STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Winton Transportation Inc.

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

October 2001 ***AOS/FWAP-02-003C***

STATE OF OHIO
OFFICE OF THE AUDITOR
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Caroline Burer, Vice President of Operations
Winton Transportation, Inc., dba. UTS
5284 Winton Road
Fairfield, Ohio 45014

Re: Medicare/Medicare Review of Provider #0872971

Dear Ms. Burer:

We have completed our audit of selected medical services rendered to Medicaid recipients by Winton Transportation Inc., now doing business as Universal Transportation Systems, for the period January 1, 1996 through June 30, 2000. We identified findings in the amount of $64,458.14, which have been paid in full to the Ohio Department of Job and Family Services. The attached report details the basis for the findings.

We appreciate your cooperation in resolving the matters identified by our audit. As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief of the Fraud, Waste and Abuse Prevention Division at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

October 2, 2001

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ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services
CPT	Physician's Current Procedural Terminology
EMT	Emergency Medical Technician
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of Winton Transportation, Provider #0872971, doing business as Universal Transportation Systems at 5284 Winton Road, Fairfield, Ohio 45014. Findings amounting to $64,458.14 were identified. The findings are recoverable as they resulted from Medicaid claims submitted by Winton Transportation for services that did not meet reimbursement rules under the Ohio Medicaid Transportation Manual and the Ohio Administrative Code (OAC).

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services (ODJFS), performs reviews of Medicaid providers' compliance with federal and state claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. ODJFS administers the Medicaid program. The Handbook explains the general guidelines and policies governing the Ohio Medicaid Program. It is intended to inform the provider of medical services of the policies concerning the amount, scope, duration and payment of medical services covered under the Ohio Medicaid Program. The Handbook also serves as a reference book for the Ohio Department of Job and Family Services and the local county departments of human services.

ODJFS' Medicaid Provider Handbook, General Information, Section II, Subsection (B),Chapter 3334, (OAC Section 5101:3-1-01), states in part, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must render or authorize medical services within the scope of their licensure and based on their professional judgement of those services needed by an individual. "Medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice."

Medical transportation services are among the services reimbursed by the Medicaid program when delivered by eligible providers to eligible recipients. The range of medical transportation services includes emergency and non-emergency ambulance transport to a Medicaid covered service, non-emergency ambulette/wheelchair vehicle transport to a Medicaid-covered service, as well as emergency and non-emergency air ambulance transport. Covered medical transportation services (ambulance and ambulette/wheelchair vehicle services) are those transports that are determined to be medically necessary and appropriate to the recipient's health. Requirements for providers of medical transportation services are covered in ODJFS' Transportation Services Manual, which is part of the Ohio Medicaid Provider Handbook.

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection (B), and OAC Section 5101:3-1-172 (E), providers are required 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 form the date of receipt of payment or until any initiated audit is completed, whichever is longer."

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud 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.

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program.."

PURPOSE, SCOPE AND METHODOLOGY

The purpose of this review was to determine whether or not the Provider was reimbursed inappropriately for Medicaid transportation services and to calculate the amount of any overpayments resulting from non-compliance.

We informed the Provider by letter they had been selected for a compliance review. An Entrance Conference was held on October 24, 2000 with Caroline Burer, Vice President of Operations.

We utilized ODJFS' Ohio Medicaid Provider Handbook and the OAC as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by Medicaid. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service. These healthcare procedures and services are codified using one or more of the following five digit coding systems:

- Current Procedural Terminology (CPT)[1],
- Health Care Financing Administration's[2] (HCFA) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

The scope of our review was limited to claims for which the Provider was paid by Medicaid during

[1]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

[2]Center for Medicare and Medicaid Services formally known as HCFA has federal oversight of the Medicaid program.

the period January 1, 1996 though June 30, 2000, during which time the Provider was reimbursed $1,039,196.14 for 72,274 Medicaid ambulette services.

To facilitate an accurate and timely review of paid claims, we did the following:

- Reviewed a statistical random sample of 185 transaction control numbers (TCN's), which is the identifier for a transportation service bill for one recipient . This sample represented 1,398 services for which the Provider was reimbursed $25,407.66 by Medicaid) .

- Asked the Provider to make available patient records involving 647 TCN's where the MMIS indicated the Provider may have been reimbursed more than once for the same service.

- Reviewed the Provider's claims history for the audit period to determine (1) if services were billed for recipients who were inpatients at hospitals at the time of transport, and (2) if transports were billed for services on Sundays.

The review also involved comparing transportation records with the claims payment history from MMIS. The documents requested from the Provider for review included:

(1) A trip log which should state the date of service, time of call, name(s) of attendant(s), time of pickup, name(s) of client(s), name of driver and certification number, departure/destination, and loaded mileage. A trip log is used to validate that a transportation service took place.

(2) The original ODJFS 3452 Physician Certification form documenting the medical necessity of the transport.

(3) Copies of each ambulette driver's certification card for basic first-aid training. This certification may be issued by the American Red Cross or an equivalent training program.

In addition, we visually inspected the Provider's place of business, including an ambulette vehicle to determine if the required equipment was in place.

Work performed on this audit was done in accordance with government auditing standards. Detailed below are the results of this review.

FINDINGS

Our sample review of 185 TCNs did not identify any material deficiencies. However, our review of 647 TCN's with potential duplicate payments identified findings in the following areas: duplicate payments, undocumented services, services billed without physician certifications of medical necessity, and services billed to the Medicaid program that should have been billed to another state agency. In addition, our analysis of the Provider's paid claims history identified

findings associated with transportation services billed for hospital inpatients and unsubstantiated claims for Sunday transports.

Table 2 summarizes the findings for each area, and the bases for these findings are discussed below.

Table 1: Summary of Findings

Bases for Findings	Amount of Finding
Duplicate Payments	**$ 3,522.73**
Other Findings from Review of Potential Duplicate Payments **– Undocumented Services** **– No Physician Certifications/Unsigned** **– Transports Billed for Non-Medicaid Services**	 **$14,649.14** **$ 4,047.03** **$39,369.83**
Transportation Services Billed for Hospital Inpatients	**$1,100.81**
Transportation Billed for Sunday Transports	**$1,768.60**
Insufficient Medical Information	**No finding made**
Total Findings	**$64,458.14**

Source: Auditor's analysis of the Provider's paid claims for January 1, 1996 through June 30, 2000.

Duplicate Payments

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B (6), (OAC Section 5101:3-1-198) (E), overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery.

Our analysis of the Provider's paid claims history for the January 1, 1996 through June 30, 2000 review period identified 647 TCN's, or 1,561 instances[3], representing $31,304.49 in reimbursements, where it appeared that the Provider billed and was reimbursed twice by the ODJFS for transportation services for the same recipient on the same date of service. In order to confirm if two services were performed on the same day, we asked the provider to provide transportation records to verify these questionable claims.

[3] An "instance" represents a line item on a provider's claim and might represent, for example, one half of a round trip transport and/or the mileage for that transport.

The Provider acknowledged that 320 instances, representing $3,522.73 in reimbursements, were duplicate payments that had resulted from erroneous billings.

For the remaining services, the Provider contended that recipients had in fact been transported twice on the same day. However, after analyzing the records supplied by the Provider in support of these transports, we identified 969 instances, representing $18,696.17 in reimbursements, that did not meet the requirements for reimbursement because the services were not documented in the trip records and/or lacked proper Physician Certifications. Therefore, we were unable to verify that the services were provided or that they were medically necessary.

Undocumented Services. Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section IV, Subsection B, (OAC Section 5101:3-1-172) (E), the provider must maintain records for a period of six years from the date of receipt of payment or until any initiated audit is completed, whichever is longer, to fully describe the extent of services rendered.

In our review of the additional documentation sent in by the Provider for duplicate claims, we could not find support for 770 instances in which the Provider was billed and reimbursed. The records provided to us lacked both a trip record and a Physician's certification for the dates in question. The instances included one or both of the claims that had been associated with the potential duplicate payments. Without documentation, we were unable to verify that services were performed.

As a result, we identified $14,649.14 in findings, which represents the amount reimbursed to the Provider for services that were not documented in the transport records.

No Physician Certifications or Signatures. Pursuant to OAC Section 5101:3-15-05[4], medical transportation providers must maintain records which fully describe the extent of services provided. One of the records that must be maintained is the original physician certification form documenting the medical necessity of the transport.

Completion of form 3452 (Physician Certification) is required by OAC Section 5101:3-15-02 in order for the transportation provider to be eligible for reimbursement for Medicaid services. This certification record validates the medical necessity of the transportation service.

The physician certification is analogous to a physician's order or a prescription. Just as a prescription is required in order for a pharmacy to dispense medications and must be maintained as a record kept by the pharmacy, the physician certification for transportation services is the document that validates the medical necessity to transport the patient and must be maintained as a record by the transportation provider.

In our review of the duplicate documentation we discovered that the provider billed and was

[4]This cite was repealed and incorporated into OAC Section 5101:3-15-02 on March 1, 2000.

reimbursed for services where the records did not meet the requirements for transportation services. In particular, (1) the patient records did not contain the required Physician Certification or (2) the patient records contained an unsigned Physician Certification. We found 199 instances where the physician certification was missing (181 instances) and/or where the physician certification was present but not signed (18 instances).

As a result, we identified $4,047.03 in findings, which represents the amount reimbursed to the Provider for services that lacked Physician certifications or signatures on the certifications.

Transportation Billed for Non-Medicaid Services. Pursuant to the Ohio Medicaid Provider Handbook, AMB. 1114.1, all ambulette transportation services provided to Medicaid recipients who do not meet the medical necessity requirements for such transports and are residents of a long-term care facility (nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) should be billed to the facility.

In our review of the additional documentation sent in by the provider for duplicate claims, we identified a patient who was being transported to and from a workshop for the mentally challenged. The workshop is funded by the Ohio Department of Mental Retardation and Developmental Disabilities (MR/DD), and transports to the workshop are not a Medicaid-covered service. The Provider acknowledged that the patient was being transported to and from the workshop, but believed billing these services to the Medicaid program was allowable. We informed the Provider that in this case, transportation costs should have been billed to the Hamilton County Board of MR/DD, which is responsible for the transport of the patient and any other party who participates in services through the MR/DD program.

As a result, we identified $39,369.83 in findings for 2,825 services that had reimbursed by the Medicaid program for this patient over our review period.

Transportation Services Billed for Hospital Inpatients

One of our tests determined that the Provider billed for transportation services ostensibly provided while recipients were inpatients at a hospital. We determined that the Provider had billed and been reimbursed for 70 services, totaling $1,100.81, for transporting 11 such recipients between January 1, 1996 through June 30, 2000.

The Provider explained that in many instances a trip had been billed because it was a scheduled transport, but the client was a “no show” and had not informed the Provider of their admission into the hospital. In other instances, the Provider stated that the patient had been legitimately transported from the hospital. In the latter instances, the Provider supplied a trip log for the transport, but could not support that a physician had ordered the transport. (See explanation of the Physician Certification requirement above.)

Transportation Billed for Sunday Transports

Our analysis of the Provider's claims data also identified 251 services where the Provider billed and was reimbursed for trips that took place on a Sunday. Under normal circumstances, ambulette transports are to scheduled medical appointments (e.g. dialysis treatment) and would not occur on a Sunday. We contacted the transport destinations (generally dialysis centers) and verified that the patient was seen at the dialysis clinic for 149 services on a Sunday, generally due to a holiday falling on a Monday. In the other 102 services involving 25 recipients, we could not verify that the services had occurred because the Provider could not provide any documentation, and the dialysis clinic was not able to verify that the patient was seen on that particular day, or we had no response from the clinic. Therefore, we identified $1,768.60 in findings for reimbursements for unsupported Sunday transport claims.

Insufficient Medical Information to Support Medical Necessity

Our review of the sample and the potential duplicate payments noted one other area of deficiency within the transportation records. Most of the records we reviewed in our sample lacked information necessary to completely meet the compliance criteria of medical necessity. Although we did not calculate overpayments for this deficiency, it is detailed below along with a recommendation intended to prevent future instances of non-compliance and lessen the risk of overpayments. This deficiency was brought to the Provider's attention during our review.

The Transportation Manual, Section AM. 1101. states, "a physician must certify on the ODJFS 3452 Physician Certification Form ambulance and ambulate/wheelchair vehicle transportation services to be medically necessary. The physician must state the medical problems which contraindicate transportation by any other means on the date of transport."

To verify the medical necessity of a transportation service, the physician is required to designate the condition of the patient, e.g. "wheelchair bound," "ambulatory with assistance," "bed confined before and after trip", etc. by completing Section 17 of the Physician Certification Form. Moreover, certain designations in Section 17 that are followed by a "**" also require the physician to explain in Section 18 why the patient cannot be transported by common carrier or wheelchair/ambulate, and if bed confined, the physician is also required to list the diagnosis. During our sample review, we noted 94 instances were Section 17 and/or Section 18 had not be completed.

Recommendation: The Provider should implement controls to ensure that the original physician certification is completely filled out by the physician and describes in detail as to why the patient cannot be transported by common carrier or any other means of transportation and why the patient needs to be transported by wheelchair/ambulate.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on February 2, 2001 to give the Provider and opportunity to provide additional documentation or otherwise respond in writing to the findings. The Provider supplied additional information and records, and after reviewing this new information, we adjusted our findings. After being advised of the adjusted amount, the Provider remitted payment to ODJFS for $64,458.14, the full amount of the findings.

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WINTON TRANSPORTATION, INC.

BUTLER 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 2, 2001