GREATHOUSE MEDICAL TRANSPORTATION, LLC
CUYAHOGA COUNTY

MEDICAID COMPLIANCE REPORT

FOR THE PERIOD JANUARY 1, 2008 THROUGH DECEMBER 31, 2010

Dave Yost · Auditor of State

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GREATHOUSE MEDICAL TRANSPORTATION, LLC
CUYAHOGA COUNTY

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Independent Auditor's Report On Compliance With Requirements Applicable to Medicaid Program

Christine Greathouse, Owner
Greathouse Medical Transportation, LLC
3937 Elmwood Road
Cleveland Heights, Ohio 44121

Re: *Medicaid Provider Number 2690306*

Dear Ms. Greathouse:

We examined Greathouse Medical Transportation, LLC (the Provider) for compliance with Ohio Administrative Code (Ohio Admin. Code) § 5101:3-15 during the period of January 1, 2008 through December 31, 2010. Our examination was performed according to our authority in Section 117.10 of the Ohio Revised Code.

The Provider entered into an agreement with the Ohio Medicaid Agency to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the Provider's 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. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Our examination included reviewing, on a test basis, evidence about the Provider's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our conclusions. Our examination does not provide a legal determination on the Provider's compliance with specified requirements.

We examined 1,160 ambulette services and found significant non-compliance with Medicaid rules relating to certificates of medical necessity, documentation of service delivery and driver eligibility. We identified 1,039 errors relating to non-compliance with those requirements as detailed in the attached Compliance Report. We found the Provider was overpaid by Ohio Medicaid for ambulette services between January 1, 2008 and December 31, 2010 in the amount of $930,624. This finding plus interest in the amount of $82,404.84 totaling $1,013,028.84 is due and payable to the Ohio Department of Medicaid (ODM)[1] upon ODM's adoption and adjudication of this examination report. After adjudication by ODM, additional interest may be assessed until the finding and interest is paid in full.

[1] Effective July 1, 2013, ODM replaced the Ohio Department of Job and Family Services as the state Medicaid agency.

When the AOS identifies fraud, waste or abuse by a provider in an examination,[2] any payment amount in excess of that legitimately due to the provider will be recouped by ODM, Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B). Therefore, a copy of this report will be forwarded to ODM because it is the state agency charged with administering Ohio's Medicaid program. ODM is responsible for making a final determination regarding recovery of our findings and any accrued interest. If you agree with the findings contained herein, you may expedite repayment by contacting ODM's Office of Legal Services at (614) 752-3631.

Copies of this report are also being sent to the Medicaid Fraud Control Unit of the Ohio Attorney General's Office; the U.S. Department of Health and Human Services/Office of Inspector General; and the Ohio Emergency Medical Services Board. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Sincerely,

Dave Yost
Auditor of State

October 28, 2013

[2] "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 Report for Greathouse Medical Transportation, LLC

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. Hospitals, long-term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid patients. 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).

The Auditor of State performs examinations to assess provider compliance with Medicaid reimbursement rules to ensure that services billed to Ohio Medicaid are properly documented and consistent with professional standards of care, and medical necessity. 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)

The Provider's Ohio Medicaid provider number is 2690306 and the Provider is a transportation company located in Cuyahoga County, Ohio that renders ambulette services to Ohio Medicaid recipients. The Provider received reimbursement of $1,166,782.61 for 83,795 ambulette services rendered on 21,133 recipient dates of service[3] during the examination period.

Some Ohio Medicaid patients confined to a wheelchair may be eligible to receive transportation services provided by an ambulette provider. An ambulette is a vehicle designed to transport wheelchair bound individuals. Ohio Admin. Code § 5160-15-01(A)(4) Qualifying ambulette services must be certified as medically necessary by an attending practitioner[4], for individuals who are:

1. Non-ambulatory,
2. Able to be safely transported in a wheelchair, and
3. Do not require an ambulance.

Ohio Admin. Code § 5160-15-03(B)(2). All medical transportation services must be prescribed by a Certificate of Medical Necessity (CMN) except for ambulance transports to a hospital emergency room and ambulance or ambulette transfers of individuals, who are non-ambulatory, from one hospital to another hospital if the services provided at the second hospital are covered by Medicaid. *See* Ohio Admin. Code § 5160-15-02(E)(4)

[3] A recipient date of service is defined as all services for a given patient on a specific date of service.

[4] "Attending practitioner" is defined as the practitioner (*i.e.*, primary care practitioner or specialist) who provides care and treatment to the patient on an ongoing basis and who can certify the medical necessity for the transport. 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 § 5101:3-15-01(A)(6).

Ambulette providers must maintain records describing the transportation services including:

- The time of scheduled pick up and drop off, attendant name, patient name and Medicaid number, driver name, vehicle identification, name and address of the Medicaid covered service provider at the Medicaid covered point of transport, pick-up and drop-off times, the type of transport provided, and mileage;
- The original CMN; and
- Current certification or licensure for the driver and attendants.

See Ohio Admin. Code § 5160-15-02(E)(2)

Purpose, Scope, and Methodology

The purpose of this audit was to examine Medicaid reimbursements made to the Provider for services and 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 audit period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of ambulette services that the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2008 through December 31, 2010.

We received the Provider's claims history from ODM's Medicaid Management Information System (MMIS) database of services billed to and paid by Ohio's Medicaid program. We identified only services for which the Provider received reimbursement, and eliminated services which had previously been identified as overpayments by ODM. These overpayments were due to the Provider having no supporting documentation, invalid CMNs, and billing for unloaded transports (no passenger) during the timeframe of October 5, 2006 to June 30, 2010.

Due to the large number of services billed during the audit period, we selected a statistical random sample based on the recipient dates of service to facilitate a timely and efficient examination of the Provider's ambulette services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). We also examined a judgmental sample of employee files for those employed as drivers during the examination period, to ensure that the driver qualification requirements were met. In addition, we reviewed annual vehicle records to verify that ambulettes were appropriately licensed by the Ohio Medical Transportation Board (OMTB).

An engagement letter was sent to the Provider on September 13, 2012, setting forth the purpose and scope of the examination. We held an entrance conference with the Provider on October 1, 2012. Our fieldwork was performed in October 2012. During field review, the owner directed us to look through documents in the basement of her personal residence to support the services in our statistical sample. The files stored in the owner's basement were not organized in a consistent manner. We shared with the Provider lists of missing records, giving the Provider a chance to locate additional documentation. The owner told us that she looked through records in various other places including the attic, a crawl space, and storage closet within her personal residence, and eventually other private residences. The owner admitted to us that the records were a mess because she had relatives help her with filing and because she could not keep up with the paperwork.

On November 28, 2012 we submitted a comprehensive list of missing records to the Provider. The owner contacted us over 30 times before we sent out a draft report to discuss the examination and described her struggles in finding and organizing the requested documentation. The owner also told us she was hiring someone to organize the records so she could find the missing documents.

The Provider did submit additional documentation after our fieldwork which we reviewed for compliance.

Results

We reviewed 1160 ambulette transportation services and identified 1,039 errors. The sample included 580 paid claims for the transportation services and 580 paid claims for mileage. The reimbursements for those services with errors were identified as a finding (overpayment). While certain services had more than one error, only one finding was made per service. The bases for our findings are discussed below in more detail.

The overpayments identified for 259 of 296 statistically sampled recipient dates of service (946 of 1,160 services) were projected to the Provider's population of paid services resulting in a projected overpayment repayable to ODM of $930,624 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $876,030 to $985,217. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

A. Certificate of Medical Necessity

All transportation providers are required by Ohio Admin. Code § 5101:3-15-02(E)(2) to obtain a CMN 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)

The Provider responded to an official survey from ODM's Surveillance and Utilization Review Section in January of 2012, acknowledging it was aware of the requirement to have CMNs in order for ambulette services to be covered by Medicaid and further acknowledging it had been aware of this requirement since the date it "first became licensed".

The examination found 141 services in which there was no CMN and an additional 20 services where the CMN was not valid. A CMN is invalid when not signed by an authorized attending practitioner. The Provider indicated its practice was and is to obtain CMNs for every transport, except for dialysis patients.

In addition, for the CMNs that were present and signed by authorized practitioner, we noted that many were not complete. These CMNs did not consistently contain the medical condition which requires the patient to use an ambulette and did not indicate that the recipient met the criteria for an ambulette transport. We did not identify findings for these incomplete CMNs.

The errors for the 161 transports with either no CMN or an invalid CMN were used in the overall finding projection.

Recommendation:

The Provider should establish a system to obtain the required CMNs and to review those CMNs to ensure they are complete prior to billing Medicaid for the transport. The Provider should also develop record retention procedures to ensure the retention of required documentation. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

B. Trip Documentation

Trip documentation should describe the transport from the time of pick-up, to the time of drop-off, mileage, addresses to and from the named destination points, vehicle identification, and the driver's name for each trip. Complete trip documentation is necessary prior to billing Ohio Medicaid. *See* Ohio Admin. Code § 5101:3-15-02(E)(2)(a).

The examination found the following non-compliance issues with the Provider's trip documentation:

- 285 services where the documentation was incomplete – missing pick up and drop off times, identification of destination points, identification of driver, and complete addresses;
- 139 transports in which the vehicle was not identified;
- 80 services with no service documentation; and
- 80 services in which the mileage billed was not supported by the documentation.

We found the Provider's records to be disorganized, making it difficult to find information. The Provider's acknowledged that the documentation was disorganized and some documentation could not be found for some patients. The Provider's explanations for the missing documentation included the following:

- Documents were misfiled in the wrong year or the inactive file or had not ever been placed into the patient files;
- Records were in the homes of a family member and the contractor who performed billing services for the Provider;
- Boxes of records were located in the attic, rafters, and crawl space under an addition of the Provider's house;
- The disorganization was caused by family members who helped with filing; and
- The company experienced a rapid business growth, which caused documentation to become too voluminous.

One factor contributing to the 286 transports with incomplete documentation was related to round trips as the Provider's documentation often did not contain details for the return trip. For several transports, the only documents we found were schedules with handwritten mileage. The schedules commonly had extraneous handwritten notes in the margins and on the backs of the documents. There were also frequent revisions to documents via white-out and crossing out information. Furthermore, information added to the schedules was often handwritten in free spaces on the page, and did not indicate to which transport the information pertained.

We verified that the Provider had vehicles licensed by the OMTB; however, the Provider did not record which vehicle was used for 139 of the 580 transports reviewed. As a result, we could not verify that the licensed vehicles were used for all the transports reviewed.

The errors with trip documentation were used in the overall finding projection.

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 prior to submitting claims to Ohio Medicaid for reimbursement. Also, the Provider should develop procedures so that records are stored in safe manner that maintains confidentiality of the information and that provides information on where specific

records are stored. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Multiple Passengers

In billing for services, the Provider must specify certain information. For a multi-passenger trip, the Provider must indicate whether the service was provided to the first passenger or to an additional passenger; and indicate any other factor necessary for the correct adjudication or payment of the claim. *See* Ohio Admin. Code 5101:3-15-04 (D)

The Provider's trip documentation shows that multiple passengers were present on some transports; however, our review of the Provider's claims data found no instance of the claims submitted using the required modifier to indicate multiple passengers. Due to the lack of pick-up and drop-off times on a significant number of trips, it is difficult to determine the scope of the issue with multiple passengers.

Recommendation:

When multiple passengers are on the same transport, the Provider should develop procedures to ensure that the trips are identified and properly modified when billing is submitted to Ohio Medicaid. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Mileage

Excessive mileage charges, resulting from the use of indirect routes, are not a covered service. Ohio Admin. Code 5101:3-15-03 (E)(3) We noticed multiple instances where the mileage of the first part of a round trip was significantly different than mileage of the second part of the trip. Some of this discrepancy was explained when the trip log showed that there were multiple passengers on the transport. We also found instances where billed mileage did not match documented mileage. In 80 transports, the billed mileage exceeded the documented mileage, and these errors were used in overall finding projection. Other instances did not result in an overpayment. The Provider indicated it billed based on mileage documented by drivers; however, this was not supported in our comparison of mileage documented to units billed.

Recommendation:

The Provider should develop procedures to ensure mileage billed is the same as the actual trip mileage. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Canceled Trips

The medical transportation provider must obtain written documentation from the Medicaid covered service provider before billing the department for transport. The documentation must include: (a) A business name, address, and phone number of the Medicaid covered service provider, (b) The date and time of the cancelled or unavailable service, (c) A description of the reason(s) for the cancellation or unavailability of the service, (d) A statement indicating that the Medicaid covered service provider was unable to notify the Medicaid transportation provider or the individual of the cancellation or unavailability of the service prior to the arrival at the destination, and (e) The printed name and signature of the business/office manager or nurse. *See* Ohio Admin. Code 5101:3-15-03 (L)(3)

During the review period, the Provider billed 374 canceled trips, according to the billing modifier used. We reviewed one trip in our sample that had a canceled trip billing modifier and the documentation did not meet conditions to be a covered service as the patient was a "no show". Based on our review of documentation at the Provider's office, we saw no evidence of

documentation required for billing a cancelled trip. Our observations are consistent with the findings from the ODM review and indicate a pattern of billing for unloaded transports.

The one error found in the sample was used in the overall finding projection.

Recommendation:

The Provider should develop procedures to obtain the necessary documentation for those cancelled trips that meet the requirements to be a covered service and develop a review mechanism to ensure that only those trips are submitted to Ohio Medicaid 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 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 haphazardly selected 11 drivers from the Provider's personnel files and reviewed the personnel records for documentation regarding driver qualifications. Based on our review none of the drivers were in compliance with the required elements of the driver qualifications. Specific non-compliance issues identified include:

- 11 drivers did not complete passenger assistance training;
- 6 drivers were either lacking a background check or it was not completed within the 60 day period;
- 4 drivers had convictions of offenses requiring the application of personal character standards but no indication in the personnel files that Provider applied these standards;
- 4 drivers were either lacking a driving record from the BMV or it was not provided at time of application for employment;
- 5 drivers did not have first aid and/or CPR certification or it was not obtained within the 60 day period;
- 4 drivers were either lacking alcohol and drug testing or it was not completed within the 60 day period;
- 3 drivers were either lacking a physician statement or it was not completed within the 60 day period; and
- 1 driver was not eligible as he is a repeat theft offender.

We noted that one driver was excluded from the Provider's insurance policy but continued to provide ambulette services. In addition, three drivers did not have copies of driver's licenses in their personnel files, but we were able to confirm through the BMV reports that each one had a license during the examination period. Also, drivers that had first aid and CPR certifications did not maintain current certifications. One driver had a 19 month lapse before renewing her first aid certification.

There were 293 transports in the sample in which the driver did not meet the provider qualifications. These 293 errors were used in the overall finding projection.

Recommendation:

The Provider should develop and implement a system to ensure that the required checks, training and related documentation for all drivers are completed within the timelines established in the Medicaid rules. The Provider should address the identified issues to ensure compliance with Medicaid rules and 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 October 4, 2013, and the Provider was afforded an opportunity to respond to this examination report.

The Provider responded on October 28, 2013, that it would need approximately one year to respond to the draft examination report and that we left the Provider's records in a different state than how they were maintained. The Provider claimed it performed the services that were billed and it believed the services were medically approved transportation consistent with all applicable rules and approved authorizations.

AOS Response: The Provider was given a reasonable time to respond to the draft report. We spoke with the Provider twice on October 10, 2013, regarding the draft report and the list of services with errors to support the charges for service we identified as overpayments. On October 18th, the Provider requested additional time to respond to the draft report and we notified the Provider that same day that the response deadline was extended to October 28, 2013. On October 28th, the Provider requested an additional one year extension. As noted above (see *Purpose, Scope and Methodology)*, we gave the Provider an extensive list of missing records 11 months ago following our fieldwork. The Provider contacted us over 30 times to discuss the missing records. During these conversations, the owner told us she was having people organize her documentation so she could find the missing records. While the Provider supplied some additional records for us to review, the Provider failed to provide records to support the instances of non-compliance identified in this report. When we conducted our on-site fieldwork, we followed the Provider's instructions to leave the records that had been pulled for review for the Provider to file.

APPENDIX I

Summary of Statistical Sample Analysis of Greathouse Medical Transportation, LLC
For the period January 1, 2008 through December 31, 2010
Ambulette Services

Description	Analysis
Type of Examination	Variable Sample
Number of Population Recipient Dates of Service (RDOS)	21,133
Number of Population RDOS Sampled	296
Number of Population Services Provided	83,795
Number of Population Services Sampled	1,160
Total Medicaid Amount Paid for Population	$1,166,782.61
Amount Paid for Population Services Sampled	$16,199.92
Projected Population Overpayment Amount	$930,624
Upper Limit Overpayment Estimate at 95% Confidence Level	$985,217
Lower Limit Overpayment Estimate at 95% Confidence Level	$876,030
Precision of Population Overpayment Projection at the 95% Confidence Level	54,594

Source: AOS analysis of MMIS information and the Provider's medical records
Note: The Summary of Statistical Analysis reflects only the population and sample used to calculate the overpayment projection.

Dave Yost • Auditor of State

GREATHOUSE MEDICAL TRANSPORTATION, LLC

CUYAHOGA 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
NOVEMBER 13, 2013

88 East Broad Street, Fourth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.ohioauditor.gov