747, headquartered at 7485 Colerain Avenue, Suite 1, Cincinnati, Ohio 45239. 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 letter of arrangement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified \$565,088.23 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.¹ Additionally, we assessed accrued interest of \$119,767.74, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of \$684,855.97, which is repayable to ODJFS as of the release of this audit report. Additional interest of \$123.85 per day will accrue after February 19, 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, 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

¹ Compliance testing was based on the rules as they existed at the time the service was rendered.

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

date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.”

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

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider’s Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance.

Following a notification letter, we held an entrance conference at the Provider’s headquarters on June 4, 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 \$1,285,180.85 for 83,073 services rendered on 19,517 recipient dates of service. A recipient date of service (RDOS) is defined as all services received by a particular recipient on a specific date.

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

Prior to beginning our fieldwork, we performed a series of computerized tests on the Provider’s Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for the following exceptions:

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.

- 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 transport services billed while the recipient was a hospital inpatient.
- Claims for services rendered on Sundays.
- Claims reimbursed with mileage greater than 50 miles.
- Payments made for services to deceased patients for dates of service after the date of death.

From our exception testing we identified potentially incorrect reimbursements for duplicate payments, services billed while the recipient was a hospital inpatient, services rendered on Sundays, transports greater than 50 miles, and services to deceased patients. When performing our audit fieldwork, we reviewed all available documentation for claims identified by our exception testing (i.e., 100 percent review).

Additionally, while performing our review of the Provider's paid claims, we noticed a large number of claims for attendant services. Therefore, we chose to include these claims in our exception testing for a 100 percent review. All claims analyzed as part of our exception testing were separated from the Provider's total population of claims so as not to double count and overstate any potential findings.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we selected a statistically random sample of 342 RDOS. This would provide the maximum probable number of records that would be required by our audit to perform a statistical projection. We then selected a pilot of the first 100 randomly selected RDOS to begin our review. We determined from our initial review that we should also review the next 100 RDOS in random order. The total results were then projected across the entire population to determine the total finding. Note: the final 142 of the originally selected 342 RDOS were not reviewed.

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

Our fieldwork was performed between June 2007 and April 2008.

RESULTS

We identified findings of \$63,533.23 for services in our exception testing. Additionally, we identified findings from our sample that when projected total \$501,555.00. Together, our findings from our exception testing and projected sample total \$565,088.23, 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: billing for attendant services, duplicate payments, transportation services billed for hospital inpatients, transports occurring on Sundays, transports greater than 50 miles, and services billed for

deceased recipients. 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.

Billings for Attendant Services

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 identified 5,443 services where the Provider billed as if an attendant was in the vehicle during transport. According to the Provider, the attendants were not employees of the company, but were family members and/or nursing aides who accompanied the recipients on their transports. Because the “attendants” were not employees of the company, the Provider was not allowed to bill Medicaid for these attendant services. Therefore, a finding totaling \$49,307.32 was made on the amount reimbursed to the Provider for all billed attendant services.

Duplicate Payments

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

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

We identified 498 services where the Provider appeared to have billed for more than one transport for the same recipient on the same date of service. We determined that 216 services were actually billed as duplicates, as the Provider did not have documentation to validate that more than one transport occurred on the date in question.

For the remaining 282 services, we reviewed the Provider’s documentation and took findings on 186 services due to the following 239 errors:

- 83 instances where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 56 instances where the patient’s non-ambulatory status was brought into question by additional documentation;

- 31 instances where there was insufficient documentation to verify the services occurred;
- 20 instances where the Certificate of Medical Necessity (CMN), which certifies the basis for the necessity of the transport, received from the Provider did not cover the date of service in question;
- 15 instances where the number of miles billed exceeded the amount supported in the Provider's documentation;
- 15 instances where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 16 instances where the documentation in support of the transport did not contain a complete address of the pick-up and/or drop-off location; and
- 2 instances where the Provider did not supply a CMN to cover the service.

There were services that had more than one error; however, only one finding was made per service. Findings totaling \$6,547.34 were made on the amount reimbursed to the Provider for the errors listed above.

Transportation Services Billed for Hospital Inpatients

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

...A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

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

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

(E) Service Limitations

The following services are not covered:

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

We performed an analysis of the Provider's billed services to identify if there were transportation services billed for patients while they were hospital inpatients. Our analysis identified 272 of these services. Note, of these services, 26 were already included in our exception test for attendant services and were therefore excluded from this test.

For the remaining 246 services, we reviewed the Provider's documentation and took findings on 244 services due to the following 244 errors:

- 230 instances for which we did not receive documentation that a transport occurred; and
- 14 instances where the attending practitioner did not certify that the patient met the conditions for a covered transport.

Findings totaling \$4,001.22 were made on the amount reimbursed to the Provider for the errors listed above.

Transports Occurring on Sundays

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...

According to the Provider, its normal business hours are Monday through Saturday, except when providing transports for patients receiving dialysis services during a holiday timeframe, when a Sunday transport could occur. We performed an exception test and identified 212 services performed on a Sunday. Note, of these services, 8 were already included in our exception test for attendant services and were therefore excluded from this test.

For the remaining 204 services, we reviewed the Provider's documentation and took findings on 111 services due to the following 126 errors:

- 67 instances where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 25 instances where the number of miles billed exceeded the amount supported in the Provider's documentation;
- 22 instances where there was insufficient documentation to verify the services occurred;
- 4 instances where the patient's non-ambulatory status was brought into question by additional documentation; and
- 8 instances where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code.

There were services that had more than one error; however, only one finding was made per service. Findings totaling \$1,583.78 were made on the amount reimbursed to the Provider for the errors listed above.

Transports Greater than 50 Miles

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.

Our analysis of the Providers' paid claims identified 40 transport services with billed mileage greater than 50 miles. Note, of these services, two were already included in our exception test for attendant services and were therefore excluded from this test.

For the remaining 38 services, we reviewed the Provider's documentation and took findings on 31 services due to the following 43 errors:

- 12 instances where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 11 instances where the number of miles billed exceeded the amount supported in the Provider's documentation;
- 8 instances where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 4 instances where the documentation in support of the transport did not contain a complete address of the pick-up and/or drop-off location;
- 4 instances where there was insufficient documentation to verify the services occurred; and
- 4 instances where the Provider did not supply a CMN to cover the service.

There were services that had more than one error; however, only one finding was made per service. Findings totaling \$1,580.58 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...

We identified 36 services where the transports occurred after the recipient's date of death. The Provider did not submit any documentation to dispute the results of the exception test. Therefore, a finding totaling \$512.99 was made on the amount reimbursed to the Provider for services billed to deceased recipients.

Summary of Exception Testing

Total combined findings of \$63,533.23 resulted from our exception tests, which included billing for attendant services, duplicate payments, transportation services billed for hospital inpatients, transports occurring on Sundays, transports greater than 50 miles, and services billed for deceased recipients. Some of the more common errors denoted during our exception testing included services lacking supporting documentation, services lacking CMNs, services lacking complete CMNs, patients' non-ambulatory status in question, CMNs completed by unauthorized practitioners, excessive mileage billed, and attending practitioners not certifying that the patient met the conditions for a covered transport.

Unsupported Services in Sample

Ohio Admin.Code 5101:3-1-27 (B)(1) states in pertinent part:

“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 a statistically random sample of RDOS for review. Our sample was chosen from the remaining population of services after removing all claims associated with our exception testing. During our review of these patients' transportation records, we identified findings which can be attributed to several issues including: services lacking supporting documentation, excessive mileage billed, issues with CMNs, patients whose non-ambulatory status was in question, billing for canceled trips, and unlisted street addresses.

As was with the exception tests, there were services in our sample that had more than one error; however, only one finding was made per service. The findings were then projected across the total sampled population, resulting in a total finding of \$501,555. The bases for this finding are provided 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.

We determined that 22 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.

Excessive Mileage Billed

Ohio Admin.Code 5101:3-15-03 lists service limitations including non-covered services. It states in pertinent part:

(E) Service limitations

(3) Excessive mileage charges, resulting from the use of indirect routes

Our review of the Provider's documentation revealed a pattern where mileage billed consistently exceeded documented mileage. Therefore, we used independent map engines to verify the mileage billed. We determined that there were 249 instances where the Provider either billed mileage in excess of what its records supported or the mileage was greater than that listed on independent map engines or both. The amounts for the excessively billed mileage were used in calculating the projected finding.

Issues with Certificates of Medical Necessity

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

a. The ambulette services must be medically necessary...

Additionally, Ohio Admin.Code 5101:3-15-02 (E), Documentation requirements 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.

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

- (4) Practitioner certification form

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

- (b)...a registered nurse, with an order from the attending practitioner, may write the practitioner’s name on the ordering line of the practitioner certification form, sign his or her own full name and the professional letters “R.N.” after the practitioner’s name on the signature line and enter the date of the signature. . . .
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. . . .

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

- (A) The following definitions are applicable to this chapter

- (6) “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).

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 219 errors:

- 129 instances where the Provider did not supply a CMN to cover the service or the CMN received from the Provider did not cover the date of service in question;
- 55 instances where the CMN was incomplete;
- 35 instances where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code; and
- 4 instances where the CMN was not dated by the attending practitioner; and therefore, we could not determine if it covered the date of the sampled services.

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.

Patients' Non-Ambulatory Status in Question

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;

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 141 instances where the patients' non-ambulatory status was in question. In some instances, the attending practitioner actually stated on the CMN that the patient was ambulatory. Additionally, there were instances where the Provider noted on its own pre-screening document that patients were ambulatory. In other instances, the attending practitioner did not certify that the patient met the conditions for a covered transport on the CMN (i.e., did not certify the patient was non-ambulatory; did not need an ambulance; and/or that the patient needed a wheelchair). Therefore, the amounts reimbursed for the corresponding services were used 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.

Unlisted Street Addresses

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

Our review of the Provider's documentation identified two transportation services where we were unable to verify the transport mileage with independent map engines because a specific street address for the destination/subsequent pick-up location was not documented in the Provider's records. Since we were unable to verify the correct mileage because a street address was unavailable, a finding was made on the amount reimbursed for the mileage only. The amounts reimbursed for these services were used in calculating the projected finding.

Summary of Sample Findings

The overpayments identified for 147 of 200 RDOS (involving 459 of 802 services) from our simple 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 \$572,261 with a precision of plus or minus \$84,372 (14.74 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 \$501,555. This allows us to say that we are 95

percent certain the population overpayment amount is at least \$501,555. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Summary of Findings

A total of \$565,088.23 in findings was identified. These findings result from the combination of our exception testing (\$63,533.23) and our statistical sample projection (\$501,555). For those services selected in our exception testing and sample, we reviewed all corresponding records in their entirety (i.e., 100 percent review).

Other Observations

We reviewed the Provider's employee files and other documentation maintained to determine if the Provider complied 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. However, failure to comply with applicable regulations could place patients in harm's way and jeopardize the Provider's status with the Medicaid program.

Required Documentation Lacking for Drivers

We reviewed the Provider's employment files for 37 drivers to determine if required procedures were followed and required documentation was kept on file. Our results are as follows:

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 the 37 driver personnel files for CPR/EMT certifications and proof of passenger assistance training revealed the following:

- 4 drivers did not have documentation of passenger assistance training; and
- 1 driver did not have a CPR certificate or an alternate EMT certificate.

Lack of Driver Criminal Background Checks

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

(a)(iii)

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.

(b) A provider may employ an applicant on a temporary provisional basis pending the results of the required information set forth in paragraphs (C)(3)(a) (iii), (C)(3)(a)(iv) and (C)(3)(a)(v) of this rule if the following conditions are met . Providers who are in the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.

(i) The length of the temporary provisional period shall be sixty days or the period established by another state government agency or board with the authority under Ohio law to regulate providers of ambulette services, whichever is greater.

(ii) No applicant shall be accepted for permanent employment as an ambulette driver or attendant unless all the requirements of paragraph (C)(3)(a) of this rule have been met.

Our review showed 5 of the 37 personnel files did not contain evidence that a criminal background check had been performed on the employee. Additionally, we found three drivers who did not have a background check within the 60-day timeframe. These three drivers received BCI checks from 3 to 11 months after their hire date.

Lack of Medical Statements

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

(a) (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...

(b) A provider may employ an applicant on a temporary provisional basis pending the results of the required information set forth in paragraphs (C)(3)(a) (iii), (C)(3)(a)(iv) and (C)(3)(a)(v) of this rule if the following conditions are met. Providers who are in the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.

(i) The length of the temporary provisional period shall be sixty days or the period established by another state government agency or board with the authority under Ohio law to regulate providers of ambulette services, whichever is greater.

(ii) No applicant shall be accepted for permanent employment as an ambulette driver or attendant unless all the requirements of paragraph (C)(3)(a) of this rule have been met.

Our review of driver personnel files showed that six employees lacked medical statements and three employees lacked drug screen results. Additionally we found three drivers who did not have medical statements within the 60-day timeframe. These three drivers had statements dated from four months to two years after their hire date.

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 driver personnel files found four files which did not contain driving record results. Additionally, the Provider's documentation showed one driver had eight points on his/her driver's license as of two days prior to his/her date of hire. Therefore, pursuant to Ohio Admin.Code 5101:3-15-05(C)(3)(a)(vi), this applicant should not have been hired as an ambulette driver.

PROVIDER'S RESPONSE

A draft report along with detailed listings of services for which we took findings was mailed to the Provider on January 15, 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.

On February 2, 2009, we received a telephone call from Ms. Jayne Barnes, the Provider's owner, who indicated that the Provider was not prepared to furnish refuting documentation at that time and was seeking to retain an attorney. We discussed a potential extension to respond; however, Ms. Barnes could not provide us with an estimate as to what time was needed to identify and furnish any refuting documentation nor could she estimate the time needed to retain counsel. We therefore indicated that we would move forward with the audit's release as scheduled and informed her that once ODJFS issues its notice of findings (i.e., presumptive adjudication order), she would have the opportunity to formally appeal the findings via the hearing process outlined in Ohio Rev.Code Chapter 119. Our findings remain \$565,088.23.

APPENDIX I

**Summary of Sample Record Analysis for Hometowne Transportation, LLC Population
For the period April 1, 2003 through March 31, 2006
Ambulette Sample Population – Provider Number 2209747**

Description	Audit Period [April 1, 2003 – March 31, 2006]
Type of Examination	Simple Random Sample
Description of Population Sampled	All paid services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	\$1,222,251.26
Number of Population Recipient Dates of Service	19,282
Number of Population Services Provided	76,856
Amount Paid for Services Sampled	\$12,815.23
Number of Recipient Dates of Service Sampled	200
Number of Services Sampled	802
Estimated Overpayment using Point Estimate	\$572,261
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	+/- \$84,372 (14.74%)
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	+/-70,705(12.36%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	\$501,555



Mary Taylor, CPA
Auditor of State

HOMETOWNE TRANSPORTATION, L.L.C.

HAMILTON COUNTY

CLERK'S CERTIFICATION

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

Susan Babbitt

CLERK OF THE BUREAU

**CERTIFIED
FEBRUARY 19, 2009**