Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Eaton Medical Transport, Inc. (DBA EMT, Inc.)

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

March 25, 2008

Eaton Medical Transport, Inc. (DBA EMT, Inc.)
Chris Atkins, Vice-President
251 West Lexington Rd
Eaton, OH 45320

Dear Mr. Atkins:

Attached is our report on Medicaid reimbursements made to Eaton Medical Transport, Inc., Medicaid provider number 0350865, (doing business as E.M.T., Inc.) for services rendered for the period October 1, 2002 through September 30, 2005. We identified $2,700.07 in findings plus $537.94 in interest accruals that are repayable to the Ohio Department of Job and Family Services (ODJFS). After March 25, 2008, additional interest will accrue at $0.59 a day until repayment occurs. Our audit was performed in accordance with Section 117.10 of the Ohio Revised Code and our interagency agreement with ODJFS. The specific procedures employed during this audit are described in the purpose, scope and methodology section of this report. Interest is calculated pursuant to Ohio Administrative Code 5101:3-1-25 (A).

We are forwarding this report to the 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 the ODJFS' Legal Office at (614) 466-4605. To facilitate repayment, a "provider remittance form" has been attached to this report.

Copies of this report are being sent to Eaton Medical Transport, Inc., the Director and Legal Division of ODJFS, the Ohio Attorney General, and the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website (www.auditor.state.oh.us).

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

Sincerely,

Mary Taylor, CPA
Auditor of State

cc: Eaton Medical Transport, Inc.
Ohio Attorney General
Ohio Medical Transportation Board
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services

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ACRONYMS

ALS	Advanced Life Support
AOS	Auditor of State
AMA	American Medical Association
BLS	Basic Life Support
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DBA	Doing Business As
MMIS	Medicaid Management Information System
Ohio Admin.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Eaton Medical Transport, Inc., doing business as EMT, Inc. (hereafter called the Provider), provider #0350865, doing business at 251 West Lexington Rd., Eaton, Ohio 45320. Within the Medicaid program, the Provider is listed as an ambulance and ambulette service provider. An ambulance is defined as a vehicle designed to transport individuals in a supine position. An ambulette is defined as a vehicle designed to transport individuals sitting in wheelchairs.

We performed our audit in accordance with Ohio Rev.Code §117.10 and our interagency agreement with the Ohio Department of Job and Family Services (ODJFS). As a result of this audit, we identified $2,700.07 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code. These findings plus interest of $537.94 are repayable to ODJFS. Additional interest of $0.59 per day[1] will accrue after March 25, 2008 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. 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.

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

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

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[1] *Ohio Admin.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Admin.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was September28, 2005, as the latest payment date in the random sample used for analysis.*

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

Ohio Admin.Code 5101:3-1-29(B)(2) states: " 'Waste and abuse' are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an over utilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program."

PURPOSE, SCOPE, AND METHODOLOGY

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

Following a letter of notification, we held an entrance conference at the Provider's place of business on March 7, 2006 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 2002 through September 30, 2005. The Provider was reimbursed $1,682,335.36 (excluding Medicare crossovers) for 106,918 services rendered on 29,766 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code 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 field work, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for:

- Potential duplicate payments to identify whether payments were made for the same recipient, on the same date of service, for the same procedure codes, and procedure code modifiers, and for the same dollar amount.
- Payments made for services occurring after the date of death of deceased recipients.

[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.

- Payments made for transportation services billed for recipients, excluding admission and discharge dates, while they were in the hospital.

The test for services billed for recipients during an inpatient hospital stay was negative; however, the other two exception tests identified potentially incorrect reimbursements.

To facilitate an accurate and timely audit of the Provider's transportation services, we also analyzed two samples from the Provider's paid claims: the first sample was drawn from ambulance basic life support (BLS) services not already identified for review by our exception tests and consisted of 124 recipient dates of service (RDOS), which included 349 services. The second sample was drawn from ambulette services not already identified for review by our exception tests and consisted of 140 RDOS, which included 537 services.

Our ambulance review was limited to BLS services only because Advanced Life Support (ALS) services only accounted for 6.9 percent of services rendered and 13.3 percent of reimbursements received for ambulance services. In addition, 52.4 percent of ALS services and 61.6 percent of ALS reimbursements were for emergency transports. Our review therefore did not analyze ALS transports because of the relatively small percentage that non emergency ALS transports represented of the Provider's ambulance services.

Our work was performed between January 2006 and June 2007.

RESULTS

We identified findings of $2,700.07 for incorrectly billed ambulette and BLS ambulance services. This total consisted of $1,308.28 in findings identified by our exception tests, $1,137.68 in actual findings from our sample of BLS ambulance services, and $254.11 in actual findings from our sample of ambulette services. The circumstances leading to these findings are discussed below:

Results of Exception Testing

Our exception tests consisted of a 100 percent review of all services identified by our computerized analysis as having potential findings. During the review of these services, other issues which caused findings were identified. These services are also discussed in this section of the report.

Duplicate Payments

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

> ***
>
> (A) To…submit claims only for service actually performed…
>
> ***

Our testing identified instances where it appeared the Provider billed and was paid twice for the same service and the same patient, on the same date of service. Upon review of the Provider's documentation, we identified 42 instances, with findings of $820.84, where duplicate billing occurred.

Our review also identified the following issues which resulted in findings:

- Eighteen instances, with findings totaling $266.00, of incomplete or missing physician certification of medical necessity.
- Four services, with findings totaling $74.42, where third party insurance should have been billed for the transport.
- Two instances, with findings totaling $20.65, where a second passenger was billed as if they were the first passenger in the vehicle.
- Two services, with findings totaling $33.81, billed for ambulatory patients.
- Two services, with findings totaling $22.22, where mileage was incorrectly billed using the transport base rate code.

Total findings of $1,237.94 were made for the above issues found while reviewing the population of possible duplicate payments.

Billing for Services to Deceased Recipients

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

> ***
>
> (B) To…submit claims only for service actually performed…
>
> ***

We identified four services where the date of service billed was after the patient's date of death. Therefore, a finding was made for $70.34, the amount reimbursed to the Provider for the services.

Summary of Exception Testing

Total combined findings of $1,308.28 resulted from our 100 percent exception testing, which included $1,237.94 in findings from our duplicate payments testing and $70.34 billed for a deceased recipient.

Unsupported Services in Ambulance Sample

Our sample of BLS ambulance services, not included in our exception testing, consisted of 124 RDOS' with 349 services. Our analysis of the Provider's documentation for these services identified findings for 22 services. The bases for our findings are discussed below.

Non-Covered Services

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

> (1) Covered transportation services include the ambulance or ambulette transport of medicaid patients to and from public and private psychiatric hospitals for inpatient psychiatric hospital services only when the patient is age twenty-one and younger, or sixty-five and older…
>
> ***

We identified 12 services where the Provider transported patients to an inpatient psychiatric hospital who were older than 21 and under 65 years of age. As such, they were ineligible for transportation to an inpatient psychiatric hospital by the Provider.

Therefore, a finding of $751.30 was made on the amount reimbursed to the Provider for these services.

Lack of Documentation for Transportation Services

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

> 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 identified six services were the Provider's documentation did not substantiate the service billed. Therefore, a finding of $242.42 was made on the amount reimbursed to the Provider for these services.

Incorrectly Billed Ambulette Services Provided by Ground Ambulance

Ohio Admin. Code 5101:3-15-05 states in pertinent part:

> ***
>
> (B) From October 1, 2003 through December 31, 2005 a transportation provider, who meets the requirements set forth for both ambulette and ground ambulance providers as specified in rule 5101:3-15-02 of the Administrative Code, may be reimbursed for providing the ambulette service with an ambulance vehicle if the following criteria is met.
>
> (1) The patient must meet the criteria for the ambulette service as specified in paragraph (B) of rule 5101:3-15-03 of the Administrative Code except for

paragraph (B)(2)(b) and (B)(2)(e) of rule 5101:3-15-03 of the Administrative Code.

(2) The ground ambulance vehicle must meet requirements as specified in rule 5101:3-15-02 of the Administrative Code.

(3) The rendering transportation provider has documented that their ambulette vehicles were unavailable and has documented referral attempts to a competing transportation provider or the rendering transportation provider has documented that delaying, deferring or missing the transport to or from the medicaid covered service would jeopardize the patient's health or cause excessive patient waiting time.

***

(C) Reimbursement of the ambulette service provided in an ambulance as specified in paragraph (B) of the rule.

(1) For the one-way ground ambulance transport of one passenger, the provider shall be reimbursed a base rate for the service and a loaded mileage rate for each mile the passenger was transported.

(a) The amount of reimbursement for the base rate shall be the lesser of the provider's billed charge or twenty-eight per cent of the medicaid maximum rate as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code for "Basic life support, non-emergency (BLS non-emergency)"; and

(b) The amount of reimbursement for the loaded mileage shall be the lesser of the provider's billed charge or forty-eight per cent of the loaded mileage code for ambulance.

(c) For the total reimbursement, the provider must bill the "Basic life support, non emergency (BLS-Non-Emergency)" code and the code for the loaded mileage. Both codes must be modified with the appropriate medicaid covered point of transport modifier and U3, ambulette services by ambulance vehicle modifier (total modifiers in total).

***

We identified four services where ambulette services were rendered using ground ambulances. However, the billings for these services were not correctly modified which caused the Provider to be reimbursed at a higher rate.

Therefore, we recalculated the reimbursement for the ambulette services as specified in Ohio Admin.Code 5101:3-15-05. A finding was made for $143.96, the difference between the amount reimbursed to the Provider and the recalculated amount.

Summary of Ambulance Sample

The findings for 22 of 349 services from our stratified random sample were projected across the Provider's ambulance population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review). Since both the error rate of services tested and the finding amount were below our protocol's criteria, we did not project the sample results to the payment subpopulation. Thus, for the services in our ambulance sample the overpayment will be the actual finding of $1,137.68.

Unsupported Services in Ambulette Sample

Our sample of ambulette services, not included in the exception testing, consisted of 140 RDOS, with 537 services. Our review of the Provider's documentation identified findings for 4 of the 140 RDOS, or (14 of 537 services). The bases for the findings are discussed below.

Practitioner Certification Forms Not Received or Incomplete

Ohio Admin. Code 5101:3-15-02(E)(2) states in pertinent part:

> Records which must be maintained include, but not limited to, the record listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. All records and documentation required by this rule must be retained in accordance with rules 5101:3-1-17.2 and 5101:3-1-27 of the Administrative Code.
>
> ***
>
> (b) The original "practitioner certification form," completed by the attending practitioner, documenting the medical necessity of the transport, in accordance with this rule…
>
> ***

We identified six services where the practitioner certification was not received from the Provider or when received was incomplete. A finding was made on the reimbursement received for these services in the amount of $91.91.

Transport of Ambulatory Patients

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

> Service limitations
> The following services are not covered.
>
> ***

> (8) Transport of a patient who is ambulatory at the time of the transport unless the patient meets criteria in paragraph (A)(2) of this rule.
>
> ***

We identified four services where the patients were ambulatory at the time of the ambulette transport. A finding was made on the reimbursement received for these services in the amount $63.54.

Multiple Passenger Transport Billed as First Passenger Transports

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

> Ambulette services coverage and limitations
>
> (1) Covered ambulette services
> The following ambulette services are covered if the criteria for coverage is met in accordance with paragraph (B)(2) of this rule.
>
> (a) "Ambulette services" is the transport of one individual, or the first passenger of a multiple passenger transport in an ambulette.
>
> (b) "Ambulette services, second passenger" is the transport of the second passenger of a multiple passenger transport in an ambulette.
>
> ***

Ohio Admin. Code 5101:3-15-04(C) states in pertinent part

> Reimbursement of ambulette services.
>
> ***
>
> (2) For the one-way transport of the second passenger of a multiple passenger ambulette transport, the provider shall be reimbursed as follows:
>
> (a) The amount of reimbursement for the base rate of the second passenger of a multiple passenger transport shall be the lesser of the provider's billed charge or fifty per cent of the medicaid maximum rate set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code.
>
> (b) No reimbursement shall be made for loaded mileage.
>
> ***

During our review of the Provider's documentation, we identified four services where the Provider billed for a first passenger transport with loaded mileage. As the patient was the second

passenger, of a multiple passenger transport, we reduced reimbursement for these services to second passenger transports without loaded mileage. Therefore, a finding was made for $98.66.

Summary of Ambulette Sample

The findings for 14 of 537 services from our stratified random sample were projected across the Provider's ambulette population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review). Since both the error rate of services tested and the finding amount were below our protocol's criteria, we did not project the sample results to the payment subpopulation. Thus, for the services in our ambulette sample the overpayment will be the actual finding of $254.11.

Summary of Findings

A total of $2,700.07 in findings was identified. These findings result from the combination of our actual sample results of $1,391.79 and our 100 percent exception testing results of $1,308.28.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on February 20, 2008 in order to afford the Provider an opportunity to submit additional documentation or otherwise respond in writing. We gave the Provider until March 6, 2008 to submit documentation; however, as of March 11, 2008, we had not received any form of communication from the Provider. Therefore, our findings remain as $2,700.07.

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PROVIDER REMITTANCE FORM

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

Ohio Department of Job and Family Services
Office of Fiscal Services (Attn: Accounts Receivable)
P.O. Box 182367
Columbus, Ohio 43218-2366

1. **Provider Name and Address:**
   Eaton Medical Transport, Inc. (DBA E.M.T., Inc.)
   251 W. Lexington Rd
   Eaton, OH 45320

2. **Provider Number:** **0350865**

3. **Review Period:** **October 1, 2002 through September 30, 2005**

4. **AOS Finding Amount (including accrued interest):** **$3,238.01**

5. **Interest "as of" Date:** **March 25, 2008**

6. **Date Payment Mailed:** ________________

7. **Additional Interest Owed:**
   (Calculated by multiplying $0.60 by the difference in days between #5 and #6) ________________

8. **Total Amount Repaid:**
   (Sum of # 4 and #7) ________________

<u>IMPORTANT</u>:

To help ensure that your payment is properly credited, please fax copies of this remittance form and your check to our office at (614) 728-7398, **ATTN:** Medicaid/Contract Audit Section.

Mary Taylor, CPA
Auditor of State

EATON MEDICAL TRANSPORT, INC.

PREBLE 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
MARCH 25, 2008

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