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Non-Emergency Medical Transportation Reviews

Focusing on Compliance

OIG 99-0269

December 1999

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EXECUTIVE SUMMARY

Non-emergency medical transportation involves getting a patient to and from the source of medical care when the medical condition is not life threatening. This includes non-emergency ambulance, medi-car, taxicab, service car, livery or private automobile. The Department of Public Aid (DPA) administers the non-emergency medical transportation program as part of the Medical Assistance Program (MAP).

The rising cost of non-emergency medical transportation is a concern at the federal and state levels. In Illinois, the number of clients has decreased slightly but expenditures have increased over 10% annually since calendar year 1997, indicating a need for monitoring. The Medical Transportation Report (December 1997) and the Payment Accuracy Review (PAR) (August 1998) indicated that payment for non-emergency medical transportation was a problem.[1] In July 1999, DPA formed a Medical Transportation Workgroup to look at the existing problems and recommend improvements. Also, in July 1999, the OIG conducted a special review described in this report to provide updated data on the problems resulting in discrepant claims for non-emergency medical transportation.

This review was designed: (1.) to examine service discrepancies occurring in a selection of claims from a specific group of non-emergency medical transportation providers and (2.) to verify the non-emergency medical transportation service was actually delivered.

The selection process resulted in the inclusion of 64 providers in the review. Each provider received more than $25,000 in non-emergency medical transportation payments in calendar year 1998. Dates of service for March 1999 were reviewed. The providers were not selected randomly from the non-emergency medical transportation provider universe. Because of that, these findings cannot be projected to that universe, but can still provide indications of the problems one would expect to find if the entire universe was reviewed. The findings have been weighted for the 64 providers[2].

Key Findings

- A total of 6,068 discrepancies were found in the 12,323 actual services reviewed with some services having more than one discrepancy.

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[1] The Payment Accuracy Review estimated that nearly 1/3 of all non-emergency medical transportation payments were likely inappropriate.

[2] It was necessary to weight the data because the samples were drawn from each of the 64 non-emergency medical transportation providers utilizing different sampling intervals. Before the data could be combined across the 64 non-emergency medical transportation providers to calculate overall error rates, the data from each provider was multiplied by a weighting factor representing its statistical probability for selection.

- Record keeping was identified as a critical issue. Missing or inadequate records were found in 32.1% of the services and accounted for 78.4% of the total discrepancies.

- A total of 17.2% of all discrepancies involved the billing of excess mileage.

- An attempt was made to verify that non-emergency medical transportation services matched a MAP service on the same date. Only 52.1% of non-emergency services could be matched to a MAP claim, and the remainder were questionable.

- Inconsistent procedures exist among local offices of the Department of Human Services (DHS) regarding the prior approval process.

- We estimate that the 64 providers included in this study were overpaid $246,810 for March 1999 dates of service. This figure constitutes 33% of their payments for March 1999 services.

Recommendations

This review indicates a need to improve payment accuracy and ensure maintenance and retention of transportation records by non-emergency medical transportation providers. The following recommendations should be considered:

- Include non-emergency medical transportation providers in the proposed Random Claims Sampling review process. Each provider should have an equal chance of being selected, regardless of the amount of dollars associated with the claims.

- Require standard documentation forms, such as trip tickets and dispatcher's logs. The use of DPA forms would help remind providers to maintain the correct records.

- Provide informational notices and outreach training to providers so they understand DPA record keeping requirements and billing procedures.

- Evaluate accurate methods of calculating mileage.

- Privatize the prior approval process by contracting with an administrative service organization to perform client screening, determine medical need to authorize non-emergency medical transportation and monitor utilization patterns.

- Provide training to DHS local office staff on the prior approval requirements.

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BACKGROUND

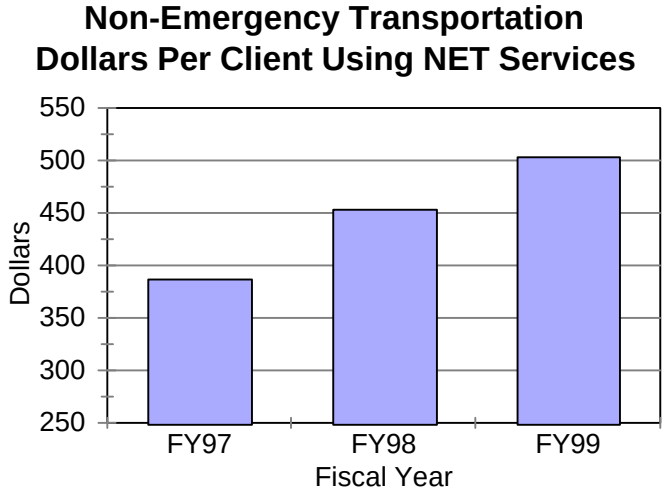
Overview

DPA's MAP pays for medically necessary services performed by providers for persons who receive cash assistance and for those who are ineligible for cash assistance but who cannot afford medical care. DPA administers the program under the Illinois Public Aid Code and Titles XIX, Grants to States for Medical Assistance Programs (Medicaid) and XXI, States Children's Health Insurance Program of the Social Security Act. Title XXI is the KidCare Share, Premium and Rebate programs in Illinois.

DPA has administered the MAP, which includes all Medicaid services, since its inception in 1966. Prior to July 1997, the DPA local office staff was responsible for authorizing non-emergency medical transportation through a prior approval process to and from the source of medical care. In July 1997, DHS assumed this responsibility when the local office staff came under DHS jurisdiction.

Non-emergency medical transportation expenditures have increased over the last three fiscal years. Expenditures have gone from $33.2 million in fiscal year 97 to $41.5 million in fiscal year 99. Although the dollars expended increased by 24.9% over the last two fiscal years, the number of clients who used non-emergency medical transportation services decreased by 4%. Some cost increase may have been due to policy changes, such as the early intervention and mental health options. The following chart and graph provide an overview of non-emergency medical transportation for the past three fiscal years:

NON-EMERGENCY MEDICAL TRANSPORTATION			
FISCAL YEAR	**CLIENTS USING NET SERVICES**	**SERVICES**	**DOLLARS**
1997	85,906	2,627,167	$33,207,645
1998	81,890	2,955,996	$37,112,859
1999	82,436	3,362,336	$41,469,175



Previous reports issued by the OIG on Medical Transportation (December 1997) and the Payment Accuracy Review (PAR) (August 1998) indicated problems beyond the escalating costs of non-emergency medical transportation. The Medical Transportation Report studied payment and monitoring practices in the entire medical transportation area. The report recommended improvements in the prior approval process and better provider and local office education. The PAR report indicated that more than 31% of the dollars paid for non-emergency medical transportation services were estimated to be in error.

DPA formed the Medical Transportation Workgroup in July 1999 to examine further the non-emergency medical transportation program and make recommendations to reduce costs and improve program integrity. This report validates the magnitude of the problems and the need for changes within the program.

Selection Process

Of a total of 1,634 non-emergency medical transportation providers, 156 were selected for review based on paid claims of more than $25,000 in calendar year 1998. This group was reduced to 64 providers because of past or current Bureau of Medical Quality Assurance (BMQA) audits and federal reviews or because the provider was no longer in business. The claims reviewed were for 12,323 services provided during March 1999.

The unit of selection for the review was the claim. A claim may have up to eight services and the resulting billing amounts. Each service on the claim was reviewed. Non-emergency transportation claims are designed to allow billing of one client with multiple service (procedure) codes and/or trips on one form. A service is defined as a one-way trip for an individual to a medical service or a similar trip for an attendant. A round trip would be counted as two services. A claim could also have services for loaded mileage. Loaded mileage is defined as mileage in excess of 10 miles. Ten miles are included in the base payment, except for taxicabs. Taxicab mileage is billed on actual mileage.

A maximum of 50 paid claims was selected out of the total universe of March 1999 dates of service for any single provider. Most selected providers had at least 50 claims, while some had several hundred. It was then determined how many claims existed for a provider with dates of service in March 1999. The number of claims was divided by 50 to determine the size of the interval required to select 50 claims ensuring that the selection was impartially conducted. If a provider had less than 50 claims, all the provider's claims were reviewed.

Review Process

A letter informed 64 providers of the review and requested the records be made available for review. Staff from the Bureau of Quality Control (BQC) and BMQA conducted the reviews for the OIG. For the selected services, staff visited the provider and requested copies of the following:

- **Trip Tickets or Dispatcher's Logs -** A trip ticket lists one person's destination and pick-up times**.** A dispatcher's log lists multiple persons' destinations and pick-up times. The trip tickets or dispatcher's logs were examined for:

    - Origin and destination of the trip.
    - One way or round trip.
    - Category of service, i.e., medi-car, service car.
    - Pick-up times and destinations.
    - Mileage - If extra mileage was billed, staff obtained the complete origin and destination address, i.e., street number, street name, city, state and zip code. The computer software package, Door to Door, was used to verify the excess mileage calculations.
    - Attendant presence and need - If an attendant service was billed, staff verified if:
      - The use of an attendant was authorized per prior approval.
      - The use of an attendant was medically necessary, if no prior approval is required.
      - An attendant was indicated on the trip ticket or dispatcher's log.

- **Prior approvals** - Prior approvals were reviewed to ensure that the service dates billed matched the service and dates approved. Prior approval is required in all instances, except for medical transportation provided for clients who reside in long term care (LTC) facilities. This does not include clients who live in sheltered care facilities. Providers are responsible for keeping proof of prior authorization.

The staff also utilized the Medicaid Management Information System (MMIS) to verify that a paid or rejected medical service was provided on the day of the non-emergency medical transportation. Client eligibility files were examined to determine if the client was enrolled in Medicare. Medicaid/Medicare clients often use DPA's non-emergency medical transportation program to visit a provider who bills Medicare. That provider in turn may submit a claim to DPA for the remainder of the service not covered by Medicare. The provider often does not bill Medicaid if the claim amount is small.

The document reviews were conducted according to the basic record requirements from the DPA Handbook for Medical Transportation Services. Those requirements are:

- Identification of client (name, address and client number).
- Name and address or facility name of person requesting service.
- Copy of transportation prior approval request.
- Copy of transportation invoice.
- State of Illinois vehicle license plate number.
- Type of vehicle used, i.e., ambulance, medi-car, service car, etc.
- Copy of trip ticket which documents the medical necessity for the following:
    a. Non-emergency medical transportation which does not require prior approval;
    b. Administration of oxygen by an ambulance provider; and
    c. Use of an attendant or stretcher by a medi-car provider.
- Ambulance providers are to document medical necessity for the transportation on the trip ticket.
- Providers of advanced life support transportation are to include a copy of the emergency medical services run sheet or other form as required by the Illinois Department of Public Health.

DPA regards the maintenance of records as essential. Records are key documents for the audit of payments. In the absence of proper and complete records, payments may be recovered.

ANALYSIS

Discrepant Services

Reviewers classified discrepant services into the following eight categories:

Category A had no trip ticket or dispatcher's log and no prior approval (when required) or those documents were unacceptable.

Category B had no trip ticket or dispatcher's log, no attendant documented on trip ticket or dispatcher's log, but prior approval was present or not required for an LTC patient. This category also included payments for an attendant who had valid prior approval but was not documented on the trip ticket or dispatcher's log.

Category C had no prior approval present but a trip ticket or dispatcher's log was present as appropriate. This category was also used if there was a prior approval present, but it did not authorize an attendant.

Category D involved billing for a non-covered service, such as a canceled trip, or the trip ticket showed one address but prior approval showed a different address.

Category E occurred when the client was in the hospital on the date transportation was supposed to have occurred. No evidence existed that the non-emergency medical transportation service was rendered.

Category F involved the provider billing for more mileage than a verified distance for a trip. Allowances were made for the accuracy of the verification, which was performed by a computer software program. These allowances were +/-2 miles (one way trip) in urban setting and +/-5 miles (one-way trip) in rural setting. Urban setting means a population of greater than 100,000.

Category G consisted of the use of the wrong service (procedure) code by the provider, such as billing for medi-car when service car was actually used.

Category H included other errors not identified in the above categories, such as questionable prior approvals.

The following table summarizes the type of discrepancies in descending order by frequency of occurrence. Errors related to record keeping categories (A, B and C) represented 78.4% of all discrepancies. Billing for excess mileage (F) was 17.2% of the total discrepancies.

Discrepancy Categories And Frequencies	
Type of Discrepancy	**Percent**
No prior approval present (C)	39.9
No trip ticket/or dispatcher's log, no attendant documentation (B)	27.1
Excess mileage billed (F)	17.2
No trip ticket or dispatcher's log, no prior approval (A)	11.4
Other error (H)	2.2
Billing for a non-covered service (D)	1.2
Wrong procedure service code billed (G)	0.6
Service was not rendered (E)	0.5
Totals	**100.0%**

Verification of Service Dates

The dates of service for non-emergency medical transportation services were matched using MMIS with corresponding Medicaid claims to see if a client was transported to a medical service on the same date. Some services were unable to be verified through MMIS because of four possible factors. A service may have been provided, but the bill may not have been submitted by the provider. Another instance would be if the bill had not been processed by DPA in time to be reflected in this review. In some cases, the service may have been paid by Medicare. The fourth reason is the service was not provided at all or the transportation was to a non-medical destination. It was not possible to identify all such incidences.

Given these qualifications, the reviews of the 64 providers indicated that the dates on the service claims agreed with the dates of medical service in the medical provider records 52.1% of the time. The dates did not correspond on 24.8% of the claims. The remaining 23.1% identified claim dates for Medicare clients, which cannot be verified through MMIS.

On an individual provider basis, nine providers had no discrepancies in the claim date and the service date. The other 55 providers had discrepancy levels ranging from a low of 2% to a high of 78.3%.

Prior Approvals

Reviewers made certain observations when obtaining prior approval documents. They found that local DHS offices were inconsistent in following established DPA policy. A variety of exceptions were employed. For example, one local office made up its own prior approval forms. In another instance, the local office kept all the prior approval records and the providers served by that office were not given the prior approval documentation for their records. When questioned, the local DHS offices said they had permission from DPA to operate under these exceptions. These exceptions may have been granted years ago but no documentation could be found.

Potential Overpayments

The information gathered from the reviews was used to develop estimates of overall cost discrepancies for the 64 providers in the review. Initial information was broken down by providers having all services discrepant, those with some services discrepant and providers with no services discrepant.

The estimated dollar amount of discrepancies in the reviewed services was $246,810 or 33% of their estimated March expenditure of $747,090 for the providers in this review. It is noteworthy that this is within 2% of the projected overpayment described in the Payment Accuracy Review.

The following table emphasizes the relationship of those providers with all services discrepant to the total estimated dollars in error found in the review. Eleven providers accounted for 25% of the overpayments.

Provider Detail			
Provider with:	**Number of Providers**	**Estimated Paid Dollars**	**Estimated Dollars in Error**
All services discrepant	11 (17.2%)	$61,636 (8.2%)	$61,636 (25%)
Some services discrepant	49 (76.6%)	$658,123 (88.1%)	$185,174 (75%)
No services discrepant	4 (6.2%)	$27,331 (3.7%)	N/A
Totals	**64**	**$747,090**	**$246,810**

FINDINGS

- A total of 6,068 discrepancies were found in the 12,323 actual services reviewed with some services having more than one discrepancy.

- Record keeping was identified as a critical issue. Missing or inadequate records were found in 32.1% of the services and accounted for 78.4% of the total discrepancies.

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RECOMMENDATIONS

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CONCLUSION

Through this study, the OIG obtained a snapshot view of non-emergency medical transportation in the Illinois MAP. The project confirmed concerns that the Department and the legislature have expressed in the past about this type of service provider. Four primary areas of concern have been identified: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation. Monitoring of non-emergency medical transportation providers needs to be strengthened. Adoption of the report's recommendations, many of which have been developed in consultation with the Division of Medical Programs, will provide a higher degree of integrity in this area.

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