Audit Report

Acadian Ambulance Services

A Texas Medicaid Ambulance Provider

July 28, 2021
OIG Report No. AUD-21-015

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS AUDIT

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of ground emergency ambulance services at Acadian Ambulance Service of Texas, LLC (Acadian). Emergency ambulance services are allowable when the client has an emergency medical condition. For purposes of this audit, auditors examined payments from three selected MCOs.

The audit objective was to determine whether Acadian billed Superior HealthPlan (Superior), Texas Children's Health Plan (TCHP), and UnitedHealthcare (United) for claims for ground emergency ambulance services in accordance with applicable statutes, rules and procedures in the managed care environment for the period from September 1, 2018, through May 31, 2020.

WHAT THE OIG RECOMMENDS

Acadian should (a) code non-medically necessary encounters appropriately, (b) ensure it maintains sufficient support for all claims, and (c) repay $43,925.88.

MANAGEMENT RESPONSE

OIG Audit presented audit results, issues, and recommendations to Acadian in a draft report dated July 6, 2021. Acadian provided management responses that agreed with the recommendations for two of the three issues in the report. Acadian's management responses are included in the report following the issues.

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ACADIAN AMBULANCE SERVICES

A Texas Medicaid Ambulance Provider

WHAT THE OIG FOUND

Acadian met most of the requirements tested. For all 180 ground emergency transport claims tested for all three managed care organizations (MCOs), Acadian recorded accurate client and receiving facility data, accurately calculated mileage from pick-up to destination, and transported patients to an appropriate facility such as a hospital. However, Acadian did not always report transports correctly or maintain all needed support for claims. Specifically:

- Four of 180 (2.2 percent) claims tested were not medically necessary according to documentation in Acadian's billing system. The claims were billed although Acadian determined that they were not medically necessary.

- Auditors found that Acadian billed 8 of 176 applicable claims (4.5 percent) tested for a higher level of service than should have been charged based on services documented in medical records. Incorrectly classifying claims at a higher level of service can lead to overpayment for services:
  - Acadian billed six claims as advanced life support (ALS), but the medical records do not contain documentation that supports ALS services or an ALS assessment. Therefore, it should have billed for basic life support services for these claims.
  - Acadian billed two scheduled, hospital-to-hospital transports as emergency transports without evidence of emergency services provided.

- Acadian did not provide sufficient support for one out of 134 (0.7 percent) transports tested for patients that did not have a corresponding receiving facility claim, which makes the claim not supported for payment under Medicaid rules. Key fields in the record provided by Acadian did not match the MCO claims data, which indicates Acadian filed the claim with the incorrect patient details.

BACKGROUND

Acadian provides services including ground and air transportation, emergency and non-emergency ambulance transportation, mobile healthcare, and other services. During the audit scope, Acadian received $15,872,273 for providing 53,297 ground emergency ambulance claims through Texas Medicaid. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in (a) placing the member's health in serious jeopardy, (b) serious impairment of bodily functions, (c) serious dysfunction of any bodily organ or part, (d) serious disfigurement, or (e) with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

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INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of ground emergency ambulance services at Acadian Ambulance Service of Texas, LLC (Acadian). Emergency ambulance services are allowable when the client has an emergency medical condition (see text box for a definition).

Acadian provides services including ground and air transportation, emergency and non-emergency ambulance transportation, mobile healthcare, and other services. It operates in Louisiana, Texas, Tennessee, and Mississippi. During the audit scope, Acadian received $15,872,273 for 53,297 ground emergency ambulance claims processed through Texas Medicaid.[1] This includes fee-for-service payments directly from the Texas Health and Human Services Commission (HHSC) of $3,318,055, as well as payments from 18 managed care organizations (MCOs) of $12,554,218. For purposes of this audit, auditors examined payments from three selected MCOs totaling $7,420,042.[2]

An **emergency medical condition** is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the member's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

Source: Managed Care Organization Provider Handbooks

Objective and Scope

The audit objective was to determine whether Acadian billed Superior HealthPlan (Superior), Texas Children's Health Plan (TCHP), and UnitedHealthcare (United) for claims for ground emergency ambulance services in accordance with applicable statutes, rules and procedures in the managed care environment.

The audit scope covered ground emergency ambulance claims for the period from September 1, 2018, through May 31, 2020. The scope also included a review of significant controls and control components including medical coding and billing controls, training policies, and strategic plans through the end of the scope period.

[1] Fee-for-service and encounter data were pulled from the Texas Medicaid Administrative System Oracle database. The database is maintained by the Texas Medicaid and Healthcare Partnership (TMHP) on behalf of the Texas Health and Human Services Commission.

[2] Based on paid claims data received from each of the three MCOs.

Methodology

To accomplish its audit objective, OIG Audit collected information through discussions and interviews with responsible staff at Acadian, Superior, TCHP, and United, and through request and review of supporting documentation maintained by Acadian and the MCOs.

OIG Audit reviewed records supporting services delivered by Acadian to selected clients for the period September 1, 2018, through May 31, 2020. OIG Audit selected and tested statistically valid random samples of clients who received ground emergency ambulance services. Additionally, OIG Audit selected and tested non-statistical risk-based samples of (a) ground emergency ambulance transports without a corresponding medical claim at a receiving facility, and (b) mileage outlier claims with the highest mileage in our scope.

OIG Audit performed the following tests:

- Evaluating whether services in a random sample of claims were supported by medical records. Auditors evaluated (a) the reasonableness of mileage billed, (b) support for procedure codes billed, (c) existence of patient signature and receiving facility information, and (d) documentation of Acadian's evaluation of medical necessity. Auditors did not make a determination of whether claims were medically necessary. Instead, auditors reviewed fields in Acadian's billing system to determine whether Acadian followed its processes in determining medical necessity. Additionally, auditors did not determine whether transports were correctly classified as emergency, except for certain claims where a treatment was not clearly documented.

  Details about the sampling methodology are given in Appendix A.

- Analyzing data to identify claims with the highest billed mileage, then testing 12 of the highest mileage claims to (a) recalculate mileage and (b) determine whether the receiving facility appeared to support the necessary treatment based on information in Acadians' medical records.

- Reviewing claims for ground emergency ambulance transports that did not have a corresponding medical claim at a receiving facility the day before, the day of, or the day after the transport. Auditors reviewed Acadian's

medical records supporting the claims and sent a certification form to receiving facilities to determine whether the receiving facility had a record for the patient's transport.

- Reviewing Acadian's system of internal controls, including components of internal control,[3] within the context of the audit objectives.

Auditors assessed the reliability of paid claims data by (a) performing testing of required data elements, (b) reviewing sample screenshots and the system that produced them, and (c) interviewing Acadian staff knowledgeable about the data. In addition, auditors traced a statistically valid random sample of data to source documents. Auditors determined that the data was sufficiently reliable for the purposes of this report.

OIG Audit presented audit results, issues, and recommendations to Acadian in a draft report dated July 6, 2021.

Acadian provided management responses that agreed with the recommendations for two of the three issues in the report. Acadian's management responses are included in the report following the issues.

Criteria

OIG Audit used the following criteria to evaluate the information provided:

- 1 Tex. Admin. Code § 371.1667 (2016)
- Texas Medicaid Provider Procedures Manual, Vol. 1, § 1 (2018 through 2020)
- Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" (2018 through 2020)
- Ambulance Ancillary Services Agreement between Texas Children's Health Plan, Inc., and Acadian (2016)
- Participating Provider Agreement between Superior HealthPlan, Inc. and Acadian Ambulance Services of Texas, LLC (2015), as amended
- Texas Children's Health Plan Provider Manual (2018 through 2020)

[3] For more information on the components of internal control, see the United States Government Accountability Office's *Standards for Internal Control in the Federal Government* (Sept. 2014), https://www.gao.gov/assets/gao-14-704g.pdf (accessed Apr. 16, 2021).

- Superior HealthPlan Provider Manual (2018 through 2020)
- United Healthcare Administrative Guide/Provider Manual (2018 through 2020)

Auditing Standards

Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

AUDIT RESULTS

Auditors tested 180 ground emergency ambulance claims (60 for each MCO) to determine whether they were supported and complied with applicable statutes, rules, and procedures. For all 180 ground emergency transport claims tested, Acadian:

- Recorded accurate client and receiving facility data. Auditors verified data recorded in Acadian's systems matched data it submitted to MCOs. Data tested included client name, date of birth, date of service, and facility address.

- Accurately calculated mileage from pick-up to destination. Auditors re-calculated the number of miles between the pick-up and destination locations using MapQuest and determined miles billed by Acadian were correct within certain parameters.

- Transported patients to an appropriate facility such as a hospital. Auditors verified the receiving facilities' addresses per their website matched the addresses in Acadian's billing system and determined the destinations appeared to be reasonable facilities to provide emergency services.

Auditors identified issues related to the documentation of the medical necessity of the ground emergency transport, billing for a higher level of service, and billing certain non-emergency facility-to-facility transports as emergency. Additionally, auditors tested the reasonableness of 134 claims for ground emergency ambulance transports that did not have a corresponding medical claim at a receiving medical facility. Auditors determined there was reasonable documentation for all but one claim.

OIG calculated an error rate for overpayment amounts identified for the statistically valid random sample of clients tested, which was applied to the population of associated claims using extrapolation. See Appendix A for the sampling, testing, and extrapolation methodology.

OIG Audit communicated other less significant issues to Acadian in a separate written communication.

Issue 1: Acadian Incorrectly Reported and Was Paid for Non-Medically Necessary Transports

Acadian identified 4 of 180 claims (2.2 percent) tested as not medically necessary when it processed the claims in its billing system. However, Acadian did not use the required modifier and the claims were incorrectly paid as medically necessary claims. The amount overpaid on these claims totaled $1,850.51. To be eligible for reimbursement, claims must be for medically necessary services.[4]

Providers are required to maintain and retain all necessary documentation, records, and claims to fully document the medical necessity of services and supplies provided and delivered to a client with Texas Medicaid coverage.[5]

Acadian did not use the required GY modifier for the four claims identified as not medically necessary. Compliance staff at the three MCOs chosen for this audit confirmed that they expect providers to code non-medically necessary claims with a "GY" modifier, in accordance with the Texas Medicaid Provider Procedures Manual (TMPPM) Ambulance Services Handbook.[6] This allows encounter data to be tracked for reporting purposes even if the data does not represent a payment.

Acadian provided to auditors an email exchange it had with HHSC regarding how to properly code non-medically necessary claims in 2017 and 2018. The e-mails show Acadian reached out to HHSC to make a complaint that MCOs continued to pay claims submitted with a GY modifier. Acadian stated it tried submitting these claims without a GY modifier but marked as "no medical necessity" as a test. However, in that email exchange, HHSC instructed Acadian to use the GY modifier for non-medically necessary claims in accordance with the TMPPM.

[4] 1 Tex. Admin. Code § 371.1667(4)(D) (May 1, 2016) states, "A person is subject to administrative actions or sanctions if the person fails to make, maintain, retain, or produce documentation sufficient to demonstrate compliance with any federal or state law, rule, regulation, contract, Medicaid or other HHS policy, or professional standard in order to establish medical necessity, medical appropriateness, or adherence to the professional standard of care related to services or items provided."

[5] Texas Medicaid Provider Procedures Manual, Vol. 1, § 1.6.3 (Sept.2018 through Feb. 2020) and § 1.7.3 (Mar. 2020 through May 2020).

[6] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.5.7 (Sept. 2018 through May 2020).

Table 1 details the four non-medically necessary claims by MCO (Superior and TCHP) and dollar amount. United did not have any errors in this category.

Table 1: Claims for Non-Medically Necessary Transports in Sample Testing

MCO	# of Claims	Error Rate	Dollar Amount of Error in Sample
Superior	1	1.7%	$ 748.76
TCHP	3	5.0%	1,101.75
Total	4	2.2%	$1,850.51

Source: OIG Audit

The $1,850.51 is part of the extrapolated recovery noted in the "Overpayments to Acadian" section of this report.

Recommendation 1

Acadian should submit non-medically necessary transports with a GY modifier in accordance with TMPPM requirements and MCO expectations.

Management Response

Acadian provided to auditors an email exchange it had with HHSC regarding how to properly code non-medically necessary claims in 2017 and 2018. The e-mails show Acadian reached out to HHSC to make a complaint that MCOs continued to pay claims submitted with a GY modifier. Acadian stated it tried submitting these claims without a GY modifier but marked as "no medical necessity" as a test. However, in that email exchange, HHSC instructed Acadian to use the GY modifier for non-medically necessary claims in accordance with the TMPPM. On all four of the claims, Acadian requested via certified letter that the MCO recoup the payment due to not being medically necessary. Over the past six months we have continued to test with the GY and received invalid modifier denials on no medical necessity claims. Though we are continuing to try and submit test claims, we continue to receive invalid denials and inappropriate payments. We will continue to communicate these issues to HHSC directly. While we agree with the OIG recommendation to submit with the GY modifier, our continuous testing with the MCO's still indicates that we are getting incorrect payments and denials.

Action Plan

Acadian Ambulance will file claims with no medical necessity to MCOs with both Medically Necessary -No, and GY modifiers.

Responsible Manager

Medicaid/Medicaid Health Maintenance Organization Manager

Target Implementation Date

Immediately

Issue 2: Acadian Could Not Provide Support for the Service Level Billed

Auditors found that Acadian billed 8 of 176 applicable claims[7] (4.5 percent) for a higher level of service than should have been charged based on services documented in medical records. Acadian:

- Billed basic life support (BLS) services as advanced life support (ALS) on six claims.
- Classified claims as emergency without supporting the emergency condition on two claims.

Basic Life Support Services Billed as Advanced Life Support

Acadian billed six claims as ALS, but the medical records do not contain any documentation reflecting ALS services or an ALS assessment. Therefore, its documentation supports billing for BLS services for these claims. Table 2 details the overpayments by MCO and dollar amount.

Table 2: Claims Billed as ALS instead of BLS

MCO	# of Claims	Dollar Amount of Error in Sample
Superior	1	$ 45.05
TCHP	2	90.10
United	3	135.15
Total	6	$270.30

Source: OIG Audit

According to the TMPPM Ambulance Services Handbook, ALS is emergency care that uses invasive medical acts, including an ALS assessment or at least an ALS intervention.[8] OIG Audit verified with compliance staff from Superior, TCHP, and United that ambulance providers should follow the TMPPM Ambulance Services Handbook when determining whether a claim should be classified as BLS or ALS.

[7] The four non-medically necessary claims identified in Issue 1 were removed for this test.

[8] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.3 (Sept. 2018 through May 2020).

Acadian could not provide support for a consistent process to classify claims as ALS. Incorrectly classifying claims at a higher level of service can lead to overpayment for services.

The $270.30 is part of the extrapolated recovery noted in the "Overpayments to Acadian" section of this report.

Recommendation 2a

Acadian should:

- Develop documented policy and criteria for when to classify claims as ALS versus BLS in accordance with the TMPPM Ambulance Services Handbook.

- Ensure coding staff are trained on the policy.

Management Response

Acadian's current process begins in our dispatch center by utilizing an Emergency Medical Dispatch (EMD) program, ProQa, for all incoming emergency and non-emergency calls. The ProQa information obtained, and medic documentation is reviewed by a two-step authentication process: (1) automated billing pre-programmed billing rules based upon ProQa problem nature with appropriate dispatch; and (2) manual review for all claims where the problem nature identified at the point of dispatch was not identified as a BLS or ALS emergency. As mentioned, this is a process that is currently in place and has been thoroughly explained throughout this audit process.

Action Plan

Continue with current process

Responsible Manager

Coding and Documentation Center Manager

Target Implementation Date

In place

Auditor Comment

OIG Audit appreciates the feedback provided by Acadian in its management response letter and respects Acadian's position on reported issues. OIG Audit offers the following comments regarding Acadian's management response for

Recommendation 2a. The process noted in Acadian's management response was provided during the audit. Audit testing disclosed that the process noted for determining ASL services was inconsistent. The six claims noted in Issue 2 did not fall under the automated procedure Acadian noted and so were not listed as ALS in the pre-programmed billing rules of the ProQa process.

Per the TMPPM Ambulance Services Handbook, ALS is emergency care that uses invasive medical acts, including an ALS assessment, or at least an ALS intervention.

For the six claims billed as ALS noted in Issue 2, no interventions were performed, and as a result, the claims should have been billed as BLS.

Non-Emergency Facility-to-Facility Claims Billed as Emergency

Acadian billed two scheduled, facility-to-facility transports as emergency transports without supporting evidence of emergency services provided. According to the TMPPM, facility-to-facility transports may be considered an emergency[9] if emergency treatment is not available at the first facility and the client still requires emergency care.[10] The MCOs in the scope of the audit expect Acadian to follow the TMPPM Ambulance Services Handbook. The claims totaled $108.46 and were paid by Superior.

Acadian stated it classifies facility-to-facility transports as an emergency when a patient leaving the emergency department requires post stabilization services for a condition that was related to the emergency care. It stated that if the patient stays in the emergency department, the patient has potential to relapse. However, Acadian could not provide support that the client still required emergency care as required by the TMPPM. Billing non-emergency services as emergencies results in overpayments to the provider.

The $108.46 is part of the extrapolated recovery noted in the "Overpayments to Acadian" section of this report.

Recommendation 2b

Acadian should develop a process to identify when facility-to-facility transports meet the definition of an emergency medical condition (as defined in the MCOs' provider handbooks) in accordance with the TMPPM.

[9] The definition for emergency medical condition is given in the text box on page 1 of this report.

[10] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.1 (Sept. 2018 through May 2020).

Management Response

Please reference Section 2.2.1 Emergency Ambulance Transport Services "Facility-to-Facility transport may be considered an emergency if emergency treatment is not available at the first facility and the client still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the client involved." A patient being transferred from the ED requiring post-stabilization services for a condition that was related to the emergency care is considered emergent. If the patient were to stay in the ED, the patient has the potential to relapse. Taking into account the information stated above, these claims are filed as either A0427, or A0429, and if SCT A0434.

Action Plan

Continue with current process based on interpretation of regulation 2.2.1

Responsible Manager

Medicaid/Medicaid Health Maintenance Organization Manager

Target Implementation Date

Currently in place

Auditor Comment

OIG Audit appreciates the feedback provided by Acadian in its management response letter and respects Acadian's position on reported issues. OIG Audit offers the following comments regarding Acadian's management response for Recommendation 2b.

Acadian billed these two scheduled, facility-to-facility transports as emergency transports without supporting evidence of any provided emergency services.

Issue 3: Acadian Submitted a Claim with Incorrect Patient Data

OIG Audit identified 134 claims paid to Acadian for ground emergency ambulance transports for which the patient did not have a corresponding medical claim at a receiving facility.

Acadian provided medical records for 133 out of 134 claims. These records included information such as patient name and date of birth, name and address of the receiving facility, and a narrative describing the reason for the ambulance

transport and services provided. Medical records serve as Acadian's record that the transport occurred.

Acadian did not provide sufficient support for one out of 134 (0.7 percent) transports tested for patients that did not have a corresponding receiving facility claim ($888.01 total). Key fields in the record (client name, date of birth, and Medicaid ID) provided by Acadian did not match the MCO claims data, which indicates Acadian filed the claim with the incorrect patient details.

Therefore, this claim is not supported for payment under Medicaid rules. The TMPPM requires providers to maintain and retain all necessary documentation, records, and claims to fully document the services and supplies provided and delivered to a client with Texas Medicaid coverage.[11]

Recommendation 3

Acadian should:

- Repay HHSC $888.01
- Ensure all claims submitted to MCOs are for the correct patient

Management Response

Acadian was able to identify that this claim was sent out with the incorrect patient name due to human error. Upon identifying the issue the MCO was refunded.

Action Plan

Acadian continuously educates and trains our staff to accurately verify patient demographics.

Responsible Managers

- *Coding and Documentation Center Manager*
- *Medicaid/Medicaid Health Maintenance Organization Manager*

Target Implementation Date

Currently in place

[11] Texas Medicaid Provider Procedures Manual, Vol. 1, § 1.6.3 (Sept.2018 through Feb. 2020) and § 1.7.3 (Mar. 2020 through May 2020).

OVERPAYMENTS TO ACADIAN

Overpayments identified for each of the three statistically valid samples of claims were used to calculate an error rate, which was applied to the respective MCO claims population using extrapolation. The total extrapolated overpayment amount is $43,037.87. See Appendix A for the sampling, testing, and extrapolation methodology.

Auditors also identified one overpayment in a non-statistical sample totaling $888.01.

Extrapolation

The populations included in this audit consisted of the following paid claims to selected MCOs from September 1, 2018, through May 31, 2020:

- Superior: 9,506 claims totaling $3.83 million
- TCHP: 3,680 claims totaling $1.48 million
- United: 5,372 claims totaling $2.12 million

OIG selected three statistically valid samples, a total of 180 claims for which MCOs paid Acadian $86,211.10. The 12 claims with exceptions are detailed in Issues 1 and 2 and summarized in Table 3:

Table 3: Summary of Exceptions Subject to Extrapolation

MCO	Issue 1	Issue 2	Total
Superior	$ 748.76	$153.51	$ 902.27
TCHP	1,101.75	90.10	1,191.85
United	0.00	135.15	135.15
Total	$1,850.51	$378.76	$2,229.27

Source: OIG Audit

By extrapolating the results of each of the three samples to the appropriate population of claims within the scope of the audit, OIG determined that the exceptions represented an overpayment for the populations of $43,037.87.

The estimated overpayment amount was calculated by extrapolating the dollar value of the errors across the appropriate sample population:

Superior	$12,166.86
TCHP	25,403.59
United	5,467.42
Total	$43,037.87

Other Overpayment

In addition to overpayments identified in statistical samples, auditors identified one overpayment of $888.01 in the non-statistical sample in Issue 3.

Therefore, based on the results of this audit, Acadian should return the total overpayment amount of $43,925.88 to the state of Texas.

CONCLUSION

Acadian met most of the requirements tested. For all 180 ground emergency transport claims tested for three MCOs, Acadian recorded accurate client and receiving facility data, accurately calculated mileage from pick-up to destination, and transported patients to an appropriate facility such as a hospital.

However, Acadian did not always report transports correctly or maintain all needed support for claims. Specifically:

- Four of 180 (2.2 percent) claims tested were not medically necessary according to documentation in Acadian's billing system. The claims were billed although Acadian determined that they were not medically necessary.

- Auditors found that Acadian billed 8 of 176 applicable claims (4.5 percent) tested for a higher level of service than should have been charged based on services documented in medical records:
  - Acadian billed six claims as ALS, but the medical records do not contain documentation of ALS services or an ALS assessment. Therefore, it should have billed for BLS services for these claims.
  - Acadian billed two scheduled, hospital-to-hospital transports as emergency transports without evidence of emergency services provided.

- Acadian did not provide sufficient support for one out of 134 (0.7 percent) transports tested for patients that did not have a corresponding receiving facility claim. Key fields in the record (client name, date of birth, and Medicaid ID) provided by Acadian did not match the MCO claims data, which indicates Acadian filed the claim with the incorrect patient details.

OIG Audit offered recommendations to Acadian, which, if implemented, will help ensure compliance with their contracts, the TMPPM, and TAC rules.

Acadian should return $43,925.88 to the state of Texas.

OIG Audit thanks management and staff at Acadian for their cooperation and assistance during this audit.

Appendix A: Sampling, Testing, and Extrapolation Methodology

OIG Audit examined ground emergency ambulance claims for the period from September 1, 2018, through May 31, 2020. After an initial assessment of risks and associated controls, OIG Audit performed testing from three ground emergency ambulance claims populations.

Testing for compliance with laws, requirements, and Acadian's internal processes

Auditors tested three statistically valid random samples of 60 claims each (180 claims total). OIG obtained separate claims populations for each of the three MCOs audited, then selected a sample of 60 from each population. The population sizes for each MCO were as follows:

- Superior: 9,506 claims totaling $3.83 million
- TCHP: 3,680 claims totaling $1.48 million
- United: 5,372 claims totaling $2.12 million

Extrapolation

The estimated overpayment amount of $43,037.87 for the samples tested was calculated by extrapolating the dollar value of the errors of each sample as identified in Issues 1 and 2 across the appropriate populations. The overpayment for each population was calculated based on a 90 percent confidence level.

Acadian was kept apprised of all aspects of the audit process and, in order to ensure audit findings were accurate, was offered multiple opportunities to provide relevant documentation and information.

The Texas Legislature has recognized HHS OIG's authority to utilize a peer-reviewed sampling and extrapolation process. HHS OIG has formally adopted RAT-STATS software as the statistical software to be utilized for the extrapolation process to be consistent with the Office of Inspector General for the United States Department of Health and Human Services.[12]

Receiving Facility Confirmations

The OIG identified and tested 134 emergency ambulance claims that did not have a corresponding medical claim the day before, the day of, or the day after the ambulance transport. The items were generally not representative of the

[12] 1 Tex. Admin Code § 371.35 (May 15, 2016).

populations for the entities; therefore, it would not be appropriate to project the test results to those populations.

In addition to reviewing Acadian's medical records, auditors sent certification forms to each receiving facility. The forms inquired whether the receiving facility had a record for the patient's transport. Auditors received completed Records Certification Forms for 60 of 134 (44.8 percent) claims. Of those, 39 confirmed that the patient was either dropped off by ambulance or received services from the facility on the claim's date of service.

High-Mileage Transports

Auditors selected a risk-based, nonstatistical sample of 12 claims with the highest mileage to examine whether the mileage billed was reasonable and accurate. These sample designs were chosen to address specific risk factors identified in the populations. The sample items were generally not representative of the populations for the entities; therefore, it would not be appropriate to project the test results to those populations.

Appendix B: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy J. VerColen, CPA, Deputy Inspector General of Audit and Inspections
- Joel A. Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Julia Youssefnia, CPA, Audit Project Manager
- Leia Villaret, Senior Auditor
- Paris Pham, Staff Auditor
- Aleah Mays-Williams, Staff Auditor
- Karen Mullen, CGAP, Quality Assurance Reviewer
- Constance Stagman, Acute Care Surveillance Manager
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Cecile Erwin Young, Executive Commissioner
- Kate Hendrix, Chief of Staff
- Maurice McCreary, Jr., Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Stephanie Stephens, State Medicaid Director, Medicaid and CHIP Services
- Katherine Scheib, Deputy Associate Commissioner, Medicaid and CHIP Services
- Camisha Banks, Director, Medicaid and CHIP Services

- Latoya King-Escalante, Manager, Special Projects Team, Medicaid and CHIP Services
- Aminat Dennis, Special Projects Team Coordinator, Medicaid and CHIP Services
- Adriana Ramirez-Byrnes, Project Manager, Medicaid and CHIP Services

Acadian

- Rusty Wood, Director for Acadian Ambulance, Texas Market
- Asbel Montes, Health Policy Advisor
- Corey Chapman, Director of Revenue Cycle
- Allyson Pharr, Executive Vice President of Legal and Governmental Affairs
- Lauren Starling, Billing Compliance Manager
- Carrie Landry, Medicaid/Medicaid Health Maintenance Organization Manager
- Natalie Roberts, Coding and Documentation Center Manager

Managed Care Organizations

- Richelle Fleischer, President, Texas Children's Health Plan
- Don Langer, Chief Executive Officer, Texas and Oklahoma, United HealthCare
- Mark Sanders, Chief Executive Officer, Superior HealthPlan
- Deborah Deska, Compliance Officer for Texas, United HealthCare
- Jennifer Gasior, Director of Compliance, Superior HealthPlan
- Jenny Lee Garza, Compliance Manager – Regulatory Compliance and Deliverables, Superior HealthPlan
- Sharon McWhorter, Director, Controls and Compliance, Texas Children's Health Plan
- Robert Anderson, Manager, Special Investigations Unit, Controls and Compliance, Texas Children's Health Plan

Appendix C: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews

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- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
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