Inspections Report

Ambulance Claims Oversight

Molina Healthcare of Texas, Inc.

June 1, 2023
OIG Report No. INS-23-009

Inspector General

Texas Health and Human Services

Ambulance Claims Oversight

Molina Healthcare of Texas, Inc.

Results in Brief

Why OIG Conducted This Inspection

In 2021 and 2022, the Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division performed two audits of ground emergency ambulance services. As part of testing, auditors identified non-medically necessary claims, submitted with the required modifier, were paid as medically necessary.

Summary of Review

The inspection objective was to determine whether Molina Healthcare has processes and controls to ensure ambulance claim payments comply with select requirements. The inspection scope covered the period from September 1, 2021, through August 31, 2022.

During the scope of the inspection, Molina Healthcare received $3.3 billion in Texas Medicaid funds and served an average of 252,925 Texas Medicaid recipients from eight counties each month.

For more information, contact:
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Key Results

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) conducted an inspection of ambulance services claims paid by Molina Healthcare of Texas, Inc. (Molina Healthcare), a Texas Medicaid managed care organization (MCO).

Molina Healthcare's claims system has controls in place to identify non-medically necessary claims and deny the claims as required. However, Molina Healthcare's claims system did not have controls to consistently ensure compliance with required (a) prior authorizations, (b) claims modifiers, or (c) procedure code combinations. Specifically, Molina Healthcare allowed payment for:

- 10 of 45 tested nonemergency ambulance claims, without required prior authorization.
- 6 tested emergency ambulance claims, without the required modifier. Additionally, 3 of the six did not have the required transport procedure codes.

Recommendations

Molina should:

- Strengthen its claims processing controls to (a) identify claims requiring a prior authorization and (b) deny the claim if a prior authorization is not obtained.
- Clarify its standard operating procedures language and train its claims processing staff on nonemergency and emergency transport claims processing.

Management Response

Molina agreed with the inspection recommendations and indicated corrective actions would be implemented by July 31. Molina's management responses are included in the report following each recommendation.

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Inspection Overview

Overall Results

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) conducted an inspection of Medicaid ambulance services claims paid by Molina Healthcare of Texas, Inc. (Molina), a Texas Medicaid managed care organization (MCO) contracted to provide Medicaid and Children's Health Insurance Program (CHIP) services to members.

The inspection reviewed Molina's paid claims and selected either (a) non-medically necessary claims, or (b) claims without an emergency modifier (ET) and prior authorization number to test.

Molina's claims processing system has controls to identify non-medically necessary claims and deny the claims as required. However, Molina did not consistently ensure it paid claims in compliance with required (a) prior authorizations, (b) claims modifiers, or (c) procedure code combinations. Specifically, Molina allowed payment for:

- Nonemergency ambulance claims that did not contain a required prior authorization.
- Emergency ambulance claims without the required modifier.
- Emergency ambulance mileage claims without the required transport procedure code.

This report is considered written education in accordance with Texas Administrative Code.[1] Inspection findings identified in this report (a) may be referred to the Texas Health and Human Services Commission (HHSC) for potential pursuit of enforcement remedies or (b) may be subject to OIG administrative enforcement measures,[2] including administrative penalties.[3] OIG Inspections offered recommendations to Molina, which, if implemented, will help ensure Molina's ambulance claim payments comply with applicable requirements.

[1] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

[2] 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

[3] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

OIG Inspections presented preliminary inspection results, issues, and recommendations to Molina in a draft report dated May 23, 2023. Molina agreed with the inspection recommendations and indicated corrective actions would be implemented by July 31. Molina's management responses are included in the report following each recommendation.

OIG Inspections thanks management and staff at Molina for their cooperation and assistance during this inspection.

Objective

The inspection objective was to determine whether Molina has processes and controls to ensure ambulance claim payments comply with select requirements.

Scope

The inspection scope covered the period from September 1, 2021, through August 31, 2022.

Background

Texas Medicaid ambulance services include both nonemergency and emergency transports. An emergency transport service is a Medicaid benefit when the member has an emergency medical or behavioral health condition. Molina network providers must use the ET modifier when billing a claim for an emergency transport.[4] A nonemergency ambulance transport is a Medicaid benefit for members to or from scheduled medical appointments or licensed treatment facilities, or to the member's home after discharge from a hospital when the member has a medical condition for which the use of an ambulance is the only means of transportation. The requesting healthcare provider must obtain prior authorization from the member's health plan for all nonemergency ambulance transports.[5,6,7,8]

[4] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.4.4 (Sept. 2021 through Aug. 2022).

[5] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.2 (Sept. 2021 through Aug. 2022).

[6] Tex. Hum. Res. Code § 32.024(t) (Sept. 1, 2021).

[7] Uniform Managed Care Contract 8.1.8.1 (Sept. 1, 2021).

[8] 1 Tex. Admin. Code § 354.1115 (2) (Sept. 1, 2009).

OIG Inspections confirmed with Molina that Molina expects its providers to (a) obtain prior authorization for nonemergency ambulance transports and (b) code emergency transports as required by the Texas Medicaid Provider Procedures Manual (TMPPM) Ambulance Services Handbook.

During the scope of the inspection, Molina received $3.3 billion in Texas Medicaid funds and served an average of 252,925 Texas Medicaid recipients from eight counties each month.

What Prompted This Inspection

In 2021 and 2022, the OIG Audit and Inspections Division audited ground emergency ambulance services which identified ambulance providers submitted non-medically necessary claims with the required modifier and the claims were paid by some MCOs as medically necessary. Appendix B lists those audit reports.

Detailed Results

OIG Inspections reviewed 51 ambulance claims paid by Molina from September 1, 2021, through August 31, 2022, to determine whether they complied with Texas Medicaid requirements. Of those 51 claims:

- 45 were nonemergency transports, ten of which did not include the required prior authorization.
- Six were emergency transports, of which none included the required ET modifier, and three of which included mileage procedure codes without one of the required transport procedure codes.

Molina asserted that its providers should follow the TMPPM Ambulance Services Handbook to code emergency transports. TMPPM guidelines require emergency claims to be submitted with an ET modifier, or with a prior authorization if the ET modifier is not used.[9] TMPPM guidelines for emergency transports also require procedure code A0425, claims for mileage, be denied unless it is billed with an associated transport procedure code A0427, A0429, A0433, or A0434.[10] The inspection focused on the following modifiers:

- GY: A non-medically necessary transport
- ET: An emergency transport

Molina network providers must use the GY modifier to submit claims to indicate no medically necessary condition existed.[11] When Molina receives a claim submitted with a GY modifier, it automatically denies the claim.

However, Molina paid ten nonemergency claims that did not have prior authorization and six emergency claims missing the ET modifier. Additionally, three

[9] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.4.4 (Sept. 2021 through Aug. 2022).

[10] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.4.6 (Sept. 2021 through Aug. 2022).

[11] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.5.7 (Sept. 2021 through Aug. 2022).

of the six emergency claims did not have the required procedure code combination to be paid.

The following sections of this report provide additional detail about the findings of noncompliance observed by OIG Inspections.

Observation 1: Molina Paid Ten Nonemergency Transport Claims Without Required Prior Authorization

Molina paid some nonemergency transport claims missing the required prior authorization. Prior authorization is required to determine whether there is medical necessity for nonemergency transport claims. Ten of the 45 nonemergency transport claims reviewed (22.2 percent) did not have a required prior authorization. In a non-emergency circumstance, ambulance services require prior authorization.[12,13,14,15] The requesting health care provider submits a prior authorization request to the MCO, which determines medical necessity for the nonemergency transport.

Molina's claims processing system requires prior authorization for nonemergency out-of-network provider transport claims. However, the claims processing system allowed nonemergency in-network provider transport claims to pay without required prior authorization.

Molina asserted it paid (a) seven claims because its system edits did not require prior authorizations for the nonemergency transports for in-network providers, and (b) three claims because claims processing staff erroneously overrode the system edits that required the prior authorization. Additionally, Molina asserted the standard operating procedures used by claims processing staff contained ambiguous language causing differing interpretations of the correct action to take.

Claims for nonemergency transports without required prior authorization may result in payments made for non-medically necessary transports.

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[12] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.2 (Sept. 2021 through Aug. 2022).

[13] Tex. Hum. Res. Code § 32.024(t) (Sept. 1, 2021).

[14] Uniform Managed Care Contract 8.1.8.1 (Sept. 1, 2021).

[15] 1 Tex. Admin. Code § 354.1115 (2) (Sept. 1, 2009).

Recommendation 1

Molina should:

- Strengthen its claims processing system controls to (a) identify all claims requiring a prior authorization and (b) deny claims if a prior authorization is not obtained.
- Clarify its standard operating procedures and train claims processing staff related to nonemergency transport claims processing.

Management Response

Action Plan

Molina is enhancing our claim system configuration and standard operating procedures to ensure processing controls are in place to:

- Properly identify all claims requiring a prior authorization;
- Deny all nonemergency transport claims missing authorizations;
- Molina's claim team will update the standard operation procedures regarding ambulance claims processing to correct and remove the identified ambiguity and;
- Molina will conduct training/retraining to all claims staff on processing procedures for nonemergency and emergency transport pended claims.

Responsible Manager

Manager of Claims, Encounters, and Configuration

Target Implementation Date

July 31, 2023

Observation 2: Molina Paid Six Emergency Transport Claims Without the Required Elements

Molina paid emergency transport claims missing the required modifier or missing both the required modifier and a related procedure code. Six of the 51 (11.8 percent) ambulance claims reviewed used an emergency transport procedure code but did not include the ET modifier. Per the TMPPM, emergency transport claims without the ET modifier will be subject to prior authorization requirements.[16] Molina paid three of the six claims identified without the ET modifier and without prior authorization. Additionally, Molina paid the three remaining claims without (a) the required ET modifier, (b) prior authorization, or (c) required related procedure codes for procedure code A0425.[17]

Molina asserted that:

- Its claims processing system has a control to check the medical condition codes, procedure codes, and modifiers.
- If a claim does not contain the required elements, the system will put the claim in a "pend" status for further review by claims processing staff.
- Its standard operating procedures, used by claims processing staff, contained ambiguous language.

Additionally, Molina asserted that when claims processing staff reviewed these six claims, the staff incorrectly overrode the system, causing the claims to be paid due to claims processing staff interpretating the standard operating procedures inconsistently.

Allowing claim processing staff to manually adjudicate pending claims without clear standard operating procedures may result in ineligible claims payment.

[16] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.4.4 (Sept. 2021 through Aug. 2022).

[17] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.4.6 (Sept. 2021 through Aug. 2022).

Recommendation 2

Molina should clarify its standard operating procedures related to adjudicating pended emergency ambulance transport claims.

Management Response

Action Plan

Molina is enhancing our claim system configuration and standard operating procedures to ensure processing controls are in place to:

- Properly identify all claims requiring a prior authorization;
- Deny emergency transport claims missing required modifier(s);
- Molina's claim team will update the standard operation procedures regarding ambulance claims processing to correct and remove the identified ambiguity and;
- Molina will conduct training/retraining of all claims staff on processing procedures for nonemergency and emergency transport pended claims.

Responsible Manager

Manager of Claims, Encounters, and Configuration

Target Implementation Date

July 31, 2023

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

To achieve its objective, OIG Inspections collected information through (a) discussions with OIG Fraud Analytics and Data Operations staff (b) discussions and interviews with Molina staff and (c) a review of:

- Statutes, regulations, policies, and procedures that address the objective.
- Prior authorizations, encounter and paid claims data, and records for ambulance services.

To select an MCO for inspection, OIG Inspections considered the following criteria:

- MCOs' responses to an OIG Inspections questionnaire.
- Net revenue as reported on the MCOs' Financial Statistical Reports for the most recent state fiscal quarter available at the time of inspection initiation—March, April, and May of 2022.
- Number of counties served.

OIG Fraud Analytics and Data Operations staff identified 29,131 ambulance encounters during the scope of the inspection for Molina. Of those, no encounters had both the following criteria:

- GY modifier.
- A paid status.

Of the 29,131 encounters, OIG Fraud Analytics and Data Operations staff identified 1,503 ambulance encounters that met all the following criteria:

- No ET modifier.
- A paid status.
- No prior authorization number identified on the encounter.

Of these 1,503 encounters, OIG Fraud Analytics and Data Operations staff selected a statistically valid random sample of 65 for testing. Inspectors compared paid claim information to encounter data to verify final claim status. Inspectors

identified 14 encounters without paid claims data due to denial. Inspectors removed the 14 denied claims from the testing sample, leaving 51 ambulance claims for testing.

Since claims were removed, the results of the sample cannot be projected to the population.

Standards

OIG Inspections conducts inspections of Texas HHS programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspection reports present factual data accurately, fairly, and objectively, and present findings, conclusions, and recommendations in a persuasive manner to strengthen program effectiveness and efficiency. OIG Inspections conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Criteria

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

- 1 Tex. Admin. Code § 354.1115 (2) (Sept. 1, 2009)
- Tex. Hum. Res. Code § 32.024 (2021)
- Uniform Managed Care Contract 8.1.8.1 (Sept. 1, 2021)
- Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" §§ 2.2.2, 2.2.5.7, 2.4.4, and 2.4.6 (2021 through 2022)

Appendix B: Related Reports

- Audit of Acadian Ambulance Services, AUD-21-015, July 28, 2021
- Audit of Emergency Ambulance Services at American Medical Response, AUD-22-022, August 18, 2022

Appendix C: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on ambulance services:

"TMPPM Ambulance Services Handbook," HHSC, https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2023/2023-03-march/2_Ambulance_Services.pdf (accessed March 22, 2023)

For more information on Molina Healthcare of Texas, Inc.:

Homepage, Molina Healthcare of Texas, Inc., https://www.molinahealthcare.com/ (accessed March 21, 2023)

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this inspection report include:

- Bruce Andrews, CPA, CISA, Director of Inspections
- James Aldridge, CFE, Manager of Inspections
- Marco Diaz, Lead Inspector
- Kenin Weeks, Senior Inspector
- Tiana Clayton, Senior Inspector
- Mo Brantley, Senior Audit Operations Analyst

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- Carol Weil, Manager of Claims, Encounters, and Configuration

Appendix E: 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
- Kacy J. VerColen, Chief of Audit and Inspections
- Diane Salisbury, Chief of Data Reviews
- Susan Biles, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Matt Chaplin, Chief of Operations
- Steve Johnson, Chief of Investigations and Utilization Reviews

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