Ambulance Claims Oversight

Driscoll Health Plan

Results in Brief

Why OIG Conducted This Inspection

In 2021, the OIG Audit and Inspections Division audited ground emergency ambulance services and found an ambulance provider submitted non-medically necessary claims with the required modifier and the claims were paid by some MCOs as medically necessary.

Summary of Review

The inspection objective was to determine whether Driscoll Health Plan has processes and controls in place to deny non-medically necessary ambulance claims in compliance with applicable requirements.

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

Management Response

OIG Inspections presented preliminary inspection results, issues, and recommendations to Driscoll in a draft report dated August 21, 2023. Driscoll agreed with the inspection recommendations and indicated corrective actions had already been taken. Driscoll's management response is included in the report following the recommendation.

For more information, contact:
OIGInspectionsReports@hhs.texas.gov

Key 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 Driscoll Health Plan (Driscoll), a Texas Medicaid managed care organization (MCO) contracted to provide Medicaid and Children's Health Insurance Program (CHIP) services to members.

The inspection tested 33 of Driscoll's non-medically necessary ambulance claims, indicated by a GY modifier, during the inspection scope. Driscoll's claims processing system is programmed with Texas Medicaid–specific coding requirements. However, Driscoll's claim processing controls did not have sufficient edits in place to deny all non-medically necessary claims filed with a conflicting GY modifier and an emergency modifier. Consequently, Driscoll paid for nine non-medically necessary ambulance claims that contained a GY modifier.

Recommendations

Driscoll should:

- Retrospectively review and recover all identified payments made to providers for claims with GY modifier.
- Adjust its claims processing system programming to (a) identify all non-medically necessary claims submitted with the GY modifier and (b) deny these claims.