AMBULANCE SERVICE, INC.
JEFFERSON COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2010 THROUGH DECEMBER 31, 2012

Dave Yost · Auditor of State

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AMBULANCE SERVICE, INC.
JEFFERSON COUNTY

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

Karen M. D'Anniballe, President & Treasurer
Ambulance Service, Inc.
1439 Sunset Boulevard
Steubenville, Ohio 43952

RE: *Medicaid Provider Number 0153935*

Dear Ms. D'Anniballe:

We examined your (the Provider's) compliance with specified Medicaid requirements for driver qualifications, service documentation, and service authorization related to the provision of non-emergency medical transportation services during the period of January 1, 2010 through December 31, 2012. 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 records to verify that driver qualifications were met and verified vehicle licensure with the State Board of Emergency Medical Services (formerly the Ohio Medical Transportation Board (OMTB)). 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 specified Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Adverse Opinion on Medicaid Services

Our examination found material non-compliance with service authorization, service documentation and driver qualifications. In addition, the Provider billed combined miles for the initial and return trips using a single mileage code.

We requested written representations from the Provider acknowledging its responsibility for ensuring compliance with Ohio Medicaid rules and for responding fully to our records requests and inquiries. While the Provider signed a representation letter, it did not acknowledge responsibility for establishing and maintaining internal control over compliance and did not indicate that it had evaluated compliance with Medicaid rules or disclosed instances of non-compliance subsequent to this examination.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements for the period of January 1, 2010 through December 31, 2012.

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, 2010 and December 31, 2012 in the amount of $76,126. This finding plus interest in the amount of $6,398.76 totaling $82,524.76 (see Results section for period to recover overpayments) is due and payable to the ODM upon its adoption and adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

This report is intended solely for the information and use of the ODM, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/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

December 1, 2015

[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 AMBULANCE SERVICE, INC.

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(B) 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 from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin. Code § 5160-1-17.2(E)

During the examination period, the Provider furnished ambulette and ambulance services. The Provider received reimbursement of $248,507.43 for 12,749 ambulette services, including of 7,864 ambulette transports (procedure code A0130) and 4,885 mileage codes (procedure code S0209), rendered on 937 dates of service during the examination period. A date of service is defined as all services for a specific date of service. In addition, the Provider received reimbursement of $133,692.26 for medical transportation services; including 350 advanced life support ambulance transports (84 of which were non-emergency) and 708 basic life support ambulance transports (313 of which were non-emergency) and the corresponding mileage codes. Ambulance Service, Inc. also does business as Steubenville Ambulance Service and the owners of Ambulance Service, Inc. also own Checker Cab Company of Steubenville. The Provider also has a West Virginia Medicaid number.

Some Ohio Medicaid recipients confined to a wheelchair may be eligible to receive transportation services provided by an ambulette provider. *See* Ohio Admin. Code § 5160-15-03(B)(2) An ambulette is a vehicle designed to transport wheelchair bound individuals. Qualifying ambulette services must be certified as medically necessary by an attending practitioner for individuals who are non-ambulatory, able to be safely transported in a wheelchair, and do not require an ambulance. "Attending practitioner" is defined as the primary care practitioner or specialist who provides care and treatment to the recipient on an ongoing basis and who can certify the medical necessity for the transport. An attending practitioner can be a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, or an advanced practice nurse. Ohio Admin. Code § 5160-15-01(A)(6)

Purpose, Scope, and Methodology

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

The scope of the engagement was limited to an examination of non-emergency medical transportation services, specifically ambulette services, that the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2010 through December 31, 2012.

We received the Provider's paid claims history from ODM's Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program for ambulette transports (procedure code A0130) and ambulette mileage codes (procedure code S0209). We removed all voids, services paid at zero and services with Medicare co-payments.

Purpose, Scope, and Methodology (Continued)

From this population we selected a stratified cluster sample based on date of service (DOS) to facilitate a timely and efficient examination of the Provider's ambulette services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).The following table shows the stratified cluster sample used.

Universe/Strata	Population	Sample
Strata 1 – DOS Paid Less Than $100	139 DOS	81 DOS
Strata 2 – DOS Paid $100 - $199.99	210 DOS	52 DOS
Strata 3 – DOS Paid $200 - $299.99	231 DOS	30 DOS
Strata 4 – DOS Paid $300 - $399.99	177 DOS	30 DOS
Strata 5 – DOS Paid $400 and Above	180 DOS	34 DOS
Total:	**937 DOS**	**227 DOS**

We then obtained the detailed services for selected dates of service. A total of 2,489 services were pulled for the 227 sampled dates of service.

An engagement letter was sent to the Provider on October 9, 2014 setting forth the purpose and scope of the examination. An entrance conference was held at the Provider's location on November 3, 2014. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program.

Results

We reviewed 2,489 ambulette transportation services (1,517 transports and 972 mileage codes) and identified 1,221 errors. ODM may recover an overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made according to Ohio Rev. Code § 5164.57. The overpayments identified for 158 of 227 dates of service (937 of 2,489 services) from our stratified statistical cluster sample, where dates of service were the primary units and services were the secondary units, were projected to the Provider's population of paid services. Errors in services paid prior to July 1, 2010 were given an overpayment value of $0.00 to reflect non collectability. This resulted in a projected overpayment amount of $84,317 with a 95 percent certainty that the true population overpayment fell within the range of $74,557 to $94,077, a precision of plus or minus $9,760 (11.58 percent). Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment is at least $76,126. A detailed summary of our statistical sample and projection results are presented in **Appendix I**.

The basis for our findings is discussed below in more detail. While certain services had more than one error, only one finding was made per service.

A. Certificate of Medical Necessity (CMN)

All transportation providers are required by Ohio Admin. Code § 5101:3-15-02(E)(2) to obtain a CMN that has been signed by an attending practitioner that documents the medical necessity of the transport. Ohio Admin. Code § 5101:3-15-01(A)(6) defines an attending practitioner as a doctor of medicine, doctor of osteopathy, doctor of podiatric medicine or an advanced practice nurse.

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. Ambulette providers must obtain the completed, signed and dated CMN prior to billing for the transport. *See* Ohio Admin. Code § 5101:3-15-02(E)(4)

Our review of the CMNs to support the statistical sample of 1,517 paid transports identified 493 transports in which the CMN did not certify the recipient met any criteria for an ambulette transport, did not include a medical condition and/or was not signed by an authorized practitioner or we could not determine the credentials of the signor. Included in these 493 transports are 36 trips in which the CMN that covered the date of service was a copy of a prior CMN with an altered signature date and certification period typed onto the form. We also identified 41 paid transports in which there were no CMN to cover the transport. These errors, for those services that were paid on, or subsequent to, July 1, 2010, are used in the overall finding projection of $76,126.

In addition, we noted CMNs for 425 transports that included a medical condition and were signed by an authorized practitioner but were not complete. These CMNs did not consistently indicate that the recipient met all of the criteria for an ambulette transport, but at least one of the criteria was met. Per Ohio Admin. Code §5101:3-15-03 (B)(2), ambulette services are covered only when the individual has been determined and certified by the attending practitioner to be non-ambulatory at the time of transport and does not require ambulance services; the individual does not use passenger vehicles as transport to non-Medicaid services; and the individual is physically able to be safely transported in a wheelchair.

On October 17, 2014, the Provider responded to an ODM Surveillance and Utilization Review Section Ambulette/Ambulance Questionnaire and stated it was its practice to "obtain a physician signature only for renals and a physician or RN signature for all other trips." Ohio Admin. Code § 5101:3-15-02(E)(4) states that an registered nurse (RN) may only sign a CMN with an order from the attending practitioner as evidenced by the name of the attending practitioner ordering the transport written on the CMN.

Recommendation:

The Provider should establish a system to obtain the required CMNs, completed and signed 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 full name of the driver, 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). In addition, a transport to a Medicaid covered service that was cancelled may be reimbursed if the provider obtained written documentation from the Medicaid covered service provider documenting the cancellation. *See* Ohio Admin. Code § 5101:3-15-03(L)

B. Trip Documentation (Continued)

For the one way transport of a passenger, the provider is reimbursed a base amount for the service and a loaded mileage amount for each mile the passenger was transported. *See* Ohio Admin. Code § 5101:3-15-04 (A)

Our review of the statistical sample of 1,517 transports found 193 errors. These errors include:

- 167 transports in which the mileage billed exceeded the mileage noted on the service documentation;
- 22 transports with no service documentation;
- 2 transports in which the service documentation was marked "canceled" but the required documentation was not provided; and
- 2 transports where the name and address of the Medicaid covered service were missing therefore we could not determine if either point of transport was to a Medicaid covered service.

These errors, for those services that were paid on, or subsequent to, July 1, 2010, are used in the overall finding projection of $76,126.

We also noted nine transports in which the name of the driver was not listed on the service documentation. Furthermore, we noted transports in which the beginning and ending odometer reading was recorded on the initial or return trip, but not both. In these instances we considered the miles for the missing odometer reading to be the same as the miles for the reported odometer reading. We noted some instances where this resulted in more miles billed than we calculated should have been billed and these errors are included in the 163 transports noted above. We also noted 10 instances where our calculated number of miles agreed to the number of miles billed.

In addition, the Provider billed numerous transports with the number of miles for both the initial and return trips billed as a single mileage code with the number of miles combined instead of the mileage for the initial and return trips billed as separate mileage codes with separate miles. Although this did not result in an overpayment, these services were not properly billed and this resulted in a significantly higher number of transport codes (procedure code A0130) than mileage codes (procedure code S0209).

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Admin. Code § 5160-15-02. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. The Provider should also ensure mileage is billed separately for each transport (initial and return). The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Vehicle Requirements

According to Ohio Admin. Code § 5101:3-15-02(A)(2) providers of ambulette services must operate in accordance with applicable requirements developed by the Ohio Medical Transportation Board (OMTB) (now known as the in State Board of Emergency Medical Services) accordance with Chapter 4766 of the Ohio Revised Code.

We noted two transports on one date that were rendered in an ambulette that was not licensed by OMTB. These errors, for those services that were paid on, or subsequent to, July 1, 2010, are used in the overall finding projection of $76,126.

C. Vehicle Requirements (Continued)

Recommendation:

The Provider should ensure vehicles used for transports are properly licensed by the State Board of Emergency Medical Services. The Provider should address the identified issue 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. In addition, each driver must provide a copy of his/her driving record from the Bureau of Motor Vehicles and complete passenger assistance training. *See* Ohio Admin. Code § 5101:3-15-02(C)(3)

Each driver must obtain and maintain first aid and Cardiopulmonary Resuscitation (CPR) certification (or have an Emergency Medical Technician certification) and maintain a valid driver's license. *See* Ohio Admin. Code § 5101:3-15-02(C)(3)

We selected eight employees who rendered services in our sample and tested the hiring requirements for three of these eight employees whose hire date fell within the examination period. For these three employees we found:

- 1 did not have passenger assistance training before providing services;
- 3 had no documentation of alcohol testing;
- 2 did not have first aid and/or CPR certification before providing services; and
- 1 had CPR certification before providing services but later had a 1 month lapse in this certification.

We tested the on-going requirements of first aid, CPR and driver's license for the other five employees in our sample. We found that all five employees had a valid driver's license, one driver had a lapse of approximately four months in his first aid certification and four drivers had lapses in CPR certification ranging from approximately one to five months. We noted 48 transports rendered by a driver that did not have the required training or certifications on the date of service. These errors, for those services that were paid on, or subsequent to, July 1, 2010, are used in the overall finding projection of $76,126.

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.

Provider Response:

The Provider submitted an official response to the results of this examination which is presented in **Appendix II**.

Provider Response (Continued):

The Provider disputes the identified findings and states that the Auditor of State's Office failed to consider all available documentation. In addition, the Provider notes it did not have adequate time to review all relevant files for additional information. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Response:

Per Ohio Admin. Code § 5160-1-17.2(D)(E), providers must furnish all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions for audit and review purposes. Failure to supply requested records within 30 days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program.

Prior to our November 3, 2014 on-site visit, the Provider pulled records in response to our records request. We scanned and reviewed all of the records that were made available at that time and the Provider signed a statement on November 5, 2014 that it had provided all of the requested records. However, we received additional documents twice during the following month as the Provider indicated it had located additional records.

In order to ensure that we had received all supporting documentation, we sent a final missing records request in March, 2015. We received no documents in response to this request. We reviewed all additional records, including those provided after receipt of the draft report, for compliance and updated our results, accordingly.

Appendix I

Summary of Statistical Sample Analysis
For the period January 1, 2010 through December 31, 2012
Where the payment was made by ODM on, or subsequent to, July 1, 2010

POPULATION
The population is all paid Medicaid services, net of any adjustments, where the service was performed and payment was made by ODM.

SAMPLING FRAME
The sampling frame was paid and processed claims from MMIS and MITS. These systems contain all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLING UNIT
The primary sampling unit was a date of service and the secondary unit was a service.

SAMPLE DESIGN
We used a stratified cluster random sampling approach.

Description	Results
Number of Population Dates of Service (Primary Units)	937
Number of Population Dates of Service Sampled	227
Number of Population Services Provided (Secondary Units)	12,749
Number of Services in Sampled Dates of Service	2,489
Total Medicaid Amount Paid for Population	$248,507.43
Amount Paid for Population Services Sampled	$47,286.97
Sample Dates of Service with Errors	158
Sample Services with Errors	937
Projected Population Overpayment Amount (Point Estimate)	$84,317
Precision of Overpayment Estimate at 95% Confidence Level	$9,760 (+/- 11.58 %)
Precision of Overpayment Estimate at 90% Confidence Level	$8,191 (+/- 9.71 %)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90% overpayment precision from the point estimate)(equivalent to method used for Medicare audits)	$76,126

Source: AOS analysis of MMIS, MITS information and the Provider's records.

Appendix II

RESPONSE TO REPORT OF AUDITOR OF STATE

AMBULANCE SERVICE, INC.

MEDICAID PROVIDER NO. 0153935

November 30, 2015

This response is submitted on behalf of Ambulance Service, Inc. ("ASI") to the draft report of the State Auditor, dated October 21, 2015. The Draft Report finds that ASI has been overpaid by Ohio Medicaid in the amount of $81,176.00. This amount is an estimate based upon a review of a sample of claims submitted. ASI disputes this finding.

Initially, ASI notes that there is no suggestion that ASI failed to provide the services billed for. Rather, the disallowances are based upon ASI's alleged failure to maintain proper documentation of medical necessity, accurate trip mileage, driver training, and vehicle certification. Even in these cases, the compliance lapse is in the nature of a failure to comply with technical documentation requirements. For example, although in some cases ASI did not have current doctor's order in the ASI files, the orders were in the doctor's files and the doctor's nurse signed the certificate. While ASI appreciates the need for proper documentation, it is important to note that, even in the cases where the claim has been disallowed, a medically necessary service was provided to the patient by competent staff.

The Audit Report fails to consider much of the documentation that was made available to the Auditor's staff when they were on site at ASI for one week in November 2014. It is ASI's understanding that the Auditor selected a stratified random sample of service dates, and then reviewed all services on the selected dates. Prior to arriving on site, the Auditor sent ASI a list of selected services to be reviewed. ASI made all files for the selected patients on the list. ASI made available the records for the specific patient for the specific service date. In addition, ASI made available all records for the relevant patient for all other service dates. The Auditor's staff decided which records to review and copy. All of the records provided with this response were available to the Auditor's staff when they were on site at ASI.

In providing this response, ASI has provided as much information as it was able to locate in the time period given to respond. The report was sent to ASI on October 21, 2015 (i.e., eleven months after the conclusion of the onsite review by the Auditor's staff), and an exit conference was held on November 16, 2015. On November 16, the Auditor provided ASI with an electronic copy of the sample, which could be sorted alphabetically. This made the review and response process significantly simpler. However, given that ASI only had two weeks to do this review, ASI was not able to completely review all of the relevant patient files. While ASI cannot be certain, it is believed that there is additional documentation, other than that provided with this Response, that will support claims by ASI.

Although ASI made available all records requested by the Auditor's staff, it seems clear that some information was missed by the auditors. ASI has located and submits relevant documents that address approximately sixty of the cited disallowances. These are records that were in the files made available to the Auditor. ASI asks that the Auditor consider the information submitted with this response and adjust the Report accordingly. ASI further requests that ASI be given leave to continue to review its

records and supplement this response. The additional documentation that ASI has located and submits with the attached Addendum addresses many of the disallowances cited in the draft Report.

Karen D'Anniballe, President
Ambulance Service, Inc.

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Dave Yost • Auditor of State

AMBULANCE SERVICE, INC.

JEFFERSON 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 29, 2015

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