BEST CHOICE MEDICAL TRANSPORATION, LLC
LUCAS COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD NOVEMBER 15, 2012 THROUGH DECEMBER 31, 2013

Dave Yost · Auditor of State

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BEST CHOICE MEDICAL TRANSPORTATION, LLC
LUCAS COUNTY

TABLE OF CONTENTS

Title	Page
Independent Auditor's Report	1
Compliance Examination Report	3
Recommendation: Certification of Medical Necessity	5
Recommendation: Trip Documentation	6
Recommendation: Driver Qualifications	6
Recommendation: Attendant Services	7
Recommendation: Vehicle Identification	7
Recommendation: Use of Modifiers	8
Provider Response	8
Appendix I: Summary of Statistical Sample Analysis	9

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

Ms. Asha Faqi, Owner
Best Choice Medical Transportation, LLC
3454 Oak Alley Court, Suite 107
Toledo, Ohio 43606

RE: *Medicaid Provider Number 0074820*

Dear Ms. Faqi:

We examined your (the Provider) compliance with specified Medicaid requirements for driver qualifications, service documentation, and service authorization related to the provision of medical transportation services during the period of November 15, 2012 through December 31, 2013. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid and compared the elements contained in the documentation to the Medicaid rules. In addition, we determined if the services were authorized by certificates of medical necessity and reviewed personnel records to verify that driver qualifications were met. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion and report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Adverse Opinion

Our examination found material non-compliance with service documentation, service authorization requirements and driver qualifications. In addition, the Provider billed for attendant services which were not provided and submitted claims with incorrect modifiers, which are used to identify the origin and destination points of each trip. We also found that the Provider did not identify the vehicle used for each transport and, as a result, we could not verify that the vehicle used was properly licensed by the State Board of Emergency Medical Services. The Provider declined to submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable laws and regulations regarding Ohio Medicaid reimbursement; establishing and maintaining effective internal control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to service documentation for the period of November 15, 2012 through December 31, 2013.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We found the Provider was overpaid by Ohio Medicaid for services rendered between November 15, 2012 and December 31, 2013 in the amount of $62,076.72. This finding plus interest in the amount of $2,238.59 totaling $64,315.31 is due and payable to the ODM upon its adoption and adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM through its Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

This report is intended solely for the information and use of the Ohio Department of Medicaid, the Medicaid Fraud Control Unit of the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/Office of Inspector General, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

February 24, 2015

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT FOR BEST CHOICE MEDICAL TRANSPORTATION, LLC

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services. *See* Ohio Admin. Code § 5160-1-01(A) According to Ohio Admin. Code § 5160-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin.Code § 5160-1-17.2(E)

During the examination period, the Provider received reimbursement of $82,717.46 for 6,588 ambulette services, including 2,251 non-emergency wheelchair van transport services (procedure code A0130), 2,252 mileage services (procedure code S0209), and 2,085 attendant services (procedure code T2001) rendered on 1,044 recipient dates of service (RDOS). A recipient date of service is defined as all services for a given recipient on a specific date of service. The Provider was enrolled as a Medicaid provider on June 4, 2012 and the first date of a Medicaid rendered service was November 15, 2012.

Some Ohio Medicaid recipients confined to a wheelchair may be eligible to receive transportation services provided by an ambulette provider. *See* Ohio Admin. Code § 5160-15-03(B)(2) An ambulette is a vehicle designed to transport wheelchair bound individuals. Qualifying ambulette services must be certified as medically necessary by an attending practitioner for individuals who are non-ambulatory, able to be safely transported in a wheelchair, and do not require an ambulance. "Attending practitioner" is defined as the primary care practitioner or specialist who provides care and treatment to the recipient on an ongoing basis and who can certify the medical necessity for the transport. An attending practitioner can be a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, or an advanced practice nurse. Ohio Admin. Code § 5160-15-01(A)(6)

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of non-emergency medical transportation services, specifically ambulette and attendant services, that the Provider rendered to Medicaid recipients and received payment during the period of November 15, 2012 through December 31, 2013.

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We extracted all RDOS with 10 or more services to review as an exception test. From the remaining sub-population, we selected a simple random sample by RDOS to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). We then obtained the detailed services for all of the selected RDOS.

An engagement letter was sent to the Provider on October 1, 2014 setting forth the purpose and scope of the examination. An entrance conference was held at the Provider's location on October 22, 2014. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. After conducting our review of records on-site, we submitted a compiled list of missing records to the Provider. The Provider submitted additional documentation which we reviewed for compliance. The additional documentation included two documents that had been altered from the original records provided during our fieldwork. We did not consider the altered documents when we updated our results.

Results

We reviewed 1,761 services (603 transports, 604 mileage codes, and 554 attendant services) in our statistical sample and found 1,827 errors. The overpayments identified for 256 of 291 statistically sampled RDOS (1,403 of 1,761 services) were projected to the Provider's sub-population of paid claims resulting in a projected overpayment of $58,701 with a 95 percent degree of certainty that the true sub-population overpayment amount fell within the range of $55,481 to $61,921 (+/- 5.49 percent.). A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We also reviewed an exception test of all RODS with 10 or more services (129 transports, 129 mileage codes and 124 attendant services) and identified 410 errors resulting in an overpayment of $3,375.72. The basis for our findings is described below in more detail. While certain services had more than one error, only one finding was made per service.

On July 2, 2014, the Provider responded to an ambulette questionnaire from ODM's Surveillance and Utilization Review Section and stated that since the business was started it has been aware of the requirements that in order for an ambulette transport to be covered by Medicaid, the transport must be in an ambulette, licensed and approved as such by OMTB, that a certificate of medical necessity must be on file for the individual being transported and that in order for an attendant to be covered by Medicaid, the attendant must be a qualified employee of the company. The Provider further stated it maintained all records and documents necessary to substantiate transportation services.

A. Certificate of Medical Necessity (CMN)

All transportation providers are required by Ohio Admin. Code § 5101:3-15-02(E)(2) to obtain a CMN that has been signed by an attending practitioner that documents the medical necessity of the transport. The practitioner certification form must state the specific medical conditions related to the ambulatory status of the patient which contraindicate transportation by any other means on the date of the transport. Ambulette providers must obtain the completed, signed and dated CMN prior to billing the transport. *See* Ohio Admin. Code § 5101:3-15-02(E)(4)

Statistical Sample

Our review of the statistical sample of 603 paid transports identified 368 transports in which the CMN did not include a medical condition and/or was not signed by an authorized practitioner. These 368 errors are used in the overall projection of $58,701.

In addition, we noted CMNs for 207 transports that included a medical condition and were signed by an authorized practitioner but were not complete. These CMNs did not consistently indicate that the recipient met all of the criteria for an ambulette transport. Per Ohio Admin. Code §5101:3-15-03 (B)(2), ambulette services are covered only when the individual has been determined and certified by the attending practitioner to be non-ambulatory at the time of transport and does not require

ambulance services; the individual does not use passenger vehicles as transport to non-Medicaid services; and the individual is physically able to be safely transported in a wheelchair.

Exception Test

Our review of the exception test of 129 paid transports, in which the Provider was reimbursed for 10 or more services for one recipient on one day, identified 74 transports in which the CMN did not include a medical condition and/or was not signed by an authorized practitioner. These 74 errors are included in the overpayment amount of $3,375.72.

In addition, we noted CMNs for 55 transports that included a medical condition and were signed by an authorized practitioner but were not complete. These CMNs did not consistently indicate that the recipient met all of the criteria for an ambulette transport as noted above.

Recommendation:

The Provider should establish a system to obtain the required CMNs, completed by an authorized attending practitioner, and to review those CMNs to ensure they are complete prior to billing Medicaid for the transport. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Trip Documentation

Trip documentation records must describe the transport from the time of pick up to drop off, and include the mileage, full name of attendant, full name of driver, vehicle identification, full name of the Medicaid covered service provider, and complete Medicaid covered point of transport addresses. This requirement is necessary to calculate the correct payment prior to billing Ohio Medicaid. *See* Ohio Admin. Code § 5101:3-15-02(E)(2)(a)

Statistical Sample

Our review of the statistical sample of 603 transports found 99 errors. These errors include:

- 48 transports where the recipient was not transported to a Medicaid covered service or, due to incomplete trip documentation, it could not be determined if the transport was to a Medicaid covered service;
- 37 transports in which the mileage reimbursed was not supported by the documentation; and
- 14 transports with no service documentation.

These 99 errors are used in the overall projection of $58,701.

We also noted 589 transports with incomplete documentation. The documentation for these 589 transports did not identify the vehicle used for the transport and 32 of the 589 documents did not include pick-up and/or drop off time.

Exception Test

Our review of the exception test of 129 paid transports in which the Provider was reimbursed for 10 or more service lines for one recipient on one day identified 28 errors. These errors include:

- 19 transports where the recipient was not transported to a Medicaid covered service or, due to incomplete trip documentation, it could not be determined if the transport was to a Medicaid covered service; and

- 9 transports in which the mileage reimbursed was not supported by the documentation.

These 28 errors are included in the overpayment amount of $3,375.72.

We also noted 129 transports with incomplete documentation. The documentation for these 129 transports did not identify the vehicle used for the transport, six of the 129 documents did not include pick-up and/or drop off time and two of the documents did not include the name of the driver.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Admin. Code § 5160-15-02. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Driver Qualifications

All ambulette drivers must pass a criminal background check and have a signed medical statement from a licensed physician declaring the individual does not have a medical, physical or mental condition or impairment which could jeopardize the health or welfare of patients being transported. Also, each driver must undergo testing for alcohol and controlled substances by a certified laboratory and be determined to be drug free. Background checks, medical statements, and drug test results must be completed and documented before the driver begins providing ambulette services or within 60 days thereafter. Prior to employment, each driver must obtain first aid and Cardiopulmonary Resuscitation (CPR) certification (or have an Emergency Medical Technician certification), provide a copy of his/her driving record from the Bureau of Motor Vehicles (BMV), and complete passenger assistance training. In addition, each driver must provide copy of a BMV driving record on annual basis. *See* Ohio Admin. Code § 5101:3-15-02(C)(3)

The Provider had only one driver until a second driver was hired on December 11, 2013. We tested the two drivers and found the second driver to be ineligible because there was no alcohol testing, no signed medical statement or no diving record obtained within 14 days of application.

Statistical Sample

The 10 services provided by the ineligible driver are considered unallowable and are used in the overall finding projection of $58,701.

Exception Test

We noted two transports in which the name of the driver was not included on the service documentation but both were provided before the ineligible driver was hired.

Recommendation:

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

D. Attendants

According to Ohio Admin, Code § 5101-3-15-01(A)(5), an attendant is an individual employed by the transportation provider separate from the basic crew of the ambulette and is present to aid in the transfer of Medicaid covered recipients.

The Provider disclosed that it did not employ attendants but paid the recipient's home health aides $10.00 per hour in cash to ride in the ambulette with the Medicaid recipient and billed Medicaid for an attendant service.

Statistical Sample

We identified 554 attendant services which were not rendered and these errors are used in the overall finding projection of $58,701.

Exception Test – Reimbursement for More than 10 Service Lines for One Recipient on One Day

We identified 124 attendant services which were not rendered and these errors are included in the overpayment amount of $3,375.72.

Recommendation:

The Provider should familiarize itself with the Ohio Medicaid rules and develop internal control procedures to ensure that all services billed meet the applicable rules in order to avoid future findings.

E. Vehicle Review

According to Ohio Admin. Code § 5101:3-15-02(A)(2), providers of ambulette services must operate in accordance with applicable requirements developed by the Ohio Medical Transportation Board in accordance with Chapter 4766 of the Ohio Revised Code.

We obtained records from the State Board of Emergency Medical Services and confirmed that the Provider had one licensed vehicle in 2012 and two licensed vehicles beginning April 12, 2013. The Provider did not document the vehicle used for any transport; therefore, we could not verify which vehicle was used for each transport or determine if vehicles were properly licensed prior to use.

Recommendation:

We recommend the Provider document which vehicle is used for each transport. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

F. Modifiers

According to Ohio Admin. Code § 5101:3-15(D), modifiers for the point of transport are required for all covered services as described in the rule. A modifier is a two-position indicator wherein the first position alphabetical value reports the origin or "from" of service and the second position alphabetical value reports the destination or "to" of service.

We noted that the Provider frequently transported recipients to and from dialysis but did not use any dialysis modifiers on claim submissions. We also noted instances where the recipient was not transported to a Medicaid covered service or it could not be determined if the transport was to a Medicaid covered service but the modifier indicated a Medicaid covered service.

While there is no reimbursement differential based on modifiers, they are a required mechanism to support the actual service rendered.

Recommendation:

We recommend the Provider include an accurate modifier each claim submission. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Provider Response:

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

The Provider stated it thought the CMNs were appropriate and that it was in compliance with the Medicaid rules. The Provider also stated it will have a plan of correction in place and is implementing that process now.

APPENDIX I

Summary of Statistical Sample Analysis
For the period January 1, 2012 to December 31, 2013

POPULATION
The population is all paid Medicaid services where the service was performed and payment was made by ODM during the examination period. Services excluded from this sample sub-population included all RDOS with 10 or more services which were segregated from the rest of the Provider's services and examined in their entirety.

SAMPLING FRAME
The sampling frame was paid and processed claims from MMIS and MITS. These systems contain all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT
The primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RODS	1,014
Number of Population RDOS Sampled	291
Number of Population RDOS Sampled with Errors	256
Number of Population Services Provided	6,206
Number of Population Services Sampled	1,761
Number of Population Services Sampled with Errors	1,403
Total Medicaid Amount Paid for Population	$77,953.01
Amount Paid for Population Services Sampled	$22,105.21
Projected Population Overpayment Amount	$58,701.00
Upper Limit Overpayment Estimate at 95 Percent Confidence Level	$61,921.00
Lower Limit Overpayment Estimate at 95 Percent Confidence Level	$55,481.00
Precision of Population Overpayment Projection at the 95 Percent Confidence Level	$3,220.00 (+/-5.49%)

Source: Analysis of MMIS and MITS information and the Provider's records

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BEST CHOICE MEDICAL TRANSPORTATION, LLC.

LUCAS COUNTY

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

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
MAY 7, 2015

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