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PORTSMOUTH EMERGENCY AMBULANCE SERVICE, INC., ALSO KNOWN AS PEASI
SCIOTO COUNTY

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

Mr. Michael Adkins, President
Portsmouth Emergency Ambulance Service, Inc., also known as PEASI
2796 Gallia Street
Portsmouth, Ohio 45662

Dear Mr. Adkins:

We examined your (the Provider) compliance with specified Medicaid requirements for driver qualifications, service documentation, service authorization and vehicle licensure related to the provision of non-emergency medical transportation services during the period of January 1, 2012 through December 31, 2014. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid. In addition, we determined if the services were authorized by certificates of medical necessity (CMNs), reviewed personnel records to verify that driver qualifications were met and verified vehicle licensure with the Ohio Department of Public Safety, Division of Emergency Medical Services (EMS Board) (formerly Ohio Medical Transportation Board). 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 Disclaimer of Opinion

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.

Disclaimer of Opinion

Because of the matters described in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the compliance with the specified Medicaid requirements for the period of January 1, 2012 through December 31, 2014.

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 January 1, 2012 and December 31, 2014 in the amount of $199,887.03. This finding plus interest in the amount of $11,808.39 totaling $211,695.42 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, 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 ODM, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties.

Dave Yost
Auditor of State

December 29, 2016

[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

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 prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(B) 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 from receipt of payment 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(D)(E).

Some Ohio Medicaid recipients confined to a wheelchair may be eligible to receive non-emergency medical transportation services. Qualifying wheelchair van services must be certified as medically necessary indicating that the individual must be accompanied by a mobility-related assistive device and that transportation by standard passenger vehicle or common carrier is precluded or contraindicated. In addition, qualifying non-emergency basic life support and advanced life support ambulance services must be certified as medically necessary indicating that the individual requires medical treatment or continuous supervision during transport, requires the administration or regulation of oxygen by another person during transport, or requires supervised protective restraint during transport. The necessity of a transportation service rendered on a fee-for-service basis must by certified by a practitioner holding a current license or certification to practice in a professional capacity. *See* Ohio Admin. Code §§ 5160-15-21, 5160-15-22, 5160-15-23 and 5160-15-27

During the examination period, the Provider received reimbursement of $3,126,107.56 for 107,038 transportation services including:

- 38,822 wheelchair van, per mile, mileage codes (procedure code S0209);
- 38,795 non-emergency wheelchair van transports (procedure code A0130);
- 14,633 ground mileage, per mile, codes (procedure code A0425)
- 11,524 ambulance service, basic life support, non-emergency transports (procedure code A0428);
- 135 ambulance service, advanced life support level 1, non-emergency transports (procedure code A0426);
- 83 extra ambulance attendant services (procedure code A0424);
- 1,827 ambulance service, advanced life support level 1, emergency transports (procedure codes A0427);
- 1,209 ambulance service, basic life support, emergency transports (procedure code A0429);
- 8 ambulance service, advanced life support level 2, emergency transports (procedure code A0433); and
- 2 specialty care transports (procedure code A0434).

The Provider currently operates offices in additional Ohio cities: Chillicothe, Columbus, Gallipolis, Ironton, Jackson, Lancaster, Logan, Marietta, Newark, New Lexington, Piketon, Pomeroy and Zanesville. We selected provider number 3159442 for examination and noted that the Provider has a second Ohio Medicaid provider number (0096759). The Medicaid agreement for the second provider number was effective as of October 3, 2013 and has a service location of 1008 Fairlane Drive, Vanceburg, Kentucky with an additional location in Maysville, Kentucky. The Provider received payments totaling $2,096.46 to this number during our examination period.

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 wheelchair van, ambulance basic life support, ambulance advanced life support and attendant services that the Provider rendered to Medicaid recipients during the period of January 1, 2012 to December 31, 2014.

Although our scope did not include emergency medical transportation services, we noted five emergency ambulance transports that appeared to be billed after the date of death of the recipient. Since this matter came to our attention, we extracted these five transports and the corresponding mileage, obtained the service documentation from the Provider, and determined that these services were billed to the wrong recipient and did not involve billing services after a recipient's date of death. We performed no further testing on these services.

We received the Provider's claims history from the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed any voids, services paid at zero, services with Medicare co-payments and third party payments.

From this population, we used a statistical sampling approach to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). First, we extracted all wheelchair van transports and their corresponding mileage codes (procedure codes A0130 and S0209) and summarized this population by recipient date of service (RDOS). A recipient date of service is defined as all services for a given recipient on a specific date of service.

We calculated an estimate of the population overpayment standard deviation using the standard deviation of the actual amount paid per claim and a 70 percent error rate. We constructed strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule). We calculated an estimated overpayment mean and standard deviation for each stratum and then calculated an overall stratified sample using the estimates. The final calculated sample size is shown in Table 1.

Table 1: Wheelchair Van Sample		
Universe/Strata	**Population**	**Sample**
Strata 1: RDOS with Amount Paid Less than $75.00	15,319	119
Strata 2: RDOS with Amount Paid Between $75.00 - $99.99	2,746	32
Strata 3: RDOS with Amount Paid $100.00 and Over	1,592	31
Total RDOS:	**19,657**	**182**

We then obtained the detailed services for the stratified random sample of 182 RDOS which resulted in a sample size of 747 services.

From the remaining sub-population we extracted all non-emergency ambulance transports, their corresponding mileage codes and attendant service codes (procedure codes A0424, A0425, A0426 and A0428) and summarized this population by RDOS. We used the same approach as with the wheelchair van services to calculate estimated overpayment mean and standard deviation for each stratum and then calculated an overall stratified sample using the estimates.

Purpose, Scope, and Methodology (Continued)

The third stratum was modified from a sample of 43 RODS to a sample of 93 RDOS to adjust for skewness. The final calculated sample size is shown in Table 2.

Table 2: Non-Emergency Ambulance Sample		
Universe/Strata	**Population**	**Sample**
Strata 1: RDOS with Amount Paid Less than $200.00	3,777	81
Strata 2: RDOS with Amount Paid Between $200.00 - $274.99	2,058	63
Strata 3: RDOS with Amount Paid $275.00 and Over	816	93
Total RDOS:	**6,651**	**237**

We then obtained the detailed services for the stratified random sample of 237 RDOS which resulted in a sample size of 919 services.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. During fieldwork we reviewed personnel records and service documentation. We sent a missing records list to the Provider and the Provider submitted additional documentation which we reviewed for compliance and updated our results accordingly. This documentation included, in part, eight CMNs that were previously submitted but altered to include the name of the attending practitioner, the printed name and credentials of a signor or a medical condition. The Provider also submitted one CMN valid for the same one day as a previously submitted CMN; however, the new CMN was electronically completed and included a 2016 fax date. We did not revise our results for these nine altered CMNs.

The Provider submitted additional documentation after receipt of a draft copy of this report. We reviewed all documents for compliance and updated our results accordingly. This documentation included, in part, one CMN that was previously submitted but altered to include a medical condition. We did not revise our results for the altered CMN. The documentation also included a notarized "Attestation Statement" for a specific wheelchair van transport to provide clarification of a driver's name. This "Attestation Statement" indicated the patient could not have been safely transported in a car or wheelchair, that the patient was moveable only by ambulance stretcher and that any other means of transport would have endangered the patient's medical and physical condition. However the documentation to support the transport reflects that a wheelchair van was used and the CMN authorizing the transport was signed by a physician and indicated the patient was physically able to be safely transported in a wheelchair. Although the "Attestation Statement" did clarify the driver's name, the remaining portion of the statement clearly contradicted the service documentation.

Results

We examined 747 services in Statistical Sample 1 (wheelchair van services) and identified 293 errors. The overpayments identified for 40 of 182 RDOS (127 of 747 services) from the stratified statistical random sample were projected across the Provider's total population of paid RDOS. This resulted in a projected overpayment amount of $201,414 with a precision of plus or minus $66,149 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits).

Results (Continued)

Additional corrections were then made for skewness in all strata because they did not meet Cochran's approximation test for normality[2] and a final finding was calculated as $148,404.69. This allows us to say that we are 95 percent certain that the population overpayment amount is at least 148,404.69. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We examined 919 services in Statistical Sample 2 (non-emergency ambulance services) and identified 42 errors. We took exception with 25 of 237 statistically sampled RDOS (59 of 919 services) from the stratified random sample. Based on this error rate, we calculated the Provider's correct payment amount for this population of $1,276,145 with a 95 percent certainty that the actual correct payment amount, after correction for skewness in stratum two[2], fell within the range of $1,191,006.49 to $1,324,291.15. We then calculated examination findings by subtracting the correct population amount ($1,276,145) from the amount paid to the Provider for this population ($1,327,627.34), which resulted in a finding of $51,482.34. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

While certain services had more than one error, only one finding was made per service. The non-compliance found during our examination and the basis for our finding is described below in more detail.

A. Driver Qualifications

Ambulette 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) or proof of insurance from insurance carrier, and complete passenger assistance training. In addition, each driver must provide copy of a BMV driving record on annual basis and maintain first aid and CPR certification. Each driver must also maintain a valid drivers' license. *See* Ohio Admin. Code § 5101:3-15-02(C)(3)[3]

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[2] We applied a method described by Herbert Arkin in "Sampling Methods for the Auditor, An Advanced Treatment," McGraw-Hill, 1982. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrika Tables for Statisticians, vol 1, 3rd Edition, Cambridge University Press, New York, 1969, table 42.

[3] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

A. Driver Qualifications (Continued)

We haphazardly selected 20 drivers from the Provider's trip documentation for testing. We determined that one driver was an ambulance driver and so was excluded from our testing. From the Provider's employee roster and personnel files, we determined that 14 of the remaining 19 drivers tested were hired during the examination period and we applied the applicable hiring requirements. In addition, we tested all 19 drivers for the required annual requirements.
We found the following errors for driver qualifications:

- 2 drivers had no controlled substance test within 60 days of hire;
- 14 drivers had no alcohol test within 60 days of hire;
- 4 drivers had no documentation of a criminal background check and 3 drivers did not have the background check completed within 60 days of hire;
- 3 drivers did not have a signed physician statement and 3 drivers did not have the physician statement completed within 60 days of hire;
- 6 drivers did not have passenger assistance training at time of hire;
- 1 driver did not have the initial BMV driving record at time of hire and 1 driver had no annual driving record for 2014;
- 1 driver had no first aid and 2 drivers had lapses in first aid ranging from approximately 2 to 5 months;
- 2 drivers had lapses in CPR ranging from approximately 3 to 20 months; and
- 1 driver had a lapse in driver's license of approximately 2 months.

As a result of the material non-compliance found, six drivers were found to be ineligible for the entire examination period and an additional nine drivers were ineligible during specific spans of time within the period.

Statistical Sample 1 – Wheelchair Van Services

We reviewed the trip documentation and identified 51 transports by an ineligible driver and two transports in which the name of the driver was missing or illegible. These 53 errors were used in the overall projection of $148,404.69.

The Provider is a Clinical Laboratory Improvements Amendments (CLIA) Waivered Lab and as such performed the required controlled substance testing. Screening tests for the presence/detection of certain controlled substances are among tests granted waived status under CLIA and include specific tests by specific manufacturers. The Provider's documentation did not include the test name and test manufacturer so we could not determine if approved tests were utilized.

Ambulance Driver and Crew Qualifications

All ambulance drivers and attendants must have a current emergency medical technician certification appropriate to the level of service provided (i.e., advanced life support, basic life support, non-emergency). They must also provide a driving record from the bureau of motor vehicles at the time of application and annually thereafter. *See* Ohio Admin. Code § 5101:3-15-02(C)(2)

We haphazardly selected 20 personnel from the Provider's trip documentation for testing. From the Provider's employee roster and personnel files, we determined that 16 of the 20 personnel tested were hired during the examination period and we applied the applicable hiring requirement. We found one driver with a driving record approximately four months after hire. The one error resulted in a period of ineligibility for one personnel for driving only.

A. Driver Qualifications (Continued)

In addition, we tested all 20 personnel for the required annual requirements and found no errors.

Statistical Sample 2 – Non-Emergency Ambulance Services

We noted no transports by personnel during the period of ineligibility.

Recommendation:

The Provider should develop and implement a system to ensure that all drivers complete all requirements prior to rendering transportation services. 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 also ensure that only CLIA approved tests and manufacturers are used and maintain documentation of such. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. 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 recipient which contraindicate transportation by any other means on the date of the transport. In addition, 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 1 – Wheelchair Van Services

Our review of the CMNs identified four transports in which the CMN did not certify the recipient met any of the criteria for medical necessity, did not include a medical condition and/or was not signed by an authorized practitioner. These four errors were used in the overall projection of $148,404.69.

In addition, we noted CMNs for 205 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, but at least one of the criteria was met. 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. We did not identify an overpayment for these 205 errors.

Statistical Sample 2 – Non-Emergency Ambulance Services

We identified three services in which there were no CMN to cover the transport and 17 services in which the CMN was not signed by an authorized practitioner or we could not determine if the CMN was signed by any authorized practitioner and/or the CMN did not include a medical condition. These 20 errors were used in the overall projection of $51,482.34.

During our review we noted that some CMNs appeared to be electronically completed by the Provider, including a medical condition, but were manually signed by the authorized practitioner. This is contrary to Ohio Admin. Code § 5101:3-15-02(E)(2)(b), which states CMNs are to be completed by the attending practitioner.

B. Certificate of Medical Necessity (CMN) (Continued)

Recommendation:

The Provider should establish a system to obtain the required CMNs for any services rendered on a fee-for-service basis, ensure they are completed by an authorized attending practitioner, and ensure they are complete prior to submitting to Medicaid for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. 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 1 – Wheelchair Van Services

Our review of the trip documentation identified 12 transports in which the miles reimbursed exceeded the miles documented. These 12 errors were used in the overall projection of $148,404.69.

We also noted four transports in which the pick-up and/or drop off times were not recorded, one transport in which the pick-up and drop-off addresses for the return trip were not recorded but the same number of miles were billed and one transport in which the miles for the return trip were not recorded but were billed as the same number of miles for the initial trip. We identified no overpayment for these errors.

Statistical Sample 2 – Non-Emergency Ambulance Services

Our review of the trip documentation identified 14 transports in which the mileage reimbursed exceeded the miles documented. These 14 errors were used in the overall projection of $51,482.34. We also noted five transports in which the miles for the return trip were not recorded but were billed as the same number of miles for the initial trip. We identified no overpayment for these errors.

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. Vehicle Review

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

We obtained licensing records from the EMS Board. We identified no transports in an unlicensed vehicle in either of the two samples tested. We did note eight transports in the sample of wheelchair van services in which the vehicle number was not included on the trip documentation. We identified no overpayment for these errors.

D. Billing Codes

According to Ohio Admin. Code § 5101:3-15-05(B)(1)(c), in order to receive reimbursement for ambulette services provided in an ambulance, a provider must bill the "basic life support, non-emergency (BLS non-emergency)" code and the code for the loaded land ambulance mileage. In addition, both codes must be modified with U3 to indicate an ambulette service by an ambulance.

Statistical Sample 1 – Wheelchair Van Services

Our review of the documentation identified five wheelchair van transports provided in an ambulance that were billed with the ambulette codes and no U3 modifier. We determined that these five errors did not result in an overpayment by the Medicaid program.

Statistical Sample 2 – Non-Emergency Ambulance Services

Our review of the documentation identified three wheelchair van transports provided in an ambulance that were billed with the proper code but not modified with the U3 modifier. We calculated overpayment based on difference in reimbursement with the required modifier. These three errors were used in the overall projection of $51,482.34.

Recommendation:

The Provider should review its billing procedures and ensure the correct code and modifiers are billed. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Provider Response:

The Provider was afforded an opportunity to respond to this examination report. The Provider declined an exit conference to discuss the results of the examination and also declined to submit an official response to the results noted above.

APPENDIX I

Summary of Sample Record Analysis
Statistical Sample 1 – Wheelchair Van Services

POPULATION
The population from which this subpopulation and sample is being taken is all paid Medicaid wheelchair van services (procedure codes A0130 and S0209), net of any adjustments where the service was performed and payment was made by ODM during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from MITS. This system contained 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 stratified random sampling approach.

Description	Analysis
Number of Population RDOS	19,657
Number of Population RDOS Sampled	182
Number of Population RDOS Sampled with Errors	40
Number of Population Services Provided	77,617
Number of Population Services Sampled	747
Number of Population Services Sampled with Errors	127
Total Medicaid Amount Paid for Population	$1,301,219.24
Amount Paid for Population Services Sampled	$13,314.42
Estimated Overpayment	$201,414
Precision of Overpayment Estimate at 95% Confidence Level	$66,149
Precision of Overpayment Estimate at 90% Confidence Level	$55,514[4]
Single – tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90% overpayment precision from the point estimate. (Equivalent to method used in Medicare audits.)	$148,404.69

Source: AOS analysis of MITS information and the Provider's medical records

[4] Due to skewness in the strata, the 90 percent lower limit was adjusted to $53,010.31 using method described in "Sampling Methods for the Auditor, An Advanced Treatment" by Herbert Arkin. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, Vol 1 3rd Ed., 1969, Cambridge University Press, New York, table 42.

APPENDIX II

Summary of Sample Record Analysis
Statistical Sample 2 – Non-Emergency Ambulance Services

POPULATION
The population from which this subpopulation and sample is being taken is all paid Medicaid non-emergency ambulance services (procedure codes A0424, A0425, A0426 and A0428), net of any adjustments where the service was performed and payment was made by ODM during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from MITS. This system contained 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 stratified random sampling approach.

Description	Analysis
Number of Population RDOS	6,651
Number of Population RDOS Sampled	237
Number of Population RDOS Sampled with Errors	25
Number of Population Services Provided	23,318
Number of Population Services Sampled	919
Number of Population Services Sampled with Errors	59
Total Medicaid Amount Paid for Population	$1,327,627.34
Amount Paid for Population Services Sampled	$61,163.11
Projected Correct Population Payment Amount	$1,276,145
Upper Limit Correct Population Payment Estimate at 95% Confidence Level[5]	$1,324,291.15
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$1,191,006.49
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	$51,482.34
Precision of Estimated Correct Population Payment Amount at 95% Confidence Level	$85,138.51 (+/-6.67%) Lower[6] $3,336.19 (actual) Upper[5]

Source: AOS analysis of MITS information and the Provider's medical records

[5] Upper Limit was adjusted to Total Medicaid Amount Paid for Population less actual findings in sample ($3,336.19) to avoid negative overpayments.
[6] The lower limit was adjusted using the method described in "Sampling Methods For The Auditor, An Advanced Treatment" by Herbert Arkin. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrika Tables for Statisticians, Volume 1, 3rd Edition, Cambridge University Press, New York, 1969, table 42.

Dave Yost • Auditor of State

PORTSMOUTH EMERGENCY AMBULANCE

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
FEBRUARY 21, 2017

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