Inspections Report

Ambulance Claims Oversight

Non-Medically Necessary Ambulance Claims

Inspector General

Texas Health and Human Services

January 9, 2024

OIG Report No. INS-24-004

Texas Health and Human Services Office of Inspector General Audit and Inspections Division

AMBULANCE CLAIMS OVERSIGHT

Non-Medically Necessary Ambulance Claims

January 9, 2024

Dear Executive Commissioner Young:

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Inspections) conducted a data review to determine whether non-medically necessary ambulance claims were denied in compliance with applicable requirements.

OIG Inspections reviewed ambulance encounter data with a "GY" modifier, indicating no medical necessity, for the period from April 1, 2022, through April 30, 2023. Based on the results of the review, OIG Inspections determined that six managed care organizations (MCOs) had one or more ambulance claims submitted by an ambulance provider with a GY modifier and a paid status. Ambulance transportation must be medically necessary for the patient's condition at the time of transport to be eligible for payment under Medicaid.[1] OIG Inspections sent the encounter data to each MCO for further review to verify whether the associated claims were paid in error. The MCOs verified the claims were paid and stated they have adjusted or are currently working to adjust the encounters and deny the associated claims.

The attachment to this letter contains additional details on this review.

Sincerely,

Anton Dutchover

Anton Dutchover, CPA
Deputy Inspector General of Audit and Inspections

Attachment

cc: Raymond Charles Winter, HHS Inspector General

[1] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2 (Apr. 2022 through Apr. 2023).

Attachment

Section 1: Summary of Review Results

OIG Inspections conducted a data review of non-medically necessary ambulance encounters for all Texas Medicaid–contracted MCOs during the project scope of April 1, 2022, through April 30, 2023. The encounter data showed six MCOs had one or more ambulance encounters with a paid status and a GY modifier, indicating no medical necessity.

Requirements for Ambulance Claims with a GY Modifier

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. 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 acceptable means of transportation. MCO network providers must use the GY modifier when submitting a claim for a non-medically necessary transport.[2,3] Ambulance transportation must be medically necessary for the patient's condition at the time of transport to be eligible for payment under Medicaid.[4]

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

[3] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2.6.7 (Sept. 2022 through Apr. 2023).

[4] Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" § 2.2 (Apr. 2022 through Apr. 2023).

Table 1 shows the number of ambulance encounters with a GY modifier and paid dollar amount for each MCO.

Table 1: Non-Medically Necessary Ambulance Claims

MCO	Number of Encounters with a Paid Status	Dollar Amount
MCO 1	24	$6,940.91
MCO 2	16	0.00
MCO 3	3	752.72
MCO 4	3	740.87
MCO 5	1	272.97
MCO 6	1	0.00
Total	**48**	**$8,707.47**

Source: OIG Inspections

MCO 1

MCO 1 had 24 ambulance encounters with a GY modifier. The MCO determined the associated claims were paid in error because an edit to deny ambulance claims billed with a GY modifier was not in place at the time the claims were processed. MCO 1 asserted the system has been updated to add the edit and adjustments of the associated claims have been completed.

MCO 2

MCO 2 had 16 ambulance encounters with a GY modifier. MCO 2 determined that the encounters were submitted to HHSC as paid because the primary payor, which was not the MCO, had paid the claim. The associated claims did not result in payments by MCO 2, so no adjustments are required. MCO 2 asserted it would not include the associated claims in the Financial Statistical Reports since MCO 2 was not the payor.

MCO 3

MCO 3 had three ambulance encounters with a GY modifier. The MCO stated the claim processing system edit to deny claims for non-medically necessary services was overridden by the claims processing staff, which resulted in the associated claims being paid in error. MCO 3 asserted that its claims team will implement a monthly review of claims with a GY modifier and a paid amount. It also provided documentation to show the encounters have been adjusted and the associated claims denied.

MCO 4

MCO 4 had three ambulance encounters with a GY modifier. Upon review, MCO 4 determined the associated claims were paid in error because an edit to deny ambulance claims billed with a GY modifier was not in place at the time the associated claims were processed. MCO 4 asserted the system has been updated to add the edit, and it is working to adjust the encounters and deny the associated claims.

MCO 5

MCO 5 had one ambulance encounter with a GY modifier, which it stated was paid in error. MCO 5 asserted a system update included edits to identify and deny ambulance claims submitted with the GY modifier. The MCO provided documentation to show the encounter has been adjusted and the associated claim denied.

MCO 6

MCO 6 had one ambulance encounter with a GY modifier. MCO 6 determined that the encounter indicated a paid status because the claim processing staff overrode a claim system edit and inserted a paid claim status. MCO 6 stated the claim did not result in payment to the provider as the member and claim were covered under a Dual Eligible Special Needs Plan.[5] The associated claim did not result in payment by MCO 6, so no adjustments are required.

OIG Inspections Comment

OIG Inspections' work was limited to evaluating documentation provided by certain MCOs and did not include follow-up testing to verify MCO assertions regarding new controls implemented or other statements. OIG Inspections thanks the management and staff of each of the MCOs for their cooperation and assistance during this review.

[5] Per the Centers for Medicare and Medicaid Services, a Dual Eligible Special Needs Plan is a type of Medicare Advantage coordinated care plan that provides coverage for individuals who are eligible for both Medicare and Medicaid. A Dual Eligible Special Needs Plan is specifically designed to provide targeted care and limit enrollment to special needs individuals.

Section 2: Objective, Scope, Methodology, Standards, and Criteria

Objective and Scope

The review objective was to determine whether non-medically necessary ambulance claims are denied in compliance with applicable requirements.

The inspection scope includes Texas Medicaid ambulance encounters from April 1, 2022, through April 30, 2023.

Methodology

OIG Inspections reviewed statutes and regulations that address the objective. OIG Inspections requested encounter data from OIG Fraud Analytics and Data Operations for all Texas Medicaid contracted MCOs to review non-medically necessary ambulance encounters, indicated by a GY modifier, during the project scope.

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:

- Texas Medicaid Provider Procedures Manual, Vol. 2, "Ambulance Services Handbook" §§ 2.2 (2022 through 2023), 2.2.5.7 (2022), and 2.2.6.7 (2022 through 2023)

Section 3: Related Reports

- Inspection of Ambulance Claims Oversight: Community First Health Plans, INS-23-012, August 30, 2023
- Inspection of Ambulance Claims Oversight: Driscoll Health Plan, INS-23-011, August 29, 2023
- Inspection of Ambulance Claims Oversight: Molina Healthcare of Texas, Inc., INS-23-009, June 1, 2023
- Audit of Acadian Ambulance Services, AUD-21-015, July 28, 2021

Section 4: Report Team and Distribution

Report Team

OIG staff members who contributed to this inspection report include:

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- James Aldridge, CFE, Manager of Inspections
- Marco Diaz, CFE, Lead Inspector
- Kenin Weeks, Senior Inspector
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Section 5: 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:

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