

**Illinois Department of Public Aid
Office of Inspector General**

**MEDICAL TRANSPORTATION
A STUDY OF PAYMENT AND MONITORING PRACTICES**

**FINAL REPORT OIG #96-0062
DECEMBER 1997**



" In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct, the Inspector General shall oversee the Illinois Department's integrity functions . . ."

**THE OFFICE OF INSPECTOR GENERAL'S
LOSS PREVENTION ANALYSIS AND RESEARCH**

The Loss Prevention Analysis and Research (LPAR) Section within the Office of Inspector General (OIG) conducts short-term analyses and research projects to identify, eliminate and prevent systemic problems that may result in inappropriate payments or compromise the integrity or effectiveness of the Department's programs or operations. LPAR consists of an interdisciplinary team of specialists trained in policy research and evaluation, operational and systems analysis and performance and financial auditing.

CONTRIBUTIONS AND ACKNOWLEDGMENTS

The report was prepared by Andrew Asher under the direction of LPAR's Chief Carey Bayless and Inspector General Robb Miller. It would not have been possible, however, without the contributions of OIG's Dan Olson, Ken Randolph, William Ippolito, Jim Greene, Steve Bradley and Paul Keller, and various staff from OIG's Bureau of Investigations. Assistance, cooperation and insights were also provided by staff from within the Division of Field Operations and Division of Medical Program's Bureaus of Comprehensive Health Services and Technical Support. Through interviews, documents they shared and insightful comments, these staff provided invaluable information and their contributions are acknowledged and greatly appreciated.

A draft of this report was circulated within the Department of Public Aid, the Department of Human Services and the Medicaid Fraud Control Unit of the Illinois State Police in August 1997. We received comments from within the Department of Public Aid and made a number of changes. We did not receive any comments from the Department of Human Services or the Medicaid Fraud Control Unit. We then recirculated the report in November 1997 to both Departments and invited them to prepare a formal response to the report but neither believed it was warranted.

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EXECUTIVE SUMMARY

In Fall of 1996, the Office of Inspector General's Loss Prevention Analysis and Research Section undertook this review of medical transportation issues because of concerns raised by the Illinois State Police's Medicaid Fraud Control Unit. In addition, transportation is one of the areas where persons other than medical professionals can render service and perform their functions with almost complete autonomy. For most types of transportation providers, these persons and the firms for which they work are not licensed by any state professional or health care licensing authority.

We conducted this study to better understand: (a) existing medical transportation policies, procedures and information sharing practices; (b) the prior approval system for medical transportation; (c) medical transportation provider and claim monitoring practices; and (d) the Department of Public Aid's (DPA) vulnerability to upcoding by medicar providers and whether additional measures are desirable to reduce this vulnerability. The information presented in this report was obtained through interviews with DPA staff, reviews of DPA documents and analyses of paid claims data for Fiscal Year 1996.

Based on our analysis, we conclude that most of the medical transportation policies are sound and generally do not appear to expose DPA and the Department of Human Services (DHS) to extraordinary vulnerabilities. At the same time, though, DPA and DHS face a number of challenges and opportunities to improve the administration of the medical transportation program. These are noted below:

- While most medical transportation policies are reasonably well communicated to providers, additional clarifications would help providers better understand their responsibilities and the scope of the program's benefit. Provider staff need to develop a better understanding of the services to which recipients can and cannot be transported.
- Prior approvals of medical transportation services are not recorded in an automated format to allow reconciliation with the submitted claim.
- Prior approval determinations are made by local office staff, in many offices by case workers. This decentralized approach to prior approval administration has both advantages and disadvantages. It enables those with the greatest personal knowledge of the recipient and the local transportation providers to make prior approval and mode of transport decision. At the same time, it results in inconsistent application of DPA's policies and inappropriate expenditures. Some local office staff may not have detailed knowledge of transportation policy. In addition, there is no requirement that local office staff obtain and use timely information on a recipient's condition.

- While maximum rates for most types of transportation providers are distributed to the local offices, information on taxi cab rates are not. This information would facilitate their efforts to ensure that the most economical means of transportation available are used.
- Enrollment practices for transportation providers follow those used for other providers. As a result, no special monitoring of recent transportation provider enrollees is undertaken. The enrollment process is potentially one of DPA's strongest weapons against health care fraud. Post-enrollment monitoring of newly enrolled providers is also a powerful way to focus attention on those providers who have not yet established acceptable billing history with DPA.
- Basic, reasonable claims processing and postpayment review practices are employed to monitor the billing behavior of transportation providers. However, improvements to both review processes should be considered.
- DPA attempted to reduce the potential for upcoding by medicar providers by releasing an informational notice in September 1996. It did not have a measurable effect on the extent to which bills for attendants are submitted by these providers. Either this upcoding-reduction strategy was ineffective or upcoding is not widespread.
- Ambulance providers may also be upcoding by billing for advanced life support (ALS) services when, in fact, less costly basic life support services were rendered.

To take maximum advantage of these opportunities for improvement, we recommend that:

- DPA automate prior approval information and use it in claims adjudication. The Division of Medical Programs submitted a Project Initialization Request in July 1994 to develop an automated intake system. At the same time, corresponding changes to the claims editing system should be made to allow this information to be used in claims adjudication.
- DHS assign a transportation coordinator. This role could involve the dissemination of transportation rate information and the collaborative development of transportation policy, local office training materials and a prior approval data entry system with DPA staff.
- Both DHS and DPA work together to improve training for local office staff. Periodic, brief (1-2 hour) refresher sessions on transportation policy and procedures would be helpful. They should be coupled with more hands-on content to raise local office awareness of fraud, abuse and cost issues.

- Taxi cab rate information, including a listing of regulated and unregulated area rates, be developed by DPA and distributed to the local offices by DHS annually.
- DPA make minor improvements to the medical transportation handbook. The handbook and subsequent informational notices are reasonably detailed and clear. They communicate sufficient information for transportation providers to operate. Nonetheless, a few improvements could be made.
- DHS require local office supervisors to conduct random reviews of prior approval authorizations. This would reduce vulnerability to employee-provider collusion.
- DPA links transportation claims to corresponding medical service claims as part of its postpayment review activities.
- DPA remove the “other” destination code from the transportation claim form and the claims editing system. The “other” destination code should be replaced with more specific codes to ensure that bills for transportation to providers of non-covered services will be rejected.
- DPA develop more strongly worded notices to inform providers about billing and record retention problems.
- DPA review ALS ambulance billing policy to determine whether it can be strengthened.
- DHS and DPA jointly review and consider other monitoring strategies to prevent or detect the submission or payment of improper claims. These strategies are related to:
 - More careful monitoring of providers who recently enrolled or applied for enrollment.
 - More careful monitoring of providers who are also recipients.
 - Periodic monitoring of the extent to which ambulance trips, and in particular ALS service trips, appear to be unnecessary.

In summary, the medical transportation program, while governed by sound policies, could benefit from program administrative changes.

INTRODUCTION

Medical transportation is an area some health care fraud specialists believe may have a high level of fraud. Aspen Health Law Center's *Health Care Fraud Compliance Manual* notes that "many states are experiencing problems with transportation providers . . . who fraudulently bill Medicaid . . ." Transportation is one of the areas where persons other than medical professionals can render service and perform their functions with almost complete autonomy. For most types of transportation providers, these persons and the firms for which they work are not licensed by any state professional or health care licensing authority.

Medical transportation services costs, while a small component of overall Medicaid costs in Illinois, are nonetheless significant. In Fiscal Year (FY) 1996, DPA paid about \$37,600,000 for medical transportation services, or \$44,183 per provider.

In a March 11, 1996, letter to Inspector General Robb Miller, the Illinois State Police's (ISP) Medicaid Fraud Control Unit (MFCU) raised a number of concerns about the administration of the medical transportation program. They pointed out that: (1) the medicar and service car providers they had recently investigated appeared to routinely bill for an attendant, whether or not one was provided or necessary; (2) local office staff do not have comprehensive taxicab rate information to allow them to determine the most economical means of transportation; (3) local office staff may not be using the most economical means of transportation available; and (4) the prior approval system for medical transportation providers may be deficient.

In response to the concerns raised in this letter the Office of Inspector General's (OIG) Loss Prevention Analysis and Research (LPAR) prepared memoranda in the Spring of 1996 to DPA's Divisions of Medical Programs (DMP), Field Operations (DFO) and Policy and Training (DPT) and to its Office of General Counsel (OCG). These memoranda raised several of the issues noted by MFCU and requested information to assist the Inspector General in responding. LPAR also initiated this study of medical transportation issues. The objectives of this study are to review DPA's:

- Existing medical transportation policies, procedures and information sharing practices. (Discussed in the first section of this report.)
- Prior approval system for medical transportation. (Discussed in the second section of this report.)
- Medical transportation provider and claim monitoring practices. (Also discussed in the second section of this report.)

- Vulnerability to upcoding by medicar providers and determine whether additional measures are desirable to reduce this vulnerability. (Discussed in the third section of this report.)

To undertake this study we relied on interviews with DPA staff, reviewed DPA documents related to the medical transportation program and analyzed paid claims data for medical transportation services rendered in FY 1996.¹ Staff interviewed included: DMP staff within the Bureaus of Comprehensive Health Services and Technical Support; DFO central office staff; and OIG Bureau of Medical Quality Assurance (BMQA) staff. In the Spring of 1997, BMQA undertook a series of on-site visits of medical transportation providers and we drew upon the insights and experiences BMQA staff acquired through these reviews.

EXISTING POLICIES, PROCEDURES AND INFORMATION SHARING PRACTICES

The medical transportation handbook and subsequent informational notices identify the policies and procedures that transportation providers are expected to follow. These documents communicate the following to transportation providers:

- The record retention requirements of DPA.
- That DPA reserves the right to determine the mode of transportation.
- That approval will be granted to the nearest available and appropriate provider, by the least expensive mode of transportation which is adequate to meet the recipient's needs.
- That prior approval is generally required, with most of the specific exceptions noted.
- That payments will not be made to transportation providers in a number of specifically identified circumstances.
- That payment will only be made for transportation to providers of covered services.

The general handbook contains additional information. It indicates that providers are ultimately responsible for verifying recipient eligibility at the time of the trip. The general handbook also

¹This report was effectively completed before July 1, 1997, the date of the DHS reorganization. As a consequence, we do not refer to interviews with "DHS" staff or reviews of "DHS documents." Also, out of an interest in clarity we refer to the organizational entities that are now part of DHS by their former DPA names.

specifically identifies the services that are excluded from coverage. However, neither the general handbook nor the medical transportation handbook specifically note that:

- Payments will not be made for transportation to pharmacies.
- Only one payment will be made per trip, regardless of the number of recipients or non-recipient family members that are transported.

Despite these minor omissions, the handbook supplies transportation providers with sufficient information to operate. Local office staff that administer the prior approval system and determine the mode of transportation to be used, however, do not receive any additional material or any specialized training in transportation policy. DFO does not have a transportation coordinator within the central office to field questions or to work with DMP staff on policy, systems development, or local office staff training. DMP staff with expertise in transportation are contacted by local office staff directly.

On an annual basis local office staff receive a sheet that includes maximum reimbursement rates for ambulance, medicar and service car providers. Despite having plans to do so, central office staff have not distributed taxi cab rates for regulated and unregulated areas within each local office's jurisdiction.

EXISTING PRIOR APPROVAL, ENROLLMENT AND PREPAYMENT MONITORING PRACTICES

Prior Approval Administration

With few exceptions, the prior approval system is administered by staff within the local office. In smaller local offices, prior approval determinations tend to be made by individual caseworkers. Larger offices may centralize this function under a Medical Assistant Consultant (MAC) or other staff with detailed knowledge of DPA's medical payment policies. In either circumstance, however, the staff administering the transportation program typically have highly diverse responsibilities and work in a demanding, volume-driven environment.

Local offices appear to vary in how they administer prior approval. BMQA's interviews with transportation providers suggest that local offices differ in the types of trips they will approve. For example, one transportation company indicated that a local office they serve has requested that they send a vehicle to take a recipient to their pharmacy. A different local office this provider serves correctly pointed out that such a trip cannot be paid for under the DPA's current policy.

To meet urgent medical care needs, prior approval is granted over the telephone. After the trip is authorized the local office mails out the form to the provider for its records. Frequently, however, medical transportation providers who have been audited by BMQA and found not to possess this supporting documentation note in their hearings that the Department failed to send these forms to them.

DMP staff have reviewed provider appeals of rejected bills for trips that were inappropriately approved by local office staff. These included instances where payment policies were not followed, the recipient was not eligible for service or the provider had not been enrolled. In one recent case, the local office prior approved services for a transportation provider that was not enrolled. DMP staff had to determine whether this unenrolled provider who had already served a local office for over a year would be able to have its enrollment backdated to the date the provider began rendering services. If not, the provider stood to lose otherwise appropriate payments.²

Local office staff have considerable discretion in how they administer prior approval for medical transportation. They typically rely on their own knowledge of the recipient and his or her medical problems, but may also seek information from the recipient's transportation providers, physician or other providers. There is no requirement, however, for local office staff to obtain timely information on recipients' medical condition and functioning to make prior approval determinations. In addition, only one person typically makes a given prior approval determination and provider assignment. Both of these practices leave DPA and DHS vulnerable to collusion schemes between unscrupulous local office staff and transportation providers.

Local office staff also have the authority to grant prior approval for transportation arrangements that can extend up to six months. There are no specific policy guidelines on the types of cases that should be given these "blanket" prior approvals. In some instances, "post approval" is granted to accommodate non-emergency weekend or evening transportation services that were rendered without local office authorization.

Enrollment

The enrollment process is potentially one of DPA's strongest weapons against health care fraud. With appropriate verification procedures in place, bogus providers and operators with criminal backgrounds can be excluded from participation in the Medicaid program from the beginning. Post-enrollment monitoring of newly enrolled providers is also a powerful way to focus attention on those providers who have not yet established an acceptable billing history with DPA.

²While this is an extreme example, it points to the problems that post-service enrollment creates. Situations like this put DPA under pressure to enroll the provider and may circumvent the normal enrollment process.

Transportation providers do not receive any special scrutiny during the enrollment process. Their applications are treated much like any other provider. As a consequence, their applications are processed within ten days and no pre- or post-enrollment verification activities are undertaken. Pre-enrollment verification is possible, however. LPAR staff pointed out during a recent provider enrollment workgroup meeting that there are apparently no federal regulations that require DPA to approve provider applications this rapidly. Post-enrollment verification and monitoring is also possible. However, no special efforts are undertaken either to verify the information submitted by transportation providers or to monitor their billing practices within the first few months of enrollment.

BMQA's transportation provider visits suggest that on-site visits hold potential as a useful verification strategy. Provider application data can be verified. In addition, operating practices can be observed and help DPA identify providers who should be referred for an audit or MFCU investigation.

Claims Review

Once a claim is submitted for payment, DPA's claims processing system verifies that the procedure codes are appropriate, the recipient was eligible on the date of service and the provider was enrolled. It also verifies that data have been included for all of the required fields.

DPA does not have claims editing procedures in place to determine whether prior approval has been obtained because prior approval requests are not presently automated. Recognizing the importance of this issue and the vulnerability this gap causes, DMP had the foresight to request that DPA's Bureau of Information Systems (BIS) develop a data entry system for local office staff to enter prior approval information. To date, however, work on this July 1994 Project Initialization Request (PIR) has not yet begun due to other priorities.

Because the transportation billing form has an "other location" destination code, providers can either intentionally or unintentionally submit bills for trips that are not permitted. As a consequence, DPA may make inappropriate payments and providers who are mistakenly submitting these erroneous bills may not receive feedback which would allow them to change their billing behavior. In addition, it is our understanding that there is no cross editing of transportation provider claims with those of other providers to determine whether a covered medical service was actually submitted for that recipient on the same date the transportation was provided. This issue is being considered as a future topic for scrutiny by DPA's Medical Fraud Prevention Executive Workgroup (MFPEW).

Other Monitoring

As noted above, medical transportation is a reimbursable expense only in instances where the recipient is being transported to a provider of a covered service. As part of their postpayment review process, BMQA analysts manually examine transportation providers. Computerized Surveillance Utilization Review Subsystem (SURS) routines have identified these provider profiles as problematic. This manual review determines if corresponding medical visit claims were submitted for services rendered on the same date that the specific recipients were transported. BMQA also conducts a similar manual review of recipients as part of its surveillance of high medical use recipients. Like these provider reviews, the recipient-based analyses to identify the presence of a corresponding medical service claim are conducted manually once the computerized routines within SURS have identified a recipient with a profile that deviates from the norm.

While these reviews are useful, they could be improved upon. It would be beneficial if computerized routines could be developed to identify providers and recipients who are associated with a large number of transportation claims that have no corresponding medical claim.

Also noted earlier, recipients can enroll as private automobile providers. No special effort is made to monitor the billing behavior of provider/recipients. In addition, no effort is made to ensure that recipients have obtained a public transportation plate from the Secretary of State and provided proof of financial responsibility as required under 625 ILCS 5/8-101.

While there are few provider/recipients today, the number could rapidly increase within a short time period. In principle, there is no problem allowing recipients the same opportunity afforded to others to receive payment for transporting themselves, their relatives or members of their community to needed medical care. However, it is reasonable to expect beneficiaries of any reimbursement program who serve as their own provider to be unfamiliar with appropriate regulatory requirements and to need to rely on DPA for guidance. Also, in the event of an audit, DPA cannot expect to rely on the transported patient for reliable information. As a consequence, provider/recipients should be monitored more closely.

Beyond increased fraud risk, provider/recipients raise two additional issues. Only some of these recipients will be Medical Assistance Grant (MAG) cases. DHS might wish to review whether and how their additional income is budgeted or whether a two-tiered rate structure is warranted (for recipients' own transportation vs. the transportation they provide for others). Simultaneously, DPA could determine whether provider/recipients, being individuals and not organizational providers, need additional clarification about DPA's record retention requirements for medical transportation providers.

MEDICAR BILLING UPCODING

DPA's Vulnerability

In instances where the recipient's medical condition warrants, medicar providers can seek prior approval to allow an attendant to assist the driver. As with most prior approval decisions, these determinations are made by local office staff. Medicar providers who bill for an attendant receive additional reimbursement. They may also receive additional reimbursement if a stretcher is used to help the driver move the recipient to and from the vehicle.

A recent BMQA audit illustrates how aggressive at least one medicar provider appears to be when determining how to bill for attendants. The provider transported a recipient who is a resident of a nursing home and an attendant was provided and paid for by the nursing home. The medicar company then billed for the attendant even though they neither provided or paid for the attendant. The company defended the practice because an attendant was, in fact, present.

Because prior approval information is not automated and reconciled with the submitted claim, there is no way for the claims processing system to identify instances where providers may have billed for an attendant without permission. The only mechanism we are aware of to identify suspected instances of upcoding are SURS reviews, anonymous tips and periodic undercover investigations.

Reinforming Providers of DPA Policy

In response to our memoranda prepared in the Spring of 1996 and out of a concern about its vulnerability to upcoding, DPA released an informational notice to providers in September 1996 on the need to obtain prior approval for attendant use. It noted record retention problems identified in a "recent audit" and informed providers that failure to obtain prior approval would result in recovery of payments.

The available evidence suggests that the release of this notice had no impact on the extent to which attendant billings were submitted. This suggests either that this informational notice was ineffective or that there is little or no fraud among medicar providers in the submission of attendant billings. The latter conclusion is clearly possible. At the same time, medicar attendant upcoding is easy to commit in a manner that avoids detection. The details of the analysis are discussed in Appendix A. Other trends and patterns in medical transportation billing are discussed and presented in Appendix B.

While this notice was clear and direct, we recommend that future notices be more strongly worded. DPA could warn providers that repeated failure to adhere to the policy may result in termination and suspension actions and the initiation of a criminal investigation. This would clarify what the penalties for poor compliance are and hopefully encourage future compliance.

UPCODING BY AMBULANCES

BMQA audit experience suggests that DPA may also be vulnerable to upcoding by ambulance providers. Audits of ambulance providers suggest that billings for ALS services are, at times, unwarranted. The provider should have instead billed for basic life support (BLS) services which are reimbursed at a lower rate. The problem has been taken to an extreme by some organizations that consider their purpose to be emergency response. These organizations bill all services as ALS services, even if the trip was for a non-emergency and was prior approved by the local office. This is clearly in violation of DPA policy.

This issue may be complicated by DPA's policy of allowing reimbursement for ALS billing in emergencies even in circumstances where BLS services would have been appropriate. ALS services can be provided and billed as long as an ALS staffed and equipped vehicle is dispatched and the provider had no firsthand knowledge that only BLS services were required.

While the issues are certainly complicated, we believe that DPA should consider changing this policy. Unless ALS services are medically justified, the additional reimbursement paid to these providers adds little or nothing to the quality of care recipients receive. At the same time, we realize that providers will find Medicaid less attractive if they are expected to absorb the losses associated with 911 dispatchers' decisions. It is possible that a third category of reimbursement, which offers the provider modest additional compensation for ALS services but does not provide for full ALS rates unless such care is medically justified, might be a reasonable compromise. Such a rate structure would enable DPA to institute a potentially valuable cost-saving measure and might help to ease long-standing provider equity concerns about BLS billings.

If such a policy change were implemented, it would be possible to increase recoveries by using information from the emergency room claims to determine whether a transportation provider repeatedly provides (or a recipient repeatedly receives) ALS care when BLS services would be appropriate. Because ALS services are not required for transport to the emergency room unless a true emergency has occurred, DPA could review and possibly adopt other states' efforts to classify all diagnosis codes as associated with emergencies or non-emergent care. By classifying associated emergency room claims in this manner, we could identify providers or recipients who appear to be repeatedly misusing ambulance services. We propose that MFPEW study the feasibility of developing such postpayment surveillance routines.

CONCLUSIONS

Our review of the medical transportation program suggests that most of the policies are sound and generally do not appear to expose DPA or DHS to extraordinary vulnerabilities. At the same

time, though, DPA and DHS face a number of challenges and opportunities to improve the administration of the medical transportation program.

- While most medical transportation policies are reasonably well communicated to providers, additional clarifications would help providers better understand their responsibilities and the scope of the program's benefit. Provider staff need to develop a better understanding of the services to which recipients can and cannot be transported.
- Prior approvals of medical transportation services are not recorded in an automated format to allow reconciliation with the submitted claim.
- Prior approval determinations are made by local office staff, in many offices by case workers. This decentralized approach to prior approval administration has both advantages and disadvantages. It enables those with the greatest personal knowledge of the recipient and the local transportation providers to make prior approval and mode of transport decisions. At the same time, it results in inconsistent application of the DPA's policies and inappropriate expenditures. Some local office staff may not have detailed knowledge of transportation policy. In addition, there is no requirement that local office staff obtain and use timely information on a recipient's condition.
- While maximum rates for most types of transportation providers are distributed to the local offices, information on taxi cab rates are not. This information would facilitate their efforts to ensure that the most economical means of transportation available are used.
- Enrollment practices for transportation providers follow those used for other providers. As a result, no special monitoring of recent transportation provider enrollees is undertaken. The enrollment process is potentially one of DPA's strongest weapons against health care fraud. Post-enrollment monitoring of newly enrolled providers is also a powerful way to focus attention on those providers who have not yet established an acceptable billing history with DPA.
- Basic, reasonable claims processing and postpayment review practices are employed to monitor the billing behavior of transportation providers. However, improvements to both review processes should be considered.
- DPA attempted to reduce the potential for upcoding by medicar providers by releasing an informational notice in September 1996. It did not have a measurable effect on the extent to which bills for attendants are submitted by these providers. Either this upcoding-reduction strategy was ineffective or upcoding is not widespread.

- Ambulance providers may also be upcoding by billing for ALS services when, in fact, less costly BLS services were rendered.

RECOMMENDATIONS FOR CHANGE

In most areas, the medical transportation program is governed by sound policies. Possibly because it is associated with only a small portion of the overall Medicaid budget and it is an area where recipients may have experienced significant access problems, longer-range program administration and monitoring improvements have only recently been considered. Given the organizational changes that have occurred within the Department, however, it seems necessary to accelerate decision-making on transportation issues or accept the status quo as the manner in which transportation will be administered for the foreseeable future. As a consequence, we make the following recommendations to DPA and DHS.

1. Automate Prior Approval Information and Use in Claims Adjudication

As noted earlier, in July 1994, DPA's DMP prepared a PIR to develop a data entry system to allow local office staff to automate prior approval information. This PIR should be considered one of the DHS reorganization initiatives and be prioritized accordingly. In addition, corresponding changes to the claims editing system should be made to allow this information to be matched to incoming transportation claims and used to determine whether the claims are paid, pending or rejected.

2. Assign a Transportation Coordinator within DHS

DHS central office staff might consider playing a more active role in the administration and management of the transportation program than DFO had. This role could involve the dissemination of transportation rate information and the collaborative development of transportation policy, local office training materials and a prior approval data entry system with DPA staff. Transportation issues will likely be one of several issues handled by the assigned professional. As long as DPA remains the single state Medicaid agency for Illinois, however, staff from DPA must continue to be the ultimate authority to resolve prior approval, enrollment and payment questions related to medical transportation to comply with federal law governing the Medicaid program.

3. Improve Training for Local Office Staff

Local office staff who are expected to make prior approval and mode of transport decisions would benefit from additional training and guidance. Our interviews with Department staff,

interviews with providers conducted by BMQA and correspondence we received from MFCU suggests that additional information and guidance would be beneficial.

Periodic, brief (1-2 hour) refresher sessions on transportation policy and procedures would be helpful. These sessions should include more hands-on content that raise the awareness of local office staff to fraud, abuse and cost issues. This training could emphasize the importance of relying on recent information about the recipients' condition and functioning when making mode of transportation decisions. It could also provide local office staff with materials that identify sometimes overlooked policies and procedures and that provide advice on difficult scenarios.³

4. Distribute Taxi Cab Rate Information to Local Offices

The Department distributes information to local offices on the maximum rates available for most types of medical transportation providers. This information helps local office staff make mode of transport decisions. By itself, however, it is incomplete since it does not include taxi cab rates. In earlier discussions on transportation issues, DPA indicated that it would supply taxi cab rates for both regulated and unregulated areas within each local office's jurisdiction.

5. Make Minor Improvements to the Medical Transportation Handbook

The handbooks and subsequent informational notices are reasonably detailed and clear, and they communicate sufficient information for transportation providers to operate. Important information that is not presented in the medical transportation handbook is usually addressed in the general handbook. While these materials are appropriate, a few minor improvements could be made.

To the extent feasible, information related to areas where DPA has had compliance problems with medical transportation providers should be both included and emphasized in the actual medical transportation handbook. For example, the handbook could state more clearly that prior approval does not relieve providers from their obligations to ensure that both the recipient is eligible on the date of service and the trip is to a provider of a covered service. It could also point out and emphasize that use of attendants without prior approval, failure to document medical need or failure to retain the proper records could result not only in recoupment but the initiation of a criminal investigation. Finally, the handbook could also provide information on the other omitted issues discussed in the first section of this report.

³The prohibition against billing for more than one person per trip is an example of one such overlooked policy. According to Aspen Health Law Center's *Health Care Fraud Compliance Manual*, this type of improper billing behavior is commonly experienced by state Medicaid programs.

6. Require Local Office Supervisors to Conduct Random Reviews of Prior Approval Authorizations

The current procedure of permitting one individual staff member to authorize prior approval and make the needed transportation arrangements leaves DPA and DHS vulnerable to collusion between its employees and transportation providers. Requiring the signature of an additional local office employee who is trained in medical transportation policy on prior approval authorizations would greatly reduce this vulnerability but may not be feasible. Instead, supervisors should be required to conduct random reviews of these authorizations to verify that they have been handled appropriately.

7. Link Transportation Claims to Corresponding Medical Services

MFPEW should proceed with its plans to develop and implement measures to verify compliance with DPA's billing policies. For instance, SURS routines could be developed to identify instances where a medical service claim for the same recipient and date of service is not submitted. Other routines might address instances where the recipient is in fact in the middle of an inpatient stay on the indicated date of service or other apparent violation of DPA's policies. The SURS Enhancement project provides an opportunity to develop such postpayment monitoring routines.

8. Remove "Other" Destination Code from the Claim Form

The "other" destination code should be removed from the claim form and the claims editing system and be replaced with specific codes. This will ensure that bills for transportation to providers of non-covered services will be rejected.

9. Develop More Strongly Worded Notices

While the September 1996 informational notice was clear and direct, future notices may be more effective if they warn providers of the consequences of poor compliance.

10. Review ALS Ambulance Billing Policy

DPA policy allows for reimbursement for ALS billing even in circumstances where BLS services would have been appropriate. ALS services can be provided and billed for in emergencies as long as an ALS staffed and equipped vehicle is dispatched and the provider had no firsthand knowledge that only BLS service were required.

We believe that DPA should consider changing this policy. Unless ALS services are medically justified, the additional reimbursement paid to these providers adds little or nothing to the quality of care recipients receive. At the same time, we realize that providers will find Medicaid less attractive if they are expected to absorb the losses associated with 911 dispatchers' decisions. It is possible that a third category of reimbursement, which offers the provider modest additional compensation for ALS services but does not provide for full ALS rates unless such care is medically justified, might be a reasonable compromise. Such a rate structure would enable DPA to save money by identifying and recovering ALS payments when such billings were not medically justified.

11. Consider Other Monitoring Strategies

A number of other monitoring strategies should be considered to prevent or detect fraudulent or abusive medical transportation claims. These relate to:

- Enrollment -- Recently enrolled providers should be monitored more closely until they have demonstrated that they are legitimate and able to deliver services consistent with DPA's rules. A number of strategies available for doing so include postpayment surveillance for billing spikes and other statistical warning signs during the first six months of enrollment and periodically afterwards; enrollment data verification of new or suspicious providers; criminal or sanction history checks of operators, directors, and partners before or shortly after enrollment and unscheduled on-site visits shortly after enrollment.
- Provider/recipients -- As suggested previously, recipients can enroll as private automobile providers and transport themselves, their families and others for reimbursement. This arrangement provides less accountability than exists for most other providers. They should be monitored more closely and more frequently. DPA could determine whether these providers are adequately informed about their record retention requirements or whether additional provider education efforts are needed. DHS might review current income budgeting practices to determine whether the income anticipated from this activity should be and presently is included in the monthly budgeting calculations.
- Emergency Transportation -- Another recommendation developed by BMQA is for DPA to undertake periodic analyses of the extent to which emergency transportation services are being used inappropriately and whether this inappropriate use follows certain patterns. These analyses could examine the percent of emergency room trips where a non-emergency fee is paid, by provider and administering local office. Most importantly, the analyses could also examine

the extent to which ALS services are billed for recipients who do not appear to need emergency care, based on diagnosis information contained in the corresponding emergency room claim. The results of these analyses could be shared with the transportation coordinator, DMP transportation experts and the MFPEW, and a joint decision could be made at that time about the types of policy changes, information dissemination practices or referrals warranted. We recommend that MFPEW study the feasibility of undertaking such postpayment surveillance routines and analyses.

SUMMARY

The medical transportation program, while typically governed by sound policies, could benefit from program administrative changes. These changes will strengthen DHS and DPA operations by reducing both Departments' vulnerability to fraud, abuse and employee misconduct in the medical transportation program.

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APPENDIX A: MEDICAR ATTENDANT CARE ANALYSIS

Out of concern about reports of upcoding by medicar providers, the Department clarified its policies regarding the use of attendants by medicar providers. In September 1996, it released an informational notice reminding these providers of the need to obtain prior approval before using an attendant.

LPAR undertook an analysis of the impact of this informational notice release. We analyzed paid claims data for medicar providers in FY 1996 and the first two quarters of FY 1997 to determine whether the release of the informational notice was followed by a decrease in the percent of (a) dollars paid for attendants or (b) service units billed for attendants as a proportion of all paid service units.

Our analysis, presented below in Table A.1, suggests that virtually no change in either of these measures were observed after the release of the information notice. We compared second quarter FY 1997 figures to comparable figures from the second quarter of FY 1996, the first six months of the FY 1996 and all of FY 1996, and in no instance identified a major difference in either of the measures.

While this analysis indicates that the release of the informational notice had no impact on providers' billing behavior, we cannot be certain why. It is possible that the informational notice was ineffective in preventing fraud or abuse by medicar providers. An alternative explanation, however, is that fraudulent or abusive attendant billings by medicar providers are not widespread. We do not have the information to determine which of these explanations is more compelling.

TABLE A.1		
IMPACT OF RELEASE OF THE SEPTEMBER 1996 INFORMATIONAL NOTICE		
	Dollars Paid for Attendants as a Percentage of Total Medicare Dollars	Medicare Services as a Percentage of All Services
Second Quarter 1997	4.2 %	15.6 %
Second Quarter 1996	4.1 %	15.3 %
All of 1996	4.3 %	15.8 %

APPENDIX B: TRENDS AND PATTERNS IN TRANSPORTATION BILLING

We examined county-level patterns of transportation use and cost for FY 1996 to identify specific local offices that may benefit from an internal review of their mode of transport determinations. We recognize that our analysis is inherently exploratory and limited, since paid claims data cannot by themselves indicate whether these determinations are appropriate. At the same time, we believe the data presented can identify local offices that might want to examine their mode of transport determinations and identify whether opportunities for improvement and cost reduction are available.

The analysis suggests that some local offices may be in a position to reduce their transportation costs. Several counties had exceptionally high total payments per billed service. We identified these as counties that have values in excess of 1.5 standard deviations from the all-county average, or alternatively, those expected to be observed no more than about 7% of time.

Table B.1 displays payments per service for FY 1996 for each county in Illinois. These figures are displayed for each type of transportation provider (ambulance, medicar, taxi/livery, hospital based and other). The bottom of the table shows the statewide total, the unweighted average across counties and a “review threshold”, above which local offices within that county could be examined more closely.⁴ These above-threshold figures are shaded. It is noteworthy, however, that a small number of observations underlying a particular cell can yield misleading values. As a consequence, we shade only those cells that exceed the review threshold and are based on at least 75 observations. In addition, we have included the information underlying these figures in Table B.2 for comparison purposes. This table displays, by county and type of transportation provider, the FY 1996 number of services and paid dollar amounts.

It is important to remember that payments per service will reflect not only the mode of transport decisions made by the local office but also the billing practices of providers serving those counties, the distance recipients travel to appointments, the extent to which recipients can transport themselves and a variety of other factors. Also, the review threshold is merely a crude gauge of the cost-reduction opportunity available to the local offices within the excepted county. As a consequence, we cannot make any definitive statements about counties whose values exceed the thresholds. We do recommend, however, that a more careful review be undertaken to determine whether improvement in the management of the transportation program in the associated local offices can be made. This review could begin with a more comprehensive data analysis that examines transportation use and cost on an enrollee, fee-for-service enrollee, medical

⁴This threshold is calculated by adding the unweighted average to the product of the standard deviation and 1.5. To ensure that the threshold is not unduly influenced by extreme observations, such outliers are omitted from the threshold value calculation.

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service user and medical transportation user basis. Such an analysis was beyond the scope of this project. Along with the data presented here, this more comprehensive analysis could guide DHS in identifying local office transportation programs that warrant further review.

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