LIFECARE WHEELCHAIR TRANSPORTATION, INC.
LORAIN COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

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

Dave Yost · Auditor of State

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LIFECARE WHEELCHAIR TRANSPORTATION, INC.
LORAIN COUNTY

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

Peter de la Porte, President
LifeCare Wheelchair Transportation, Inc.
640 Cleveland Street
Elyria, Ohio 44035

RE: *Medicaid Provider Number 2791000*

Dear Mr. Peter de la Porte:

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 and 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.

Basis for Adverse Opinion on Medicaid Services

Our examination found material non-compliance with service documentation, service authorization, driver qualifications and the provision of attendant services.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to non-emergency medical transportation services 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 $118,599.00 (see Results section for period to recover overpayments). This finding plus interest in the amount of $8,141.90 totaling $126,740.90 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

June 11, 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 LIFECARE WHEELCHAIR TRANSPORTATION, 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 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 $645,136.45 for 42,316 ambulette service lines, including 20,875 non-emergency wheelchair van transport services (procedure code A0130), 20,841 mileage services (procedure code S0209) and 600 attendant services (procedure code T2001), rendered on 10,645 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.

We noted the Provider has a second Medicaid provider number (0634648) under the name LifeCare Ambulance, Inc. Under this provider number, the Provider received reimbursement of $222,060 for medical transportation services, including 39 non-emergency wheelchair van transports; 611 advanced life support ambulance transports (131 of these were non-emergency); and 1,246 basic life support ambulance transports (750 of these were non-emergency).

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 and attendant services, that the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2010 through December 31, 2012. The scope did not include any services from the Provider's second Medicaid provider number – 0634648.

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 all voided services and services paid at zero. From the remaining sub-population we extracted all transports and mileage codes and selected a simple random sample based on RDOS. From the remaining sub-population of attendant services we selected a simple random sample based on RODS. We then obtained the detailed services for all of the selected RDOS. We reviewed these samples to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

An engagement letter was sent to the Provider on September 2, 2014 setting forth the purpose and scope of the examination. An entrance conference was held at the Provider's office on September 29, 2014. During the entrance conference the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. On October 2, 2014 the Provider signed a statement that it had provided true, accurate and complete records to us. On December 2, 2014, the Provider again reiterated that it had submitted all records to support its reimbursements.

After receipt of the draft report in May, 2015, the Provider indicated it had additional documents not provided to us as previously indicated. The Provider then submitted a substantial number of additional records to support its services. We had previously requested these records be made available for our on-site fieldwork in September, 2014 and had submitted a missing records request to the Provider after our fieldwork. Due to the large volume of records that were not provided until the last stage of the examination, additional time and resources were needed to examine these additional records. We re-performed our tests using the additional records and the results below were updated accordingly.

Results

We reviewed 386 services (194 transports and 192 mileage codes) in our statistical sample and found 405 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 49 of 100 RDOS (108 of 386 services) from our statistical random sample were projected across the Provider's total sub-population of paid services. This resulted in a projected overpayment amount of $158,136 with a precision of plus or minus $50,712 at the 95 percent confidence level. 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 methods used in Medicare audits), and a finding was made for $115,700. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $115,700. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We also reviewed 144 attendant services in a second statistical sample and found 122 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 68 of 100 statistically sampled RDOS (85 of 144 services) were projected to the Provider's population of paid attendant services. This resulted in a projected overpayment amount of $3,285 with a precision of plus or minus $462 at the 95 percent confidence level. 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 methods used in Medicare audits), and a finding was made for $2,899. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $2,899. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

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

On January 24, 2012, the Provider responded to an ambulette questionnaire from ODM's Surveillance and Utilization Review Section and attested that since the business was started it has been aware of the requirements that, in order for an ambulette transport to be covered by Medicaid, the transport must be in an ambulette, licensed and approved, and that a certificate of medical necessity must be on file for the individual being transported. The Provider also attested that since the attendant rule became effective it was aware that in order for an attendant to be covered by Medicaid, the attendant must be a qualified employee of the company, may be used only in extraordinary circumstances and must have documentation supporting the need and use of an attendant. The Provider further attested it maintained all records and documents necessary to substantiate transportation services.

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. 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 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. *See* Ohio Admin. Code § 5101:3-15-03(B)(2) 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)

Statistical Sample of Transports and Mileage Codes

Our review of the statistical sample of 194 paid transports identified 26 transports in which the CMN did not indicate that the individual met at least one of the criteria for medical necessity, include a medical condition and/or was not signed by an authorized practitioner. These errors, for those services that were paid on, or subsequent to, July 1, 2010, were used in the overall finding projection of $115,700.

In addition, we noted CMNs for 142 transports that were not complete. These CMNs did not consistently indicate that the recipient met all of the criteria for an ambulette transport; however, they did indicate that at least one criterion was met, included a medical condition and were appropriately authorized.

The records submitted by the Provider after receipt of the draft report included CMNs not submitted during fieldwork. The Provider indicated that in some cases there were multiple, overlapping CMNs for some recipients and they were able to locate valid CMNs for the services. We evaluated these new CMNs for compliance and updated the reported results. The CMNs that were initially submitted for our examination were those attached to the service documentation and used to support billings. Our review of the original CMNs that were attached to the documentation for 172 services found them to be incomplete or invalid.

The records submitted by the Provider after receipt of the draft report also included eight print outs of internet searches for certain physicians. These were attached to CMNs in which the signature was illegible and did not include any professional designation or practitioner number. We could not

determine that the physician identified on the internet search signed the CMN so these CMNs remained invalid.

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 Sample of Transports and Mileage Codes

Our review of the statistical sample of 194 transports found four services lacking documentation to support the service and 21 services in which the mileage reimbursed exceeded documented mileage. These errors, for those services that were paid on, or subsequent to, July 1, 2010, were used in the overall finding projection of $115,700.

We also noted 190 transports with incomplete documentation. The documentation for these 190 transports did not identify the full name of the Medicaid service provider and one of the 190 documents did not include pick-up and drop off time. We haphazardly selected 20 non-residential addresses included on the service documentation and performed an internet search to determine if those addresses were potential Medicaid providers. All 20 addresses were for various medical offices/centers/services. In many instances the address appears to house multiple medical practitioners so we could not positively determine which provider the recipient was seen by, and therefore we could not positively determine if one point of transport was a Medicaid covered service.

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. Driver Qualifications

All ambulette drivers and attendants 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 and attendant 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 or attendant begins providing ambulette services or within 60 days thereafter. Prior to employment, each driver and attendant must obtain first aid and Cardiopulmonary Resuscitation (CPR)

certification (or have an Emergency Medical Technician certification), and complete passenger assistance training. In addition, each driver must provide copy of a BMV driving record on annual basis and maintain current first aid and CPR certification. *See* Ohio Admin. Code § 5101:3-15-02(C)(3)

We tested 25 employees identified as drivers or attendants and identified the following errors:

- 23 employees with no alcohol test and 2 employees with alcohol tests approximately 1 year after hire;
- 17 employees with lapses in first aide certification with the lapses ranging from approximately 1 to 25 months;
- 16 employees with lapses in CPR certification with the lapses ranging from approximately 1 to 50 months;
- 2 employees with no controlled substance testing, 1 employee with controlled substance testing completed approximately 1 year after hire and 1 employee with controlled substance testing performed but no test results obtained;
- 3 employees with background checks ranging between 1 month to 7 years after their 60 day conditional employment period, including 1 employee with a disqualifying conviction;
- 2 employees with no physician statement; and
- 1 employee with no annual BMV driving record.

Due to the errors found, five of the 25 employees in our sample were ineligible to render services. Of these five employees, one was convicted of felonious assault which is a disqualifying offense. Thirteen of the 25 employees had no alcohol test and also had lapses in first aid and/or CPR certifications. These 13 employees were concluded to be ineligible during the period(s) of lapse(s) in certification. Of the seven employees who were concluded to be eligible to render services during our entire examination period, only one had an alcohol test and it was completed approximately 11 months after date of hire and one had a background check approximately two years after hire. Both of these non-compliances occurred prior to our examination period.

The records submitted by the Provider after receipt of the draft report included controlled substance test results which were obtained from the company that performed the tests. While we evaluated these test results for compliance, we cannot verify that the Provider received the results at the time of hire since the Provider stated they obtained the results due to this compliance examination. In addition, the records submitted by the Provider after receipt of the draft report included first aid, CPR and passenger assistance training certifications. The Provider stated it has a training center where these programs are taught and the corresponding records were maintained at the center. We noted a significant number of lapses in these certifications. We evaluated all additional documents and updated our results. Based on the errors noted and the timing and type of information provided, it does not appear that the Provider tracked employee eligibility.

Statistical Sample of Transports and Mileage Codes

The 22 transports rendered by ineligible drivers in our statistical sample of 194 transports are considered unallowable. These errors, for those services that were paid on, or subsequent to, July 1, 2010, were used in the overall finding projection of $115,700.

Statistical Sample of Attendant Services

The eight transports rendered by ineligible attendants in our statistical sample of 144 attendant services are considered unallowable. These errors, for those services that were paid on, or subsequent to, July 1, 2010, were used in the overall finding projection of $2,899.

Recommendation:

The Provider should develop and implement a system to ensure that all drivers complete required documentation prior to employment and that only drivers who meet all hiring requirements are employed beyond the conditional employment period. 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.

D. 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. In addition, Ohio Admin. Code § 5101:3-15-03(B)()(f) states the use of an additional attendant can be covered and reimbursed only when the safe transportation of the patient requires additional handling, such as unusual patient obesity, or the need to negotiate a minimal number of accessible steps. Documentation supporting the need and use of the additional attendant must be maintained by the Provider.

Statistical Sample of Attendant Services

Our review of 144 attendant services identified the following errors:

- 98 attendant services in which no need for an attendant was documented;
- 15 attendant services in which the name of the attendant was not documented; and
- 1 attendant service in which there was no service documentation.

These errors, for those services that were paid on, or subsequent to, July 1, 2010, were used in the overall finding projection of $2,899.

The Provider's service documentation included a check box (yes or no) to document lift assistance required and a second check box with three choices (patient obesity, additional medical equipment and structural barriers in building/residence) to document the need for an attendant. Included in the 98 errors above were instances where "no" was checked for lift assistance required and no need was check marked but the Provider billed for an attendant service.

Recommendation:

The Provider should develop and implement an internal control system, including education, to ensure that attendants properly complete service documentation to include the necessity of the attendant service and the name of the attendant. In addition, the Provider should only bill for services rendered. 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 III**. We did not examine the Provider's response and, accordingly, we express no opinion on it. Our response is presented in **Appendix III**.

APPENDIX I

Summary of Statistical Sample Analysis – Transports and Mileage Codes
For the period January 1, 2010 to December 31, 2012

POPULATION
The population is all paid Medicaid services where the service was performed and payment was made by ODM on, or subsequent to, July 1, 2010. Services excluded from this sample sub-population included all attendant services which were segregated from the rest of the Provider's services and examined in a separate simple random sample.

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.

SAMPLE UNIT
The primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RODS	10,645
Number of Population RDOS Sampled	100
Number of Population RDOS Sampled with Errors	49
Number of Population Services Provided	41,716
Number of Population Services Sampled	386
Number of Population Services Sampled with Errors	108
Total Medicaid Amount Paid for Population	$639,730.45
Amount Paid for Population Services Sampled	$5,949.86
Estimated Overpayment (Point Estimate)	$158,136
Precision Overpayment Estimate at 95 Percent Confidence Level	$50,712
Precision Overpayment Estimate at 90 Percent Confidence Level	$42,435
Single-tailed Lower Limit Overpayment Estimate at 95 Percent Confidence Level (calculated by subtracting the 90 percent overpayment precision from the point estimate) (equivalent to the estimate used for Medicare audits)	**$115,700**

Source: Analysis of MMIS and MITS information and the Provider's records

APPENDIX II

Summary of Statistical Sample Analysis – Attendant Services
For the period January 1, 2010 to December 31, 2012

POPULATION
The population is all paid Medicaid services where the service was performed and payment was made by ODM on, or subsequent to, July 1, 2010. Services excluded from this sample sub-population included all transports and mileage codes which were segregated from the rest of the Provider's services and examined in a separate simple random sample.

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.

SAMPLE UNIT
The primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RODS	429
Number of Population RDOS Sampled	100
Number of Population RDOS Sampled with Errors	68
Number of Population Services Provided	600
Number of Population Services Sampled	144
Number of Population Services Sampled with Errors	85
Total Medicaid Amount Paid for Population	$5,406.00
Amount Paid for Population Services Sampled	$1,297.44
Estimated Overpayment (Point Estimate)	$3,285
Precision of Overpayment Estimate at 95% Confidence Level	$462
Precision of Overpayment Estimate at 90% Confidence Level	$386
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90% precision from the point estimate) (Equivalent to the estimate used for Medicare Audits)	$2,899

Source: Analysis of MMIS and MITS information and the Provider's records

APPENDIX III

Provider Response:

While we take seriously the deficiencies revealed in the audit as to our recordkeeping and related administrative processes (the upgrades to which are discussed below), it was encouraging that the audit confirms that there are no substantive deficiencies in the quality of services. LifeCare Wheelchair Transportation is a locally owned family business that has been in operation for over twenty-eight (28) years. LifeCare Wheelchair Transportation has transported literally millions of patients, and our extended track record of quality care and service speaks for itself. As discussed below, consistent with the Company's goals of continued improvement and to elevate the Company's recordkeeping and related administrative areas to the Company's operational quality, the Company has and will continue to take the following steps to improve its recordkeeping and related administrative functions.

LifeCare Wheelchair has undergone a number of internal control changes that have been instituted since Q1 of 2012. These controls guard against most of the compliance problems that have surfaced from the audit years 2010, 2011 and 2012 in this Medicaid report and many of the issues before that.

The recommendations and findings being reported highlight a number of areas that LifeCare Wheelchair Transportation has made significant strides in improving. In March of 2012, LifeCare created and hired a new position of CFO to serve as the main oversight person for anything related to the financial health of LifeCare Wheelchair Transportation and to serve as its compliance officer.

This Audit look back has given us areas that we can give additional attention to. Improvements have been made in the checks and balances of on-boarding staff as well as the legibility of all documentation to support billing/reimbursement.

Below are the Audit recommendations in each category. Following each Audit recommendation we have listed our current process and our plan going forward.

CMN
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.

The current process includes the following procedures to help with compliance in this area:
1. A 30 minute documentation session is given during pre-employment orientation.
2. A full-day annual meeting is held that is mandatory for all employees. Focus is given in patient secure class, CPR, and First Aid, as well as proper paperwork and defensive driving.
3. Problem employees are identified throughout the year. One-on-one instruction is given to correct improper paperwork and accounting.

Trip Documentation
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.

The current process includes the following procedures to help with compliance in this area:
1. A 30 minute documentation session is given during pre-employment orientation

2. A full-day annual meeting is held that is mandatory for all employees. Focus is given in patient secure class, CPR, and First air as well as proper paperwork and defensive driving.
3. Problem employees are identified throughout the year. One-on-one instruction is given to correct improper paperwork and accounting.

Driver Qualifications
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.

A new HR director was hired in December 2012 and the entire on boarding process has been changed. Check-off sheets have been developed and annual reviews of employee files are done to ensure compliance with state and federal standards.

Attendants
The Provider should develop and implement an internal control system, including education, to ensure that attendants properly complete service documentation to include the necessity of the attendant service and the name of the attendant. In addition, the Provider should only bill for services rendered. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

At this time, lift assists are no longer being performed or billed to the state. We previously used medics from our sister corporation to perform this work. These medics were properly trained with EMT-B or Paramedic qualifications, but did not go through the credentialing process for the Ambulette service. It just doesn't make good business sense to spend all the money to keep medics compliant from our sister corporation just to do lift assists. The end result is that lift assists may not be available in many circumstances.

Auditor of State Response:

Our examination did not include testing the quality of services. As such, this report does not confirm "that there are no substantive deficiencies in the quality of services" as stated above in the Provider's Response.

Dave Yost • Auditor of State

LIFECARE WHEELCHAIR TRANSPORTATION, INC.

LORAIN 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
JULY 7, 2015

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