Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to LifeStar Ambulance, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

October 15, 2009

Barry F. Hudgin
Mercy Health Partners
2200 Jefferson Avenue, 6th Floor
Toledo, Ohio 43604

Dear Mr. Hudgin:

Attached is our report on Medicaid reimbursements made to LifeStar Ambulance, Inc., Medicaid provider number 0627665, for the period April 1, 2004 to March 31, 2007. 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 $159,205.97 in findings. However, during the course of the audit, LifeStar Ambulance, Inc. repaid $1,486.73, leaving $157,719.24 in overpayment. Furthermore, LifeStar Ambulance, Inc., upon receipt of our September 17, 2009 draft report paid the full amount of overpayment plus $26,168.43 in accrued interest totaling $183,887.67 in repayment to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. Interest was calculated pursuant to Ohio Administrative Code 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.

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Copies of this report are being sent to LifeStar Ambulance, Inc.; the Director and Legal Divisions of ODJFS; 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 the Ohio Medical Transportation Board. In addition, copies are available on the Auditor of State website at (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

Mary Taylor, CPA
Auditor of State

cc: Cathi Lydy, LifeStar Ambulance, Inc.
Director, Ohio Department of Job and Family Services
Legal Division, Ohio Department of Job and Family Services
Medicaid Fraud Control Unit, Ohio Attorney General
U.S. Dept. of Health and Human Services/Office of Inspector General
Ohio Medical Transportation Board

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ACRONYMS

AOS	Auditor of State
CMN	Certification of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Admin.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
RDOS	Recipient Date of Service

SUMMARY OF RESULTS

The Auditor of State performed an audit of LifeStar Ambulance, Inc., (hereafter called the Provider), provider number 0627665, headquartered at 1402 Lagrange Street, Toledo, Ohio 43608. Within the Medicaid program, the Provider is listed as an ambulance service provider, furnishing both ambulance and ambulette services. An ambulance is defined as a vehicle that is designed to transport individuals in a supine position, while an ambulette is designed to transport individuals sitting in a wheelchair.

We performed our audit in accordance with Ohio Rev. Code Section 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 $159,205.97 findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] During the course of the audit, however, the Provider repaid $1,486.73 leaving $157,719.24 in overpayments. Furthermore, LifeStar Ambulance, Inc., upon receipt of our September 17, 2009 draft report paid the full amount of the overpayment due plus $26,168.43 in accrued interest totaling $183,887.67 in repayment to ODJFS. Interest was assessed in accordance with Ohio Admin.Code 5101:3-1-25.

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

[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).*

business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

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

PURPOSE, SCOPE, AND METHODOLOGY

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

Following a notification letter, we held an entrance conference at the Provider's headquarters on March 4, 2008, 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, 2004 to March 31, 2007. The Provider was reimbursed $2,090,505.84 for 85,779 services rendered on 29,355 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 for non-emergency ambulance and ambulette claims to determine if reimbursements were made for potentially inappropriate services or service code combinations. Of these tests, the following resulted in potential overpayments:

[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.*

- Claims reimbursed with one-way mileage greater than 50 miles.
- Ambulance services billed to Medicaid that are potentially covered by Medicare for dually eligible recipients.
- Potential duplicate payments where payments were made for the same recipient on the same date of service with the same procedure code and modifier.
- Transportation service claims where base codes are not accompanied with corresponding mileage codes.
- Potential duplicate claims for ambulance transport services billed to both the Medicaid and Medicare programs as the primary insurer for the same recipient, on the same date of service, for the same procedure codes, procedure code modifiers and units.
- Payments made for services to deceased patients for dates of service after the date of death.
- Claims for transport services billed while the recipient was a hospital inpatient.

When performing our audit fieldwork, we reviewed all available documentation for claims identified by our exception testing (i.e., 100 percent review). All claims analyzed as part of our exception testing were separated from the remainder of the Provider's population of claims so as not to double count and overstate any potential findings.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we selected two statistically random samples: one for ambulance services consisting of 352 RDOS and one for ambulette services consisting of 213 RDOS. The total results were then projected across the entire population to determine the total findings.

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

Our fieldwork was primarily performed between March 2008 and April 2009.

RESULTS

We identified findings of $29,518.97 for services in our exception testing. Additionally, we identified findings from our samples that when projected total $129,687. Together, our findings from our exception testing and projected samples total $159,205.97, the bases of which are discussed below. During the course of the audit, however, the Provider repaid ODJFS a total of $1,486.73 for identified overpayments in our exception testing leaving a net repayment due of $157,719.24.

Results of Exception Testing

We performed exception testing on the Provider's paid claims for the following issues: claims reimbursed with one-way mileage greater than 50 miles, duplicate payments, payments made for deceased patients after their date of death, duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs as the primary insurer, ambulance services billed to

Medicaid that are potentially covered by Medicare for dually eligible recipients, services billed while recipient was a hospital inpatient, and ambulette transportation service claims where base codes are not accompanied with corresponding mileage codes. After a review of detailed records, however, our exception tests were negative for services to deceased patients and for ambulance services where base codes lacked corresponding mileage codes. The results of our review are as follows.

Transports Greater than 50 Miles

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

> ***
>
> (H) Medical transportation providers, when providing a non-emergency ground ambulance, or ambulette service must document the reason for transport when the destination occurs outside of the patient's community, (a fifty mile radius from the patient's residence). Mileage greater than fifty miles will not be covered if the provider is unable to produce the documentation which gives the reason for the transport to be out of the patient's community.
>
> ***

We initially identified 1,260 services for trips exceeding 50 one-way miles. Our analysis revealed seven mileage services that lacked documentation to justify the transport to be out of the patient's community. We therefore disallowed the reimbursement for mileage in excess of 50 miles (one-way). For the remaining services we identified the following 457 errors that resulted in findings:

- 154 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 102 services where the Provider did not supply a certificate of medical necessity (CMN), which certifies the basis for the necessity of the transport;
- 58 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 56 services where the number of miles paid exceeded the amount supported in the Provider's documentation;
- 40 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 19 services where either no documentation was received to verify the services occurred or incomplete documentation (e.g., incomplete street address) was received to support that the service billed had actually been rendered;
- 18 services where the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 8 services where the CMN was either not dated or did not cover the date of service; and

- 2 services where the patient was transported by ambulette; however, the Provider submitted an ambulance CMN.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $21,546.77 were made on the amount reimbursed to the Provider for the errors listed above.

Duplicate Payments

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

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

We identified 642 services where the Provider appeared to have billed for more than one transport for the same recipient on the same date of service. Our analysis revealed that 14 services were billed as duplicates. Our review of the remaining 628 services identified the following 400 errors that resulted in findings:

- 153 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 72 services where there the CMN was completed by an unauthorized practitioner per the Ohio Admin. Code, or no attending practitioner was identified for instances when an authorized proxy signed the CMN;
- 56 services where the CMN supplied did not cover the date of service;
- 34 services where either the CMN was not signed by an authorized practitioner or an illegible signature was not accompanied with identifying information;
- 30 services where the provider did not supply a CMN;
- 22 services where the signature of the practitioner signing the CMN was not dated;
- 22 services where the CMN lacked the medical condition to support the medical necessity of the transport;
- 5 services lacked documentation (e.g., trip report) to support that the services billed had actually been rendered;
- 5 services where the number of miles paid exceeded the amount supported in the Provider's documentation; and
- 1 service where the Provider billed for advanced life support service but the trip report states that the service provided was basic life support.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $4,558.24 were made on the amount reimbursed to the Provider for

the errors listed above. During the course of the audit, however, the Provider repaid $10.25 of the identified overpayments to ODJFS, leaving a remaining amount due of $4,547.99.

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

Ohio Admin.Code 5101:3-1-05 states in pertinent part:

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(A) Definitions.

(1) "Medicare" is a federally financed program of hospital insurance (part A) and supplemental medical insurance (also called SMI and/or part B) for aged and disabled persons.

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(6) "Dual Eligibles or Dually Eligible Consumers" are individuals who are entitled to medicare hospital insurance and/or SMI and are eligible for medicaid to pay some form of medicare cost sharing…

(7) "Medicare Crossover Claim" means any claim that has been submitted to the Ohio department of job and family services (ODJFS) for medicare cost sharing payments after the claim has been adjudicated and paid by the medicare central processor, medicare carrier/intermediary or the medicare managed care plan and the medicare central processor or medicare carrier/intermediary has determined the deductible, coinsurance and/or co-payment amounts. Claims denied by the medicare carrier/intermediary or the medicare managed care plan are not considered medicare crossover claims…

***

(B) Medicare crossover process.

(1) The medicare program determines the portion of medicare cost sharing, if any, due to the provider based on medicare's business rules…

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(3) For medicare crossover claims, the total sum of the payments made by ODJFS, medicare and/or all other third party payers is considered payment in full…

> (b) If payment (other than the cost sharing amounts) is inadvertently received from both medicare and medicaid for the same service, the ODJFS claims adjustment unit must be notified in accordance with the provisions set forth in rule 5101:3-1-19.8 of the Administrative Code.
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> ***

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

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

Finally, Ohio Admin.Code 5101:3-15-03(A)(2)(j) states,

> Ambulance services to all eligible medicare patient are to be billed to medicare. If the patient has medicare coverage, the department will reimburse only part-B co-insurance and deductible amounts.

Our exception test initially identified 208 services where the Provider appeared to bill both Medicaid and Medicare as the primary payer for the same patient and service. We identified these services by matching claims where Medicaid paid the Medicare co-insurance and deductible amounts with those where Medicaid was billed directly and paid as primary insurer. The matching was done by recipient, date of service, procedure code and procedure code modifier. Our review revealed that Medicaid was billed and made payments for 25 services that were also paid by Medicare. Therefore, Medicaid made two payments for the same service resulting in an overpayment. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare.

The remaining services were not instances of duplicate payments; however, errors were noted for the following reasons:

- Five services where the Provider did not supply a CMN;
- One service where the attending practitioner did not certify that the patient met the conditions for a covered transport; and
- One service where there was no authorized attending practitioner identified.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $1,309.50 were made on the amount reimbursed to the Provider for the errors listed above. During the course of the audit, however, the Provider repaid $942.96 to ODJFS, leaving a net repayment due of $366.54.

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

Ohio Admin.Code 5101:3-1-05 states in pertinent part:

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> (C) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.
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> ***

We identified ambulance transport services that were provided to dually eligible recipients (persons who are eligible to receive benefits through Medicaid and are also eligible to receive benefits through Medicare Part B for ambulance transportation services). We removed the services rendered to the dually eligible patients from the remaining ambulance exception reports, the ambulance sample, and the sampled ambulance population to avoid double impact. We sent the Provider an exception report detailing those services potentially covered by Medicare that were still within 18 months of their date of service. The letter notified the Provider of our potential findings for 106 ambulance transport services, and requested supporting documentation showing proper billing to and reimbursement by Medicaid.

Based on our review of records and the Provider's written response, a total of 42 services were identified with Medicare eligibility; however, the Provider had adjusted or repaid 16 of these services prior to the initiation of our audit. We identified 26 services for which we took findings due to Medicare eligibility as follows:

- 13 services where the Provider had subsequently billed and received payment from Medicare after receiving payment from Medicaid;
- 10 services where the Provider acknowledged the finding and submitted a claim to Medicare for the services; and
- 3 services in which the Provider did not provide supporting substantive documentation explaining why Medicaid should have been billed as the primary payer.

In addition, we found seven services where the Provider furnished documentation that Medicare had denied the service but Medicaid had paid. A review of these 7 services found 4 services with 11 errors as follows:

- 2 services where the CMN supplied did not cover the date of service;
- 2 services where the signature of the practitioner on the CMN was not dated;
- 2 services where the CMN was not signed by an authorized practitioner per the Ohio Admin.Code or an illegible signature was not accompanied with identifying information;

- 2 services where the CMN received lacked the medical condition to support the medical necessity of the transport; and
- 1 service where the number of miles paid exceeded the amount supported in the Provider's documentation.

Findings totaling $1,227.16 were made on the amount reimbursed to the Provider for the errors listed above. During the course of the audit, however, the Provider submitted adjustments for 8 services totaling $271.33 to reimburse Medicaid after receiving payment from Medicare leaving $955.83 in overpayments.

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…
>
> ***

Our initial claims analysis identified 164 transportation services where the Provider appeared to have billed for an ambulette transport while the patient was a hospital inpatient. Our review found 37 services with 56 errors – 50 of these errors related to incomplete or missing CMNs. The 56 errors that resulted in findings are as follows:

- 28 services where the Provider did not supply a CMN;
- 10 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 6 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 6 services which lacked documentation (e.g., trip report) to support that the service billed had actually been rendered.
- 2 services where the CMN was not signed by an authorized practitioner per the Ohio Admin.Code or an illegible signature was not accompanied with identifying information;
- 2 services where the CMN supplied did not cover the date of service; and
- 2 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code or no attending practitioner was identified for instances when an authorized proxy signed the CMN.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $544.28 were made on the amount reimbursed to the Provider for the errors listed above.

Transportation Service Base Codes without Corresponding Mileage Codes

Ohio Admin.Code 5101:3-15-04(A)(1)(c) states:

> For the total reimbursement, the provider must bill the most appropriate code for the base service and the code for the loaded land ambulance mileage. Both codes must be modified with the appropriate medicaid covered point of transport modifiers.

Further, Ohio Admin.Code 5101:3-15-04(C)(1)(c) states:

> For the total reimbursement, the provider must bill the appropriate code for ambulette base service and the code for the loaded mileage. Both codes must be modified by the appropriate medicaid point of transport modifier.

We identified 30 services (25 ambulette services and 5 ambulance services) where the Provider appeared to have billed base codes without corresponding mileage codes. Our analysis found 14 ambulette services with a questionable Medicaid covered point of transport, as the services involved transportation from school back to the patient's residence. In addition, no CMNs were provided for these 14 services. The Provider agreed that these services were erroneously billed to Medicaid. Additionally, for one ambulette transport, the Provider had incorrectly billed mileage using the procedure code for an ambulance service instead of an ambulette service. A review of the Provider's ambulance services documentation found that all had accompanying mileage services.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $333.02 were made on the amount reimbursed to the Provider for the errors listed above. During the course of the audit, however, the Provider repaid $262.19 to ODJFS, leaving a net repayment due of $70.83.

Summary of Exception Testing

Total combined findings of $29,518.97 resulted from our exception tests. During the course of the audit, however, the Provider repaid $1,486.73 in identified exception test overpayments to ODJFS, leaving a net $28,032.24 in exception overpayments due. Some of the more common errors identified during our exception testing included transportation services lacking a CMN to justify the medical necessity of the service; services where the CMNs provided were not completed by authorized practitioners, were missing required information (e.g., medical condition), or indicated that the patients did not meet conditions for a covered transport; and instances where the number of miles billed exceeded the amount supported in the Provider's documentation.

Results of Statistical Samples

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

> "Audit" means a formal postpayment examination, made in accordance with generally accepted auditing standards, of a medicaid provider's records and documentation to determine program compliance, the extent and validity of services paid for under the medicaid program and to identify any inappropriate payments. The department shall have the authority to use statistical methods to conduct audits and to determine the amount of overpayment. An audit may result in a final adjudication order by the department.

We selected two statistically random samples that were stratified based on the amount paid for services. One sample was for ambulance services and the other was for ambulette services. Our samples were chosen from the remaining population of services after removing all claims associated with our exception testing.

The findings were then projected across the total sampled populations, resulting in a total finding of $129,686.99

Ambulance Services Sample – Detailed Results

Our stratified random sample of 352 ambulance RDOS (involving 1,008 services) identified 83 RDOS (231 services) with a combination of 447 errors resulting in a projected population overpayment of $59,680. There were services that had more than one error; however, only one finding was made per service. The bases for these errors are presented below.

Issues with Certificates of Medical Necessity

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).

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Additionally, 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 documentation specified is not maintained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.
>
> ***
>
> (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; and…
>
> ***
>
> (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. The professional letters "R.N." must follow the nurse's last name or;
>
> 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…

(c) Medical condition

The practitioner certification form must state the specific medical conditions related to the ambulatory status of the patient which contraindicate transportation by any other means on the date of the transport, and use the correct form which specifies the mode of medical transportation (ambulance or ambulette) the patient will require. The attending practitioner must clearly specify the condition of the patient which renders transport by ambulance or ambulette medically necessary.

(d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission.

***

During our review of the documentation submitted by the Provider, we found numerous errors with practitioner certification forms (i.e., CMNs), which certify the basis for the necessity of the transport. Based on our review, we took findings due to the following 430 errors:

- 168 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 59 services where the CMN was not signed by an authorized practitioner per the Ohio Admin.Code or an illegible signature was not accompanied with identifying information;
- 49 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 43 services where the CMN supplied did not cover the date of service;
- 43 services where the signature of the practitioner signing the CMN was not dated;
- 38 services where the Provider did not supply a CMN;
- 28 services where the CMN received lacked the medical condition to support the medical necessity of the transport; and
- 2 services where the patient was transported by ambulance and the Provider billed for an ambulance service; however, an ambulette CMN was supplied as support.

Without a properly completed CMN, we could not determine the medical necessity of the transportation service. We therefore disallowed the reimbursement for those services with an improperly completed CMN and used this amount in calculating the projected finding.

Transportation Services Lacking Supporting Documentation

Ohio Admin.Code 5101:3-15-02 (E)(2)(a) states:

> 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

Additionally, Ohio Admin.Code 5101:3-1-17.2 (D) states:

> 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 10 services lacked documentation (e.g., trip report) to support the service billed had actually been rendered. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Incorrectly Billed Mileage

Ohio Admin.Code 5101:3-15-01(A)(14) states in pertinent part:

> ***
>
> "Loaded mileage" is defined as the number of miles a patient is transported in the ambulance or ambulette to or from a Medicaid covered service….
>
> ***

Additionally, 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 seven services where the Provider was overpaid mileage for transports. In these instances, we determined that the Provider billed in excess of what its records supported. We therefore disallowed the reimbursement for the excess billed mileage and used this amount in calculating the projected finding.

Summary of Ambulance Sample Findings

The overpayments identified for 83 of 352 RDOS (involving 231 of 1,008 services) from our stratified random sample of ambulance transportation services were projected across the Provider's population of ambulance paid recipient dates of service, excluding those already selected for 100 percent review. This resulted in a projected overpayment amount of $71,466 with a precision of plus or minus $14,043 (19.65 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 $59,680. This allows us to say that we are 95 percent certain the population overpayment amount is at least $59,680. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Ambulette Services Sample – Detailed Results

Our stratified random sample of 213 ambulette RDOS (involving 878 services) identified 37 RDOS (139 services) with a combination of 286 errors resulting in a projected population overpayment of $70,007. There were services that had more than one error; however, only one finding was made per service. The bases for these errors are presented below.

Issues with Certificates of Medical Necessity

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).

***

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 documentation specified is not maintained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.

(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. The professional letters "R.N." must follow the nurse's last name or;

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…

(c) Medical condition

The practitioner certification form must state the specific medical conditions related to the ambulatory status of the patient which contraindicate transportation by any other means on the date of the transport, and use the correct form which specifies the mode of medical transportation (ambulance or ambulette) the patient will

require. The attending practitioner must clearly specify the condition of the patient which renders transport by ambulance or ambulette medically necessary.

(d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission.

***

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

(a) The ambulette services must be medically necessary…

***

During our review of the documentation submitted by the Provider, we found numerous errors with the practitioner certification form (i.e., CMN), which certifies the basis for the necessity of the transport. Based on our review, we took findings due to the following 274 errors:

- 90 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 82 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 30 services where the CMN was not signed by an authorized practitioner per the Ohio Admin.Code or an illegible signature was not accompanied with identifying information;
- 28 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 24 services where the Provider did not supply a CMN;
- 12 services where the CMN supplied did not cover the date of service; and
- 8 services where the attending practitioner or proxy signed but did not date the signature on the CMN.

Without a properly completed CMN, we could not determine the medical necessity of the transportation service. We therefore disallowed the reimbursement for those services with an improperly completed CMN and used this amount in calculating the projected finding.

Transportation Services Lacking Supporting Documentation

Ohio Admin.Code 5101:3-15-02 (E)(2)(a) states:

> 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

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

> 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 two services lacked documentation (e.g., trip report) to support the service billed had actually been rendered. The amounts reimbursed for these services were used in calculating the projected finding.

Incorrectly Billed Mileage

Ohio Admin.Code 5101:3-15-01(A)(14) states in pertinent part:

> ***
>
> "Loaded mileage" is defined as the number of miles a patient is transported in the ambulance or ambulette to or from a Medicaid covered service….
>
> ***

Additionally, 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 10 services where the Provider was over paid mileage for transports. In these instances, we determined that the Provider billed in excess of what its records supported. We therefore disallowed the reimbursement for the excess billed mileage and used this amount in calculating the projected finding.

Summary of Ambulette Sample Findings

The overpayments identified for 37 of 213 RDOS (involving 139 of 878 services) from our stratified random sample of ambulette transportation services were projected across the Provider's population of ambulette paid recipient dates of service, excluding those already selected for 100 percent review. This resulted in a projected overpayment amount of $140,325 with a precision of plus or minus $48,778 (34.76 percent) at the 95 percent confidence level. However, since the obtained precision range was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower-limit estimate using the lower limit of a 90 percent confidence interval (equivalent to the method used in Medicare audits).

Because of the moderate skewness in the sample results an additional lower limit adjustment was made[4] and a final adjusted lower limit finding was made for $70,007. This allows us to say that we are 95 percent certain the population overpayment amount is at least $70,007. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Summary of Findings

A total of $159,205.97 in findings was identified. These findings result from the combination of our exception testing ($29,518.97) and our statistical sample projections ($129,687). During the course of the audit, however, the Provider repaid ODJFS a total of $1,486.73 for identified overpayments in our exception testing leaving a net repayment due of $157,719.24. For those services selected in our exception testing and samples, we reviewed all corresponding records in their entirety (i.e., 100 percent review).

Matters for Attention

Although the following matters did not result in monetary findings during the current audit, we are bringing them to the attention of the Provider as areas of non-compliance as they could result in future findings. We are also bringing these issues to the attention of ODJFS as the state single agency responsible for the Medicaid program in Ohio, ODJFS is well positioned to educate providers and improve system controls to curtail these issues.

[4] *Correction in lower limit confidence level using method described in "Sampling Methods for the Auditor, an Advanced Treatment" by Herbert Arkin, McGraw-Hill, 1982. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, vol. 1, Cambridge University Press, New York, 1954, table 42.*

Ambulance Services Billed to Medicaid Potentially Covered by Medicare

Ohio Admin.Code 5101:3-1-05 states in pertinent part:

> ***
>
> (C) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.
>
> ***

Based on our testing, we identified 659 ambulance services that were provided to dually eligible recipients that were paid for by Medicaid that were potentially covered by Medicare Part B. With Medicare Part B reimbursement, Medicaid would have been the secondary payor, and would have only reimbursed the Provider for the Medicare coinsurance and deductible amounts. However, since 553 of these services were beyond the time period in which they could have been re-billed to Medicare, no final determination could be made or finding collected. Medicaid could have paid as much as $16,950.90 for these services.

In order to avoid future findings in this area, we recommend that the Provider review its procedures to ensure that recipient eligibility is fully determined and that Medicare and other insurance carriers are billed prior to Medicaid, as it is the payor of last resort.

Incomplete Patient Certification on Ambulette CMNs

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

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

> and the individual is physically able to be safely transported in a wheelchair.
>
> ***

During the course of our audit, we identified 356 services where the attending practitioner did not certify that an ambulance was not required on the ambulette CMN supplied by the Provider, per the Ohio Admin.Code. A majority of these services occurred in conjunction with other errors, including those related to the CMN.

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

Other Observations

We reviewed the Provider's employee files and other documentation maintained to determine if the Provider complied with driver requirements per the Ohio Administrative Code.

The results, as follows, did not result in monetary findings; 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 56 drivers (34 ambulance drivers and 22 ambulette drivers) to determine if required procedures were followed and required documentation was kept on file. Our results are as follows:

Lack of Driving Record Reviews

Ohio Admin.Code 5101:3-15-02(B)(2)(f) states:

> Effective January 1, 2004, each ambulance 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 ambulance driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

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 34 ambulance personnel files found 24 drivers where there was no evidence of a BMV or equivalent driving record review. In addition, of the 10 ambulance driving records reviewed, there were 3 ambulance drivers for whom there was no evidence that the driving records were provided annually. Also, of the 22 ambulette driving records reviewed, there were 21 ambulette drivers for whom there was no evidence that the driving records were provided annually.

Lack of Criminal Background Checks for Drivers

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 of 22 ambulette driver personnel files found 6 where there was no evidence that a criminal background check was performed.

Lack of Medical and Drug Screening

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 22 ambulette driver personnel files found that 3 lacked medical statements and 3 lacked drug screen results.

Lack of Required Training

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

***

(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 22 ambulette driver personnel files found that 1 lacked evidence of passenger assistance training.

PROVIDER'S RESPONSE

Detailed lists of services for which we took findings were mailed to the Provider on June 26, 2009. The Provider was afforded 10 business days from receipt of the detailed lists to furnish additional documentation to substantiate the services for which we took findings or otherwise respond in writing. Upon receipt of the detailed lists, the Provider requested an additional 20 business days to respond and furnish additional information. The additional documentation received on August 7, 2009, was reviewed and findings were adjusted as appropriate. A draft audit report was then mailed to the Provider on September 1, 2009, for final review and response. Upon receipt of the final draft the Provider stated that they were in agreement with our adjusted findings and wished to make repayment. We coordinated with ODJFS' Office of Legal Services to make arrangements for the Provider to repay the amount due plus accrued interest to the Medicaid Program. On October 1, 2009 the full repayment and interest was received by ODJFS.

APPENDIX I

Summary of Sample Record Analysis for LifeStar Ambulance, Inc.
For the period April 1, 2004 through March 31, 2007
Ambulance Sample Population – Provider Number 0627665

Description	Audit Period [April 1, 2004 - March 31, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid ambulance services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$363,714.53***
Number of Population Recipient Dates of Service	**3,109**
Number of Population Services Provided	**7,738**
Amount Paid for Services Sampled	***$49,002.95***
Number of Recipient Dates of Service Sampled	***352***
Number of Services Sampled	***1,008***
Estimated Overpayment using Point Estimate	***$71,466***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $14,043 (19.65%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/- $11,785 (16.49%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits)	***$59,680***

APPENDIX II

Summary of Sample Record Analysis for LifeStar Ambulance, Inc.
For the period April 1, 2004 through March 31, 2007
Ambulettee Sample Population – Provider Number 0627665

	Audit Period [April 1, 2004 - March 31, 2007]
Type of Examination	Stratified Random Sample
Description of Population Sampled	All paid services excluding Medicare co-payments, and exceptions tests
Total Medicaid Amount Paid For Population Sampled	***$950,359.59***
Number of Population Recipient Dates of Service	**17,149**
Number of Population Services Provided	**64,324**
Amount Paid for Services Sampled	***$13,868.82***
Number of Recipient Dates of Service Sampled	***213***
Number of Services Sampled	***878***
Estimated Overpayment using Point Estimate	***$140,325***
Precision of Overpayment Estimate at 95% Confidence Level (Two-Tailed Estimate)	***+/- $48,778 (34.76%)***
Precision of Overpayment Estimate at 90% Confidence Level (Two-Tailed Estimate)	***+/-40,936 (29.17%)***
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits) corrected for skewness[5]	***$70,007***

[5] *Correction in lower limit confidence level using method described in "Sampling Methods for the Auditor, an Advanced Treatment" by Herbert Arkin, McGraw-Hill, 1982. This technique uses tables provided by E.S. Pearson and H.O. Hartley, Biometrica Tables for Statisticians, vol. 1, Cambridge University Press, New York, 1954, table 42.*

Mary Taylor, CPA
Auditor of State

LIFESTAR AMBULANCE SERVICE, INC.

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
OCTOBER 15, 2009

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