Mary Taylor, CPA
Auditor of State

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Urgent Care Transport, Inc.

A Compliance Audit by the:

Medicaid/Contract Audit Section

Mary Taylor, CPA
Auditor of State

December 31, 2009

Dr. Timothy Wheeler, President
Urgent Care Transport, Inc.
1563 Winchester Ave.
Ashland, Kentucky 41101

Dear Dr. Wheeler:

Attached is our report on Medicaid reimbursements made to Urgent Care Transport, Inc., Medicaid provider number 2164689, 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 $455,239.99 in findings plus $85,310.73 in interest accruals totaling $540,550.72 that are repayable to ODJFS. The findings in the report are a result of non-compliance with Medicaid reimbursement rules published in the Ohio Administrative Code. After December 31, 2009, additional interest will accrue at $99.78 per day until repayment occurs. Interest is 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. However, if you are in agreement with the findings contained herein, you may expedite repayment by contacting ODJFS' Office of Legal Services at (614) 466-4605.

Copies of this report are being sent to Urgent Care Transport, 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).

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

Sincerely,

Mary Taylor

Mary Taylor, CPA
Auditor of State

cc: Kenny Boggs, Statutory Agent, Urgent Care Transport, 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 Urgent Care Transport, Inc., (hereafter called the Provider), provider number 2164689, headquartered at 1563 Winchester Avenue, Ashland, Kentucky, 41101. 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 $455,239.99 in findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code.[1] Additionally, we assessed accrued interest of $85,310.73, in accordance with Ohio Admin.Code 5101:3-1-25, for a total of $540,550.72 which is repayable to ODJFS as of the release of this audit report. Additional interest of $99.78 per day will accrue after December 31, 2009, until repayment.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the Ohio Medicaid Provider Handbook. A fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services.[2] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules to ensure that services billed are properly documented and consistent with professional standards of care; medical necessity; and sound fiscal, business, or medical practices.

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

Ohio Admin.Code 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant

[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 April 15, 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 $863,753.45 for 13,897 services rendered on 4,717 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.
- Base codes billed for more than one unit.
- 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.
- Transportation service claims where base codes are not accompanied with corresponding mileage codes.
- Payments made for services to deceased patients for dates of service after the date of death.

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 transportation services, we selected a statistically random sample for ambulance services consisting of 202 RDOS. The total results were then projected across the entire population of ambulance services to determine the total findings. Due to the relative low number of ambulette services compared to ambulance services, however, we conducted a 100 percent census of all ambulette services (165 RDOS).

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 April 2008 and January 2009.

RESULTS

We identified findings of $99,361.10 for services in our exception testing. Additionally, we identified findings from our ambulance sample that when projected total $344,593, while our ambulette census identified findings of $11,285.89. Together, our findings from our exception testing, projected sample, and census total $455,239.99, the bases of which are discussed below.

Results of Exception Testing

We performed exception testing on the Provider's paid claims for the following issues: 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, duplicate payments, base codes billed for more than one unit, base codes without corresponding mileage codes, duplicate claims for ambulance services paid for by both the Medicaid and Medicare programs as the

primary insurer, and claims for transports for deceased patients. 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 1,060 services for trips exceeding 50 one-way miles. Our analysis revealed 52 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 2,059 errors that resulted in findings:

- 568 services where the Provider did not supply a certificate of medical necessity (CMN), which certifies the basis for the necessity of the transport;
- 500 services lacked documentation (e.g., trip report) to support that the service billed had actually been rendered;
- 284 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 180 services where the documentation in support of the transport did not contain complete address of the pick-up or drop-off location;
- 154 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 96 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 74 services where the CMN provided does not cover the date of service;
- 52 services where the CMN was not dated by the attending practitioner;
- 47 services where the number of miles paid exceeded the amount supported in the Provider's documentation;
- 46 services where the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 36 services where the Provider billed for services rendered by its sister company (i.e., Portsmouth Ambulance Service, Inc.);

- 18 services that were provided by a vehicle that lacked a permit from the Ohio Medical Transportation Board (OMTB); and
- 4 services that appeared to duplicately billed.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $95,379.19 were made on the amount reimbursed to the Provider for the errors listed above.

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.
>
> ***

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 17 months of their date of service. The letter notified the Provider of our potential findings for 46 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 35 services were identified with Medicare eligibility and we took findings as follows:

- 22 services where the Provider did not provide a Medicare denial (i.e., explanation of benefit) or supporting substantive documentation explaining why Medicaid should have been billed as the primary payer; and
- 13 services where the Provider billed and received payment from Medicare after receiving payment from Medicaid for the same service.

In addition, we found another 76 errors associated with these services as follows:

- 14 services where the documentation in support of the transport did not contain complete address of the pick-up or drop-off location;

- 12 services where the Provider did not supply a certificate of medical necessity CMN;
- 10 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 10 services lacked documentation (e.g., trip report) to support that the services billed had actually been rendered;
- 8 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;
- 4 services where the CMN provided does not cover the date of service;
- 4 services where the CMN was not dated by the attending practitioner;
- 3 services that were provided by a vehicle that lacked a permit from OMTB;
- 2 services where the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 2 services where the Provider billed for services rendered by its sister company (i.e., Portsmouth Ambulance Service, Inc.); and
- 1 service where the number of miles paid exceeded the amount supported in the Provider's documentation;

There were services that had more than one error; however, only one finding was made per service. Findings totaling $1,540.62 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 34 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 the following 97 errors that resulted in findings:

- 20 services where the documentation in support of the transport did not contain complete address of the pick-up or drop-off location;
- 14 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 14 services where the CMN provided does not cover the date of service;

- 10 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 10 services where the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 10 services where the CMN was not dated by the attending practitioner;
- 10 services where the Provider billed for services rendered by its sister company (i.e., Portsmouth Ambulance Service, Inc.);
- 8 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.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $740.56 were made on the amount reimbursed to the Provider for the errors listed above.

Base Codes Billed for More Than One Unit

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

> ***
>
> (A) To…submit claims only for services actually performed…
>
> ***
>
> (D) To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.
>
> ***

We identified one service where the Provider billed two base codes instead of one and another where the Provider billed 14 base codes instead of one. We analyzed records for all 10 services associated with the 2 base codes and identified the following 33 errors:

- 5 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 5 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 5 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;

- 5 services where the Provider billed for services rendered by its sister company (i.e., Portsmouth Ambulance Service, Inc.);
- 5 services where the documentation in support of the transport did not contain complete address of the pick-up or drop-off location;
- 4 services where the Provider did not supply a CMN; and
- 4 services lacked documentation (e.g., trip report) to support that the services billed had actually been rendered.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $697.45 were made on the amount reimbursed to the Provider for the errors listed above.

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

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

> ***
>
> (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.
>
> ***
>
> (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…
>
> ***
>
> (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.
>
> ***

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 identified 15 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 for these claims. We identified six services where Medicaid paid for services that were also paid by Medicare. For four of these services Medicaid properly denied the base code due to Medicare coverage but paid the billed mileage, resulting in duplicate payments. Because Medicaid is considered "the payer of last resort," it paid for services already covered by Medicare. For the remaining 9 services we identified the following 22 errors that resulted in findings:

- 6 services where the documentation in support of the transport did not contain complete address of the pick-up or drop-off location;
- 4 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- 4 services where the CMN was not signed by the attending practitioner or an illegible signature was not accompanied with identifying information;
- 4 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 2 services where the CMN was not dated by the attending practitioner; and
- 2 services where the CMN provided does not cover the date of service.

There were services that had more than one error; however, only one finding was made per service. Findings totaling $394.24 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 medical 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 five ambulance services where the Provider appeared to have billed base codes without corresponding mileage codes. We analyzed records for all five services and identified the following 10 errors:

- Two services where the Provider did not supply a CMN;
- Two services lacked documentation (e.g., trip report) to support that the services billed had actually been rendered;
- Two services where the documentation in support of the transport did not contain complete address of the pick-up or drop-off location;
- One service that was provided by a vehicle that lacked a permit from OMTB;
- One service where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code;
- One service where the CMN received lacked the medical condition to support the medical necessity of the transport; and

- One service where the Provider billed for a service rendered by its sister company (i.e., Portsmouth Ambulance Service, Inc.).

There were services that had more than one error; however, only one finding was made per service. Findings totaling $328.84 were made on the amount reimbursed to the Provider for the errors listed above.

Services Billed for Deceased Recipients

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

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

Additionally, Ohio Admin.Code 5101:3-15-03(A)(2)(i) states in pertinent part:

> Under the Medicaid program services to individuals who are deceased are not covered…
>
> ***

Our analysis identified eight services where the transports occurred after the recipient's date of death. Therefore, a finding totaling $280.20 was made on the amount reimbursed to the Provider for these services.

Summary of Exception Testing

Total combined findings of $99,361.10 resulted from our exception tests. Some of the more common errors identified during our exception testing included transportation services lacking supporting documentation including 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; services provided by non-permitted vehicles; and services billed by the Provider but furnished by its sister company.

Results of Statistical Sample and Census

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 a statistically random sample that was stratified based on the amount paid for ambulance services. Due to the relative low number of ambulette services compared to ambulance services, we conducted a 100 percent census of all ambulette services. Services in our sample and census were chosen from the remaining population of services after removing all claims associated with our exception testing.

In addition to the actual findings of $11,285.89 identified in our ambulette census, the findings for our ambulance sample were projected across the total sampled populations, resulting in a total, combined finding of $355,878.89.

Ambulance Services Sample – Detailed Results

Our stratified random sample of 202 ambulance RDOS (involving 734 services) identified 194 RDOS (711 services) with a combination of 1,684 errors resulting in a projected population overpayment of $344,593. 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).
>
> ***

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 961 errors:

- 577 services where the Provider did not supply a CMN;
- 106 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 90 services where the CMN was completed by an unauthorized practitioner per the Ohio Admin.Code or the name of the practitioner was missing;
- 84 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 52 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 supplied did not cover the date of service; and
- 24 services where the signature of the practitioner signing the CMN was not dated.

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 537 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.

Incomplete Point of Transport Information

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

> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department . . .
>
> (2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .
>
> (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and
>
> ***

We identified 152 services where the Provider did not provide complete addresses for points of transport origin or destination. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Transports Furnished by Non-permitted Vehicles

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

> Federal, state and local laws and regulations
>
> Providers of air ambulance, ambulance and ambulette services must operate in accordance with all applicable local, state, and federal laws and regulations, including any applicable requirements developed by the Ohio medical transportation board as provided in Chapter 4765. of the Revised Code or applicable requirements developed for transportation in accordance Chapter 4766. of the Revised Code.

Ohio Admin.Code 5101:3-15-02(B)(1) states in pertinent part:

Certification Requirements

> All providers of ground ambulance services must be certified under and participating in Medicare. All Ohio providers of ground ambulance services must be licensed in accordance with Chapter 4766. of the Revised Code and comply with all specifications of Chapter 4766. of the Revised Code, unless the provider is exempt from licensure as specified in section 4766.09 of the Revised Code…

Additionally, Ohio Rev.Code Section 4766.07(A) states in pertinent part:

> Except as otherwise provided by rule of the Ohio medical transportation board, each emergency medical service organization, nonemergency medical service organization, and air medical service organization subject to licensure under this chapter shall possess a valid permit for each ambulance, ambulette, rotorcraft air ambulance, fixed wing air ambulance, and nontransport vehicle it owns or leases that is or will be used by the licensee to perform the services permitted by the license…

We identified 10 services where the Provider furnished ambulance services with vehicles that did not have permits from OMTB as required by law. We therefore disallowed the reimbursement for these services and used this amount in calculating the projected finding.

Billing for Services Not Performed

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 billed for services rendered by its sister company (i.e., Portsmouth Ambulance Service, Inc.). 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 10 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.

Billing for Cancelled Trips

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

> ***
>
> (L) Transport of an individual to a Medicaid covered service that was cancelled or unavailable may be reimbursed if:
>
> ***

(2) The transportation provider had no prior notice of the unavailability or cancellation from the Medicaid covered service provider or the individual.
(3) The medical transportation provider obtained written documentation…from the medicaid covered service provider before billing the department for transport. The written documentation must include:
    (a) A business name, address, and phone number of the Medicaid covered service provider.
    (b) The date and time of the cancelled or unavailable service,
    (c) A description of the reason(s) for the cancellation or unavailability of the service,
    (d) A statement indicating that the Medicaid covered service provider was unable to notify the Medicaid transportation provider or the individual of the cancellation or unavailability of the service prior to the arrival at the destination, and
    (e) The printed name and signature of the business/office manager or nurse.

(4) For reimbursement, the medical transportation provider must use modifier U6, service unavailable/cancelled; for both the base rate and loaded mileage procedure codes

(5) The reason for the cancellation or unavailability of the service did not occur due to the action or inaction of the individual being transported or the medical transportation provider.

Our review of the Provider's documentation identified four transportation services where the patient was not seen by the doctor but the Provider did not obtain the required documentation that the service was cancelled nor bill using the required U6 modifier. The amounts reimbursed for these services were used in calculating the projected finding.

Summary of Ambulance Sample Findings

The overpayments identified for 194 of 202 RDOS (involving 711 of 734 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 $344,593 with a precision of plus or minus $11,828 (3.43 percent) at the 95 percent confidence level. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Ambulette Services Census – Detailed Results

Our census (100 percent review) of 165 ambulette RDOS (651services) identified services with a combination of 1,340 errors resulting in an actual overpayment of $11,285.89. 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.

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.

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;
>
> ***

We determined that 636 services lacked any documentation (e.g., trip report to support the service billed had actually been rendered and also lacked a certificate of medical necessity

(CMN) to show that the service was medically necessary. The amounts reimbursed for these services were disallowed.

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:

(2) 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.

(3) 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), 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 CMN, which certifies the basis for the necessity of the transport. Based on our review, we took findings due to the following 36 errors:

- 8 services where the Provider did not supply a CMN;
- 8 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;
- 8 services where the attending practitioner did not certify that the patient met the conditions for a covered transport;
- 4 services where the CMN received lacked the medical condition to support the medical necessity of the transport;
- 4 services where the CMN supplied did not cover the date of service; and
- 4 services where the signature of the practitioner signing the CMN was not dated.

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.

Incomplete Point of Transport Information

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

> (1) Providers of air ambulance, ambulance and ambulette services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department . . .
>
> (2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. . . .
>
> (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and
>
> ***

We identified 16 services where the Provider did not provide complete addresses for points of transport origin or destination. We therefore disallowed the reimbursement for these services.

Transports Furnished by Non-permitted Vehicles

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

> Federal, state and local laws and regulations
>
> Providers of air ambulance, ambulance and ambulette services must operate in accordance with all applicable local, state, and federal laws and regulations, including any applicable requirements developed by the Ohio medical transportation board as provided in Chapter 4765. of the Revised Code or applicable requirements developed for transportation in accordance Chapter 4766. of the Revised Code.

Additionally, Ohio Rev.Code Section 4766.07(A) states in pertinent part:

> Except as otherwise provided by rule of the Ohio medical transportation board, each emergency medical service organization, nonemergency medical service organization, and air medical service organization subject to licensure under this chapter shall possess a valid permit for each ambulance, ambulette, rotorcraft air ambulance, fixed wing air ambulance, and nontransport vehicle it owns or leases that is or will be used by the licensee to perform the services permitted by the license…

We identified 14 services where the Provider furnished ambulette services with vehicles that did not have permits from the Ohio Medical Transportation Board as required by law. We therefore disallowed the reimbursement for these services.

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 two 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.

Summary of Ambulette Census Findings

Our census (100 percent review) of 165 ambulette RDOS (651 services) identified errors with every service rendered. As a result of our review we identified actual findings of $11,285.89.

Summary of Findings

A total of $455,239.99 in findings was identified. These findings result from the combination of our exception testing ($99,361.10), our projected statistical sample of ambulance services ($344,593), and our census of ambulette services ($11,285.89). For those services selected in our exception testing, samples and census, 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.

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 initially identified 333 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 287 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 $10,173.38 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 10 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 a selection of the Provider's employee files and other documentation maintained to determine if the Provider complied with select driver and vehicle requirements per the Ohio Administrative Code. We selected drivers for testing from all those who were identified as part of our exception and sample tests, using a random number generator. However, only ambulance

drivers were selected. 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 26 ambulance drivers to determine if required procedures were followed and required documentation was kept on file. Our results are as follows:

Lack of Driver and Attendant EMT Qualification

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

> Driver and attendant qualifications
>
> Providers of ambulance services must maintain on file records verifying that drivers and attendants meet the following requirements on the date of the transportation service:
>
> (a) Each individual who functions primarily as an ambulance driver complies with local, state and federal laws and regulations.
>
> (b) Qualifications of each ambulance driver meets the specifications set forth in Chapters 4765. and 4766. of the Ohio Revised Code; and
>
> (c) Each ambulance attendant must have a current emergency medical technician (EMT) certification card issued by the division of emergency medical services (EMS) under the Ohio department of public safety; and
>
> ***

Ohio Admin.Code 5101:3-15-03 (A)(2)(e) states:

> The transport must be staffed with the appropriate basic crewmembers corresponding to the level of service billed.
>
> (i) The basic crew for a basic life support ambulance is defined as at least two emergency medical technicians (EMTs) as described in section 4765.43 of the Revised Code and the driver if the driver is not one of the two emergency medical technicians.

(ii) The basic crew for an advanced life support ambulance is defined as at least two emergency medical technicians (EMTs) as described in section 4765.43 of the Revised Code and the driver if the driver is not one of the two emergency medical technicians.

(iii) The basic crew for specialty care transport must be in accordance with Chapters 4765. and 4766. of the Revised Code.

Our review of personnel records for 26 drivers who provided ambulance services found that 8 lacked evidence of an EMT certification.

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.

Our review of 26 personnel files revealed that all 21 lacked evidence of a BMV or equivalent driving record review, while only 2 were obtained within 14 days of hire.

Driver's Licenses

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

> 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. 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.
>
> ***
>
> (d) Copies of the pilot's/driver's/attendant's certification or licensure, which must be current at the time of transport, in accordance with paragraph (D)(2) of this rule for air ambulance, paragraph (B)(2) of this rule for ambulance and paragraph (C)(3) of this rule for ambulette.

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

> Driver and attendant qualifications
> Providers of ambulance services must maintain on file records verifying that drivers and attendants meet the following requirements on the date of the transportation service:
>
> (a) Each individual who functions primarily as an ambulance driver complies with local, state and federal laws and regulations.
>
> ***

Our review of 26 personnel files revealed that 9 lacked evidence of a valid driver's license.

Lack of Required Vehicle Inspections

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

> (C) Eligible providers of ambulette services.
>
> (2) All providers of ambulette services must comply with the following regulations and provide documentation of compliance to the department upon request:
>
> (a) Each provider must conduct daily inspection and testing of the hydraulic lift or access ramp prior to transporting any wheelchair bound patient; and
>
> (b) Each provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum that the following was performed: the daily inspection and testing of the wheelchair restraints, wheelchair lifts and/or access ramps, the lights, the windshield wipers/washers, the emergency equipment, mirrors, and the brakes; and
>
> (c) Each provider must provide evidence that at least an annual vehicle inspection was completed on each vehicle by the Ohio state highway patrol safety inspection unit, or a certified mechanic, and the vehicle has been determined to be in good working condition.
>
> ***

While the Provider stated that it performs daily vehicle inspections, the Provider did not maintain documentation of the daily inspections.

PROVIDER'S RESPONSE

Detailed lists of services for which we took findings were mailed to the Provider on June 24, 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's legal counsel indicated that the Provider would not furnish any additional information. A draft audit report was then mailed to the Provider on September 4, 2009, for final review and response. Prior to AOS finalizing the audit, the Provider ceased operations. The Provider did not submit any written or verbal response to the audit report.

APPENDIX I

Summary of Sample Record Analysis for Urgent Care Transport, Inc.
For the period April 1, 2004 through March 31, 2007
Ambulance Sample Population – Provider Number 2164689

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	***$374,633***
Number of Population Recipient Dates of Service	**2,068**
Number of Population Services Provided	**7,161**
Amount Paid for Services Sampled	***$39,654***
Number of Recipient Dates of Service Sampled	***202***
Number of Services Sampled	***734***
Estimated Overpayment using Point Estimate	***$344,593***
Upper Limit Overpayment Estimate at 95% Confidence Level	***$356,422***
Lower Limit Overpayment Estimate at 95% Confidence Level	***$332,765***
Precision of Estimated Overpayment at 95% Confidence Level	***$11,828 (3.43%)***
Finding Amount	***$344,593***

Mary Taylor, CPA
Auditor of State

URGENT CARE TRANSPORT, INC.

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
DECEMBER 31, 2009

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