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TLC HEALTH CARE SERVICES, LLC DBA TLC TRANSPORTATION
LUCAS COUNTY

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

Ms. Vanessa Dunton, CEO
Mr. Christopher Jaquillard, President
TLC Health Care Services, LLC DBA TLC Transportation
5517 Telegraph Road
Toledo, Ohio 43612

RE: *Medicaid Provider Number 2254831*

Dear Ms. Dunton and Mr. Jaquillard:

We examined your (the Provider's) compliance with specified Medicaid requirements for driver qualifications, service documentation, and service authorization related to the provision of ambulette services during the period of January 1, 2009 through December 31, 2011. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid and compared the elements contained in the documentation to the Medicaid rules. In addition, we determined if the services were authorized in certificates of medical necessity. We also reviewed personnel records to verify that driver qualifications were met. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

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

Auditor's Responsibility

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

Internal Control Over Compliance

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

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Basis for Adverse Opinion on Medicaid Services

Our examination found material non-compliance with service documentation, service authorization and driver qualifications. In addition, the Provider billed for attendant services which were not provided. Also, the Provider did not submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable laws and regulations regarding Ohio Medicaid reimbursement; establishing and maintaining effective internal control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to driver and attendant qualifications, service documentation and service authorization for the period of January 1, 2009 through December 31, 2011.

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

We found the Provider was overpaid by Ohio Medicaid for services rendered between January 1, 2009 and December 31, 2011 in the amount of $127,014.76. This finding plus interest in the amount of $9,997.63 totaling $137,012.39 is due and payable to the ODM upon its adoption and adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM through its Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

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

Dave Yost
Auditor of State

September 19, 2014

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

COMPLIANCE EXAMINATION REPORT FOR TLC HEALTH CARE SERVICES, LLC DBA TLC TRANSPORTATION

Background

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

During the examination period, the Provider received reimbursement of $1,339,129.05 for 91,483 ambulette service lines, consisting of 45,679 base codes, 45,698 mileage codes and 106 attendant codes, rendered on 22,608 recipient dates of service (RDOS). A recipient date of service is defined as all services for a given recipient on a specific date of service. In addition, the Provider received reimbursement of $222,493.61 as a waiver provider through the Ohio Department of Aging and the Ohio Department of Developmental Disabilities. We noted that TLC Health Care Services DBA TLC Transportation was enrolled as a provider in 2002 as a partnership, in 2003 became incorporated and in 2004 became a limited liability company.

Some Ohio Medicaid recipients may be eligible to receive transportation services rendered by an ambulette provider. An ambulette is a vehicle designed to transport individuals sitting in wheelchairs. Ohio Admin. Code § 5160-15-01(A) Individuals who are non-ambulatory, able to be safely transported in a wheelchair, do not use passenger vehicles as transport to non-Medicaid services, and do not require an ambulance may be eligible for ambulette transportation. Ohio Admin. Code § 5160-15-03

Purpose, Scope, and Methodology

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

The scope of the engagement was limited to an examination of medical transportation services, specifically ambulette and attendant services, that the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2009 through December 31, 2011.

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed voided services, services paid at zero and services previously recouped by ODM's Surveillance and Utilization Review Section (SURS). We then removed 106 paid attendant services, 4 services reimbursed for recipients on dates when they were hospital inpatients per MITS/MMIS; and 25 services reimbursed for the same recipient on the same date as waiver services. We reviewed these extracted services in separate exception tests. The remaining services were split into two sub-populations; services with a U4 (origin point of school or workplace) or U7 modifier (destination point of school or workplace) and those without a

U4 or U7 modifier. We selected a simple random sample of services with a U4 or U7 modifier based on RDOS and a simple random sample of the remaining subpopulation of services (without a U4 or U7 modifier) based on RDOS to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). We then obtained the detailed services for all of the selected RDOS and tested all selected services during fieldwork.

An engagement letter was sent to the Provider on October 24, 2013 setting forth the purpose and scope of the examination. An entrance conference was held at the Provider's location on November 6, 2013. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. In response to the draft report, the Provider submitted additional documentation on September 5, 2014. We reviewed the documents for compliance and updated our results. The Provider submitted some documents that had been altered from the original record provided during our fieldwork. We did not consider the altered documents when we updated our results.

Results

We reviewed a statistical sample of 100 services (50 transports each with a corresponding mileage code) with a U4 or U7 modifier and identified three errors. One of the errors resulted in an overpayment of $4.32.

We also reviewed a statistical sample of 1,693 services (844 transports each with a corresponding mileage code and five additional mileage codes) without a U4 or U7 modifier and identified 189 errors. In certain instances, the non-compliance resulted in overpayments and the basis for our findings is described below in more detail. While certain services had more than one error, only one finding was made per service. We took exception with 58 of 422 statistically sampled recipient dates of service (161 of 1,693 services) from the random sample of the Provider's sub-population of paid services without a U4 or U7 modifier. Based on this error rate, we calculated the Provider's correct payment amount for this sub-population, which was $1,200,359.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $1,155,901.00 to $1,244,818.00 (+/- 3.70 percent.) We then calculated findings by subtracting the correct sub-population amount ($1,200,359.00) from the amount paid to the Provider for this sub-population ($1,325,809.51), which resulted in a finding of $125,450.51. A detailed summary of our statistical sample and projection results are presented in Appendix I.

Additionally, we reviewed the following services as exception tests:

- 106 attendant services and identified 106 errors;
- 4 transports when the recipient was a hospital inpatient per MITS/MMIS and identified 1 error; and
- 25 transports reimbursed for the same recipient on the same date as waiver services and identified 16 errors.

The basis for our findings is discussed below in more detail.

On January 17, 2012 the Provider responded to an ambulette questionnaire from ODM's Surveillance and Utilization Review Section and stated that the company maintained all records and documents necessary to substantiate transportation services. The Provider further responded that since the beginning of the business, it was aware of the requirement for a CMN to be on file in order for the ambulette transport to be covered by Medicaid and that in order for an attendant to be covered by Medicaid the attendant must be a qualified employee of the company.

A. Certificate of Medical Necessity

All transportation providers are required by Ohio Admin. Code § 5101:3-15-02(E)(2) to obtain a CMN that has been signed by an attending practitioner that documents the medical necessity of the transport. Ambulette providers must obtain the completed, signed and dated CMN prior to billing the transport. *See* Ohio Admin. Code §5101:3-15-02(E)(4)(d)

Our review of the statistical sample of services without a U4 or U7 modifier identified 39 transports for which there were no CMNs and an additional four transports where the CMN was not signed by an authorized practitioner. These 43 errors were used in the overall finding projection of $125,450.51 for this sample.

In addition, we noted CMNs for 81 transports that were present and signed by an authorized practitioner but were not complete. These CMNs did not consistently contain the medical condition which requires the patient to use an ambulette and/or did not indicate that the recipient met all of the criteria for an ambulette transport.

Recommendation:

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

B. Trip Documentation

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

Statistical Samples

Our review of the statistical sample of services without a U4 or U7 modifier found 11 transports with no documentation to support the transport and 15 transports in which mileage reimbursed was not supported by the documentation.

These 26 errors were used in the overall finding projection of $125,450.51 for this sample. We also noted 14 transports where the documentation did not include the driver name and/or drop off times.

Our review of the statistical sample of services with a U4 or U7 modifier found one transport where the mileage reimbursed was not supported by the documentation. This error resulted in an overpayment of $4.32. We also noted two transports where the documentation did not include the drop off time.

Exception Tests

Reimbursement for services when the recipient was a hospital inpatient

We tested four transports in which the recipient was a hospital inpatient per MITS/MMIS. We identified one transport for which the Provider had no service documentation. This error resulted in

an overpayment of $26.39. We performed no further testing on the three transports for which the Provider had supporting documentation.

Reimbursement for non-waiver and waiver service for the same recipient on the same day

We tested 25 transports for which the Provider received non-waiver and waiver reimbursement for the same recipient on the same day to determine if the Provider had proper documentation for the non-waiver service. We identified 16 transports in which the Provider received reimbursement from both a waiver and non-waiver billing for the same transport resulting in duplicate reimbursements. These errors resulted in an overpayment of $418.80.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Admin. Code § 5101:3-15-02. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Covered Service Limitations

Transport of a recipient for purposes other than for the receipt of Medicaid services and transports to services that are covered by any Home and Community Based Services waivers specified in division level 5101:3 of the Administrative Code are not covered. *See* Ohio Admin. Code § 5101:3-15-03(E)(9)and(13)

Our review of the statistical sample of services without a U4 or U7 modifier found the following non-compliance with covered service limitations:

- 14 transports that were not to a Medicaid covered service (pharmacy, YMCA, school and church); and
- 8 transports to a waiver covered service (adult day service and developmental disability day program).

These 22 errors were used in the overall finding projection of $125,450.51 for this sample.

Recommendation:

The Provider should develop and implement procedures to ensure that transports meet requirements to be a covered service prior to submitting claims for reimbursement. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

D. Driver Qualifications

All ambulette drivers must pass a criminal background check and have a signed medical statement from a licensed physician declaring the individual does not have a medical, physical or mental condition or impairment which could jeopardize the health or welfare of patients being transported. Also, each driver must undergo testing for alcohol and controlled substances by a certified laboratory and be determined to be drug free. Background checks, medical statements, and drug test results must be completed and documented before the driver begins providing ambulette services or within 60 days thereafter. Prior to employment, each driver must obtain first aid and Cardiopulmonary Resuscitation (CPR) certification (or have an Emergency Medical Technician

certification), provide a copy of his/her driving record from the Bureau of Motor Vehicles (BMV), and complete passenger assistance training. In addition, each driver must provide copy of BMV driving record on annual basis. *See* Ohio Admin. Code § 5101:3-15-02(C)(3)

We selected 12 employees from a list of drivers submitted by the Provider and reviewed the personnel files. Specific noncompliance issues identified include:

- 1 instance where an employee's driver's license was suspended for all but 13 days of employment and the same employee had no CPR or first aid certification rendering this driver ineligible to provide services;
- 1 instance where an employee's driver's license was suspended for approximately two months;
- 12 instances where no alcohol testing was performed;
- 1 instance where a driving record was not obtained within 14 days of application;
- 2 instances where a background check was obtained more than 60 days after the date of hire;
- 3 instances where a drug test was obtained more than 60 days after the date of hire; and
- 7 instances where there was a lapse in certification periods for CPR and/or first aid.

Our review of the statistical sample of services without a U4 or U7 modifier found three services provided by the ineligible driver and/or the driver during a license suspension. These three services are considered unallowable and were used in the overall finding projection of $125,450.51.

Recommendation:

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

E. Attendants

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

Our examination of 106 attendant services disclosed that the Provider had no documentation to support any of the paid attendant services. Upon further inquiry, the Provider stated that it did use attendants at one time but was unable to locate any supporting documentation. The Provider agreed to re-pay the reimbursed amount for attendant codes during our examination period. These 106 errors resulted in an overpayment of $1,114.74.

Recommendation:

The Provider should develop and implement an internal control system to ensure that only services rendered are billed to ODM in order to avoid future findings.

Provider Response

A draft report along with a detailed list of services for which we took findings was mailed to the Provider on July 9, 2014, and the Provider was afforded an opportunity to respond to this examination report.

The Provider disagrees any sum is due and owing and disagrees that an audit was done in the manner required by applicable standards governing audits of this nature.

AOS response: As stated in the Independent Auditor's Report, we completed this examination in accordance with the American Institute of Certified Public Accountants' attestation standards. In addition, the use of statistical methods to conduct the examination and to determine the amount of overpayment is consistent with Ohio Admin. Code §5160-1-27.

APPENDIX I

Summary of Statistical Sample Analysis
For the period January 1, 2009 through December 31, 2011
Ambulette Services

Description	Results
Type of Examination	Random Sample of RDOS
Description of Population	All paid non-exception ambulette services, less services modified with U4 or U7, net of adjustments
Number of Population Recipient Dates of Service (RDOS)	22,553
Number of Population RDOS Sampled	422
Number of Population RDOS Sampled with Errors	58
Number of Population Services Provided	90,569
Number of Population Services Sampled	1,693
Number of Population Services Sampled with Errors	161
Total Medicaid Amount Paid for Population	$1,325,809.51
Actual Amount Paid for Population Services Sampled	$24,573.19
Projected Correct Population Payment Amount	$1,200,359.00
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$1,244,818.00
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	$1,155,901.00
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	$125,450.51
Precision of Estimated Correct population Payment Amount at the 95% Confidence Level	$44,459.00 (+/-3.70%)

Source: AOS analysis of ODM MMIS/MITS information and the Provider's medical records.

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TLC HEALTH CARE SERVICES, LLC DBA TLC TRANSPORTATION

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 16, 2014

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