



# Ohio Medical Transportation Board News Winter 2008

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## FRAUD, WASTE, AND ABUSE: Can your organization survive the test?

We are deviating from our normal format and dedicating the majority of this Newsletter to an issue that has nearly reached epidemic proportions in Ohio. The issue: HEALTH CARE FRAUD. This topic is extremely important to private medical transportation providers that are reimbursed through Medicaid.

**THE OMTB  
DOES NOT  
INVESTIGATE  
FRAUD BUT  
WILL REPORT  
SUSPECTED  
FRAUD!**

While the Ohio Medical Transportation Board does not investigate fraud within our industry we are required to identify possible cases of fraud to the Ohio Department of Job and Family Services (Medicaid) and to the Ohio Attorney General's Office Medicaid Fraud Control Unit.

In this article we will review the Medicaid Fraud Control Unit's Role; Show you examples of a recent Ohio Auditor's Report; and compare the documentation requirements of Ohio

Administrative Code (OAC) 5101:3, ODJFS Division of Medical Assistance and OAC 4766-3, Ambulette Requirements.

## THE ATTORNEY GENERAL'S OFFICE MEDICAID FRAUD CONTROL UNIT

The Attorney General's Office battles fraud in the health care industry through the Medicaid Fraud Control Unit. The Medicaid Fraud Control Unit is responsible for the investigation and prosecution of health care providers accused of defrauding the state's Medicaid program.

The MFCU has state-wide criminal jurisdiction over Medicaid provider fraud investigations and prosecutions. The MFCU uses three fraud units to conduct its investigations. It has its own Grand Jury and prosecuting attorneys are assigned to each case to provide legal advice and present cases to the grand jury when appropriate. In 2004, the MFCU generated Medicaid restitution and penalties of over \$37 million in civil and criminal settlements, received 690 allegations of fraud and abuse, criminally charged 71 providers, and secured convictions against 68 providers. Convicted providers were ordered or agreed to reimburse the Unit for over \$100 thousand in investigative costs. All individuals or companies convicted of Medicaid fraud mandatorily excluded from participation in the Medicare/Medicaid program for at least five years.

The Columbus based Unit is responsible for conducting Medicaid provider investigations throughout the entire state of Ohio.

## What is Medicaid Fraud?

Under ORC 2913.40, Medicaid fraud occurs when a Medicaid provider knowingly makes or causes to be made a false or misleading statement or representation for use in obtaining reimbursement from the medical assistance program. Most health care providers are honest and sincere business people. However, a small number of providers do try to take an unfair advantage of their position in giving services to Ohio's neediest citizens. The following are some of the ways providers may commit Medicaid fraud:

- Billing for services that were not provided.
- Billing for a higher level of service than the service actually rendered.
- Offering or receiving cash, merchandise, or personal services as a way to get business.
- Billing for services that were not medically necessary.

## Working with Law Enforcement and Others

The MFCU is an active member of the Ohio Health Care Fraud Task Forces. They frequently work with federal, state and local law enforcement and licensing agencies. The federal agencies include the Department of Justice, Health and Human Services—Office of the Inspector General, Federal Bureau of Investigation, and the Drug Enforcement Administration. At the state level, the Inspector General, the Departments of Job and Family Services, Health, Mental Health, Aging, Mental Retardation and Developmental Disabilities, and the State Auditor. In addition, the Medical, Nursing, Pharmacy and Medical Transportation licensing boards. At the local level, they work with county sheriffs and local police departments.

## So Where is ODJFS in this picture?

Welcome to Ohio Medicaid

Ohio's public health care program

**OAC 5101:3-1-29 Medicaid fraud, waste, and abuse** pertaining to medical transportation is outlined as follows:

- The Ohio department of job and family services is required to have in effect a program to prevent and detect fraud, waste, and abuse in the medicaid program. Where cases of suspected fraud or misrepresentation to obtain payment from the medicaid program are detected, providers will be subject to a review or an audit by the department. In all instances of fraud, waste, 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.
- Over utilization of services by a provider, while possibly not considered fraudulent acts, may constitute abuse to the medicaid program. Consequently, in all instances of fraud, waste, 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. Waste and abuse results either directly or indirectly in financial losses to the medicaid program, its consumers, or their families. Various methods of audit and review will be utilized to determine waste and

abuse. If waste and abuse is suspected or apparent, the department will take action to gain compliance and recoup inappropriate payments through audit and review.

- For purposes of this rule, the following definitions apply:
  - “Fraud” is defined as an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. If fraud is suspected or apparent, referral of the case to the attorney general’s medicaid fraud control unit and/or the appropriate enforcement officials will be made.
  - “Waste and abuse” are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an over utilization of medicaid covered services and result in an unnecessary cost to the medicaid program.
- Cases of provider fraud, waste, and abuse may include, but are not limited to, the following:
  - A pattern of duplicate billing by a provider to obtain reimbursement to which the provider is not entitled.
  - Misrepresentation as to services provided, quantity provided, date of service, or to who provided.
  - Billing for services not provided.
  - Differing charges for the same services to medicaid and non-medicaid consumers.
  - Violation of a provider agreement by requesting or obtaining additional payment for covered medicaid services from either the consumer or consumer’s family, other than medicaid co-payments as designated in rule 5101:3-1-09 of the Administrative Code.
  - Collusive activities between a medicaid provider and any person or business entity which would involve the medicaid program.
  - Misrepresenting by commission or omission any information on the provider enrollment form or included in the provider packet.
- The department will not pay for services subsequent to the date of termination which have been prescribed, ordered, or rendered by a provider who has been terminated under the medicaid program as defined in rule 5101:3-1-17.6 of the Administrative Code.
- Responsibility for the business practices of employees must be assumed by providers. It is presumed that providers will take the necessary time to thoroughly acquaint themselves and their employees with all rules relative to their participation in the medicaid program. Ignorance of medicaid program rules will not be an acceptable justification for violation of department rules.

When ODJFS suspects fraud they will run a series of inquiries on your provider number. ODJFS inquiries can be initiated by many methods. It could be an internal review of your billing history, a patient or client may have reported the potential fraud, or the Ohio Medical Transportation Board may have noticed an anomaly on your application for

licensure. Even though we don't do the actual investigation we are required to report suspected fraud to the appropriate agency.

ODJFS may cause an audit to be conducted by the Ohio Auditor's Office or may refer the case to the Ohio Attorney General's office as necessary.

The following excerpts have been taken from actual recent audit reports of licensed Ambulance and Ambulette Service Providers. Anything that was not a part of the reports will be shown in ***bold Italics*** and is presented as comment or comparison.

## ***Auditor of State:*** EXCERPTS FROM AN AUDIT REPORT

OAC 5101:3-1-17.2(D) states that 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 from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

Prior to beginning our fieldwork, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for the following exceptions:

- Potentially duplicate payments where payments were made for the same recipient on the same date of service for the same procedure codes and procedure code modifiers, and for the same dollar amount.
- Payments made for services to deceased patients for dates of service after the date of death.
- Potentially inappropriate service code combinations on claims

***During our review, we identified findings including, but not limited to: ambulette services billed as ambulance services, lack of certificates of medical necessity (CMN), lack of documentation for billed services, incorrectly billed mileage, billing for non-covered transportation services, and third-party insurance liabilities.***

OAC 5101:3-1-17.2 states in pertinent part:

(D) 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 from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

***While reviewing our respective samples for ambulance and ambulette services, we identified multiple situations where the Provider lacked sufficient documentation to support that the billed services were rendered as follows:***

**Transports Over Fifty Miles** OAC 5101:3-15-03 states in pertinent part:

(H) Medical transportation providers, when providing a non-emergency ground ambulance, or ambulette service must document the reason for transport when the destination occurs outside of the patient's community, (a fifty mile radius from the patient's residence). Mileage greater than fifty miles will not be covered if the provider is

unable to produce the documentation which gives the reason for the transport to be out of the patient's community.

***While reviewing our respective samples for ambulance and ambulette services, we identified multiple instances where the Provider lacked documentation to justify one-way transports in excess of 50 miles.***

**Incorrectly Billed Mileage** OAC 5101:3-15-01(A) (14) states in pertinent part:

“Loaded mileage” is defined as the number of miles a patient is transported in the ambulance or ambulette to or from a Medicaid covered service.

***While reviewing our respective samples for ambulance and ambulette services, we identified multiple situations where the Provider over-billed mileage for transports. This was based on comparisons between the drivers' trip logs and mileage billed to Medicaid***

***While reviewing our respective samples for ambulance and ambulette services, we identified multiple situations where the Provider either lacked a certificate of medical necessity (CMN) or it was considered invalid due to lack of required information.***

**Ambulance Services' Documentation Did Not Indicate Why an Ambulance Transport was Necessary** OAC 5101:3-15-03 (A) (2) states in pertinent part:

The criteria listed in this paragraph must be met for a land ambulance service to be covered.

(a) The land ambulance service must be medically necessary as specified below in this paragraph when the patient needs either prescheduled transportation or unscheduled transportation for which an immediate response is not required; and the patient's medical condition meets one of the descriptions in paragraphs (A)(2)(a)(iii)(a) to (A)(2)(a)(iii)(c) of this rule.

- An individual is nonambulatory and unable to use an ambulette because the individual is unable to get up from bed without assistance; the patient is unable to sit in a chair or wheelchair; and can only be moved only by a stretcher and/or needs to be restrained; or
- An individual is not in a life-threatening situation, but requires continuous medical supervision or treatment during the transport; or
- An individual does not meet the criteria in paragraph (A)(2)(a)(iii)(a) or paragraph (A)(2)(a)(iii)(b) of this rule, but requires oxygen administration during the transport, and the patient is unable to self administer or self-regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.

***While reviewing our respective samples for ambulance services, we identified multiple instances where the Provider's documentation did not sufficiently justify an ambulance versus an ambulette transport. Upon reviewing the documentation, none of the above listed requirements in OAC5101:3-15-03 (A) (2) were noted. Therefore, the transports were recoded from ambulance to ambulette services, and because ambulance services pay at a higher rate than ambulette services.***

***Our test found services where both Medicaid and Medicare were billed as primary payers for the same services. Because Medicaid paid both as a primary insurer and the Medicare co-payment amounts, a duplicate payment occurred***

An additional computerized test was performed during the audit on all provider numbers to identify ambulance transports that were provided to dually eligible recipients (identified as a person who is eligible to receive benefits through Medicaid and is also eligible to receive benefits through Medicare Part B for ambulance transportation services).

**Other Observations**

We reviewed the Provider’s employee files and other documentation maintained to determine if the Provider complied with driver and vehicle requirements per the Ohio Administrative Code.

Failure to comply with applicable regulations could place patients in harms way and jeopardize the Provider’s status with the Medicaid program.

**Required Documentation Lacking for Drivers**

We reviewed the Provider’s employment files to determine if required procedures were followed and required documentation was kept on file. ***(We have included the comparable excerpt from OAC 4766-3, Ambulette Providers in the right column. It was not an accident that these rules are similar.)***

<p><b>OAC 5101:3-15-02(C)(3)</b></p> <p>(a)(ii)Each driver and each attendant must have a current card issued and signed by a certified trainer as proof of successful completion of the “American Red Cross” (or equivalent certifying organization) basic course in first aid and a CPR certificate or EMT certification. A copy of both sides of the card must be maintained by the provider and provided upon request to the department or their designee. . . . Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or their designee.</p>	<p><b>OAC 4766-3-13</b></p> <p><b><i>(2) A valid copy of certification in CPR and at least one of the following:</i></b></p> <p><b><i>(a) Basic first aid;</i></b></p> <p><b><i>(i) Each driver/attendant must have proof of successful completion of the “American Red Cross” or equivalent certifying organization basic course in first aid as approved by the board;</i></b></p> <p><b><i>(b) First responder;</i></b></p> <p><b><i>(c) Emergency medical technician;</i></b></p>
<p>(a)(vii)Each ambulette driver and each attendant must have completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance</p>	<p><b><i>(3) A valid copy of a program designed for transporting clients with special needs that include the following elements:</i></b></p> <p><b><i>(a) Major disabling conditions;</i></b></p> <p><b><i>(b) Basic considerations for Functional factors;</i></b></p>

and transfer techniques, environmental considerations, and emergency procedures.	<p><b>(c) Management of wheelchairs;</b>  <b>(d) Assistance and transfer techniques;</b>  <b>(e) Environmental considerations;</b>  <b>(f) Emergency procedures;</b></p>
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***Our review of 77 employee personnel files for CPR/EMT certifications and proof of passenger assistance training revealed the following:***

- ***Eight did not have CPR certificates or an alternate EMT certificate; and***
- ***21 did not contain documentation that the employees underwent passenger assistance training.***

<b>OAC 5101:3-15-02(C)(3)(a)(iii)</b>	<b>OAC 4766-3-13</b>
Each ambulette driver and each attendant must submit himself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been convicted of or pleaded guilty to violations cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the Revised Code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply.	<b><i>(4) A valid copy of criminal background check in accordance with section 109.572 of the Revised Code;</i></b>

***Our review of employee personnel files showed some personnel files did not contain evidence that a criminal background check had been performed on the employee.***

<b>OAC 5101:3-15-02(C)(3)(a)</b>	<b>OAC 4766-3-13(A)</b>
(iv) Each ambulette driver and each attendant must provide a signed statement from a licensed physician declaring that they do not have a medical condition, a physical condition, including a vision impairment (not corrected), and a hearing impairment (not corrected), or mental condition which could interfere with safe driving, safe passenger assistance, the provision of emergency treatment activity, or could jeopardize the health or welfare of patients being transported.	<b><i>(5) A valid copy of a signed statement from a physician acting within their scope of practice declaring that the driver/operator does not have a medical condition, physical condition, including vision impairment (not corrected), which could interfere with safe driving, passenger assistance, the provision of emergency treatment activity, or could jeopardize the health and welfare of client and/or general public;</i></b>
(v) Each ambulette driver must undergo testing for alcohol and controlled substances by a laboratory certified for such testing under CLIA and be determined to be drug and alcohol free	<b><i>(6) A valid copy of test results from an alcohol and controlled substances test to be conducted by a laboratory certified for such testing under "CLIA" and be determined to be drug and</i></b>

	<b>alcohol free as specified in paragraphs below;</b>
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***Our review of employee personnel files showed that nine employees lacked medical statements and six employees lacked drug screen results.***

<b>OAC 5101:3-15-02(C)(3)(a)(vi)</b>	<b>OAC 4766-3-13</b>
<p>Each ambulette driver must provide from the bureau of motor vehicles his/her driving record at the time of application for employment and annually thereafter. The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment. Persons having six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.</p>	<p>(1) A valid copy of the driver/operator license issued pursuant to Chapters 4506. or 4507. of the Revised Code or its equivalent if the applicant is a resident of another state:</p> <ul style="list-style-type: none"> <li>(a) Driver/operator must be at least eighteen years of age to operate an ambulette; <ul style="list-style-type: none"> <li>(i) Each ambulette driver must have at least two years driving experience;</li> </ul> </li> <li>(b) A valid copy of the driver/operator's abstract to be obtained from the bureau of motor vehicles at the time of the application for employment and annually thereafter; <ul style="list-style-type: none"> <li>(i) The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment;</li> <li>(ii) Driver/operators having six Points or more on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette service driver;</li> <li>(iii) Ambulette service may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.</li> </ul> </li> </ul>

***Our review of employee personnel files found files where driving record results were not noted.***

***These audit finding required approximately \$350,000.00 to be reimbursed to Medicaid. Can your service afford that?***

**IN CONCLUSION**

This article shows the role of the ODJFS and the AG's Office and gives excerpts from actual audit situations. It is not meant to intimidate or threaten you but rather to educate you and make you aware. Nothing in the investigative world is done in a vacuum. There is a regular cross flow of information between agencies involved. Each agency is

required to share information involving violations of the law with the appropriate enforcement agency. Information may also come from the Patient, Client, or general public.

Here are some things you can do to help prevent an audit or make the audit less painful:

- Make sure your service is licensed with the OMTB and your vehicles have the appropriate inspections and permits prior to transporting patients/clients.
- Do not over inflate the quantity of trips you provide.
- Report actual trips only and maintain the documentation required for the audit. Remember: An audit may not focus on the present, but may look back up to six years (you are required to maintain those records)
- Maintain complete trip logs/run reports as required.
- Do not destroy employee records associated with trips. When the auditors look at reports/logs they will want to see if the employees listed were trained/certified at the time of transport.
- Ensure the mileage you claim is consistent with the logs and with the amount that was billed.
- Be intimately familiar with billing practices and/or your billing service/department. Make sure claims for reimbursement are submitted only once. Duplicate billing will be caught.
- Ensure claims are submitted only for covered services and only for covered individuals.
- Make sure you have the Certificates of Medical Necessity available.
- Cooperate fully with the Auditor or the Attorney General's Office.

Remember: **There are no degrees of fraud. If you have committed fraud you can count on these things:**

- ***You will be eventually caught.***
- ***You will be required to reimburse Medicaid***
- ***You may be forced to close your business***
- ***You may face federal indictment, and***
- ***You may be imprisoned***

The Ohio Medical Transportation Board does not want any of its licensed services to be forced to close. But, if you have come under the scrutiny of ODJFS or the AG, the Ohio Medical Transportation Board will be required to submit documentation about your service to ODJFS and the AG to aid in their Investigation.

MIND YOUR BUSINESS DILIGENTLY.

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**GOVERNOR STRICKLAND APPOINTS NEW BOARD MEMBERS:** Two new board members were appointed by Governor Ted Strickland and sworn in at the Ohio Medical Transportation Board's regular meeting on September 16, 2008. Newly appointed members are Herb de la Porte and Tonie Slocum-Champion.

The board thanks the outgoing members, Todd Walker and Mike Bakes, for their past dedicated service.



Herb de la Porte is vice president of both Lorain LifeCare Ambulance Service in Lorain, Ohio and LifeCare Ambulance Service in Elyria, Ohio. Herb began as an EMT in 1984. In August 1986 he founded LifeCare Ambulance. He is part of a family team that grew the company into the Largest Ambulance service in Lorain County providing 911 and routine transportation services to a population of around 150,000.

Herb is active in the business and in the community and the organization also supports and funds a fully accredited paramedic training center.



Tonie Slocum-Champion is a native of Cleveland. She moved to Denver Colorado in 1987, where she lived for 15 years until her return to Cleveland Ohio. Tonie has a BA from CSU in liberal studies and a minor in biology and is currently pursuing both her Masters and PhD in Public Health.

Before starting All Care Transportation, Ms. Slocum-Champion worked as a phlebotomist and Medical Technician for several Labs and Hospitals.

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## MEMBER'S CORNER

By way of introduction, I am John P. Moore, Ohio Medical Transportation Board Member and Vice Chair serving the board as a member of a public emergency medical service organization.



First, I want to thank Governor Strickland for my recent re-appointment to my fourth 2-year term on the Board, I am grateful for the opportunity to serve.

As a board member, I feel it my obligation to help ensure the professional, competent, and safe transport of those in need of medical transport. Our competent staff led by Ron Grout, Executive Director, and supported by Assistant Attorney General, Barbara Pfeiffer helps me and the other Board members to use Ohio Revised Code 4766 in pursuing this goal.

I have 30+ years of service in public sector fire/EMS. I have worked with private sector EMS services and maintain a healthy respect and relationship for their activities and personnel.

Our board assures consumers that transports monitored by our board, will be safe and efficient with appropriate regulation and inspections. I think our board has an excellent history of performing this task for our private sector EMS providers

With the growth of billing activities by public sector EMS, I feel it may be time for the public EMS providers to evaluate their need for the services provided by our board. We presently serve the private sector; however, the public services are excluded from monitoring by our Board.

When our consumers request medical transportation services from private or public services, I think their expectation of the type and quality of service received should be the same regardless of service ownership or type. I am pleased to state that our board has seen an increase of interest in OMTB activities by some public services which will help validate and verify the fact their level of service is as advertised.

What stimulates my interest in this matter is my desire to help ensure safe efficient medical transportation of persons in our state. Whether we should include the public sector EMS provider who bills for services is a question best left for our consumers to decide and the Public EMS providers to ponder.

Thank you for the opportunity to serve you and feel free to contact either me or the Board with your concerns.

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### **Retro Reflective Safety Vests Required for Firefighters and First Responders on Federally Funded Highways**

A new U.S. Department of Transportation/Federal Highway Administration regulation (Worker Visibility Final Rule - 23 CFR Part 634) requiring firefighters and other first responders responding to or working at an incident on federally funded highways to wear a retro reflective safety vest became effective on November 24, 2008. The minimum requirements for ANSI/ISEA compliant garments include use of fluorescent yellow-green, orange-red, or red background material with 360 degree retro reflective visibility. Garments should be labeled as compliant with *ANSI/ISEA 107-2004* or *ANSI/ISEA 207-2006*.

While this new regulation applies only to responses on federally funded highways, The United States Fire Administration highly recommends that all firefighters and first responders wear ANSI/ISEA compliant highway safety vests while working on any incident on the roadway.

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### **BOARD MEMBERS**

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