



# The Commonwealth of Massachusetts

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INDEPENDENT STATE AUDITOR'S REPORT ON  
THE ADEQUACY OF THE OVERSIGHT AND  
INTERNAL CONTROLS OVER THE PAYMENT OF  
TRANSPORTATION PROVIDER CLAIMS AT  
MASSHEALTH

OFFICIAL AUDIT  
REPORT  
FEBRUARY 27, 2007

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### INTRODUCTION

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MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services to approximately one million low and moderate-income individuals, couples, and families in Massachusetts. Medicaid annually pays in excess of \$6 billion on 75 million claims to 26,000 providers within the Commonwealth, of which 50% is federally funded. In fiscal year 2005 there were 2,731,218 transportation claims totaling \$76,087,427 in payments, or an average of 7,483 claims aggregating \$208,458 in payments daily. If a Medicaid member needs medical services but cannot get to the services, federal regulations require that transportation be provided to the member. Members generally use transportation services to travel from their residence or a medical facility to another facility for medical services.

Our audit was conducted as part of the Office of the State Auditor's ongoing independent statutory oversight of the Commonwealth's Medicaid program. The heightened concern over the program integrity was evidenced in January 2003, when the U.S. Government Accountability Office (GAO) placed the U.S. Medicaid Program on its list of government programs that are at "high risk" of fraud, waste, abuse, or mismanagement. Further, GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers.

Our previous audit report (No. 2004-1374-3S), issued October 13, 2005, disclosed significant weaknesses in MassHealth's ability and efforts to detect fraud in the Commonwealth's Medicaid program. Our current review was conducted to further expand on the results of our previous audit.

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, we conducted an audit of transportation provider claims for the fiscal year ended June 30, 2005. Our objectives were to determine whether transportation claims filed by transportation providers were properly supported by required documentation; services were delivered; and that the claims were complete, accurate, and in compliance with applicable laws, rules, and regulations and to determine the extent and effectiveness of MassHealth's internal controls and oversight of providers.

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### AUDIT RESULTS

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#### **INADEQUATE INTERNAL CONTROLS AT MASSHEALTH MAY HAVE RESULTED IN SIGNIFICANT OVERPAYMENTS OF TRANSPORTATION CLAIMS DURING FISCAL YEAR 2005**

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Our audit indicated that MassHealth's internal controls and policies and procedures over transportation claims processing and payment were not adequate to ensure that the claims were properly supported with the required documentation and complete, accurate, and in compliance with applicable laws, rules and regulations. We audited a sample of 125 paid claims totaling \$7,054 in fiscal year 2005 and questioned 72 claims (58%) totaling \$3,870 (questioned claims are defined as claims not in compliance with applicable laws, rules and regulations, not supported by adequate documentation, or

appear to be unreasonable). As indicated in Appendix A, the majority of these questioned paid claims involved Fee for Services (FFS) providers. MassHealth's overpayment of these transportation claims resulted because MassHealth's internal controls were not sufficient to detect overstated provider claims, review supporting claims documentation, discover duplicated provider claims, identify paid ancillary services related to denied non-emergency transportation claims, detect shared rides paid as sole passengers, or confirm that transportation actually occurred. We also obtained confirmation from three providers who acknowledged receiving overpayments in excess of \$200,000, and of the difficulties in returning the funds to MassHealth. In addition, our review indicated that additional, significant overpayments may have been made over several years to other providers whose claims were not subject to our review.

Our audit sample of claims disclosed a questioned claims rate of 58%. Transportation claims for providers totaled \$76 million during fiscal year 2005 and there could be millions of dollars in questioned claims or potentially fraudulent payments to transportation providers. Our audit found that the highest risk was with FFS Providers who accounted for 24% of the claims paid and 49% of the amount paid (\$36.9 million). Because of the inadequate system of internal controls, policies and procedures that require the transportation provider to maintain supporting documentation for claims, and the lack of post audits of transportation providers' claims, the risk of improper and fraudulent claims is significant.

Specific issues noted during our review included: (a) duplicate round trip claims were paid; (b) mileage was paid for denied transportation; (c) payments possibly were made to the incorrect provider type, which may have resulted in significantly higher costs; (d) services could not be confirmed for 34% of claims audited; (e) overstated mileage paid; (f) claims were paid without required special authorization, (g) shared rides were billed as sole-passenger trips, resulting in claim overpayments; (h) there was a lack of oversight in type and mode of transportation; (i) transportation claims were inadequately documented; and (j) providers experienced difficulty in returning overpayments.

Our report demonstrates that there is a high risk that a significant number of transportation claims are questionable and could be fraudulent and that MassHealth needs to improve its oversight and fraud detection activities. Also, the report contains several recommendations that MassHealth should consider in strengthening program integrity.

In response to the audit report, MassHealth indicated that it accepts our recommendations for streamlining and strengthening internal controls, including conducting post payment reviews of paid claims, developing edits and procedures within electronic systems to prevent errors, and examining current practices for collecting overpayments. MassHealth acknowledged that the audit report identifies areas where processes could be strengthened, and indicated that it has already begun to develop plans to address these areas.

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## INTRODUCTION

### *Background*

MassHealth, within the Massachusetts Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to healthcare services to approximately one million eligible low and moderate-income individuals, couples, and families. Massachusetts Medicaid annually pays in excess of \$6 billion on 75 million claims to 26,000 providers, of which 50% is federally funded. Medicaid expenditures represent approximately 25% of total Commonwealth expenditures.

If a Medicaid member needs medical services but does not have available transportation, federal regulations require that transportation be provided to the member. Members generally use transportation services to travel from their residence or a medical facility to another facility for medical services. Transportation services generally comprise emergency services (ambulances) and non-emergency services (ambulances, wheelchair vans, taxis, personal vehicles, or public transportation). Regulations require prior authorization for all types of non-emergency transportation, except public transportation.

MassHealth and the Human Service Transportation Office (HST), within EOHHS, administer transportation for non-emergency services to qualified members. The mission of the HST is to provide safe and efficient transportation for members to access vital health, developmental, and social services with dignity. Transportation claims are paid to Regional Transit Authorities (RTAs), Fee For Service (FFS) providers, and Adult Day Health Care (ADH) providers.

All providers are regulated under the provisions of the Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series, All Provider Manuals (130 Code of Massachusetts Regulations [CMR] 450). Specific regulations are in the Transportation Manual (130 CMR 407) for RTA and FFS transportation providers and in the Adult Day Health Manual (130 CMR 404) for ADH transportation providers. RTAs are further held to the terms of a MassHealth Specific Conditions for Human Service Transportation Broker/Mobility Manager Services contract.

MassHealth contracts with RTAs for non-emergency transportation. As transportation brokers, RTAs secure subcontractor service agreements with independent transportation companies and individuals. The RTAs submit claims directly to MassHealth for payment according to the terms of

their contract and pay their subcontractors according to the terms of the service agreements. Independent transportation companies (FFS providers) submit claims for both emergency and non-emergency transportation directly to MassHealth for payment. In fiscal year 2005 there were 2,731,218 transportation claims totaling \$76,087,427 in payments, or an average of 7,483 claims and \$208,458 in payments daily.

All forms of non-emergency transportation, except public transportation, require prior authorization from MassHealth. The authorization must consist of a verbal approval (in the case of urgent medical care), a prescription for transportation (PT-1) form, or a completed Medical Necessity Form completed by a physician, physician's assistant, nurse midwife, dentist, nurse practitioner, or managed-care representative. The PT-1 form is used by RTAs, and the Medical Necessity Form (also requiring the same signatures as the PT-1 form) is used by FFS providers. Both forms include member information, the destination, and the reason the transportation is required. The FFS transportation provider is responsible for obtaining these forms from the professional providing the approved medical service and maintaining this documentation on file for four years. This documentation consists of Medical Necessity Forms and trip logs that detail mileage and duration of trips, date of service, origin and destination of the trip, and any other required documentation (for example, any special authorization). It is the responsibility of the FFS transportation provider to maintain the hard copy documentation in support of claims.

After the services have been provided, the provider can submit a transportation claim to MassHealth in one of two formats: paper or electronic. The claim is processed into the Massachusetts Medicaid Management Information System (MMIS), which is the claims processing system used by MassHealth to pay provider claims. The system annually processes approximately 75 million claims for 26,000 providers and 80 provider types. The system uses a variety of functions and edits to record, pay, suspend, or deny claims.

### ***Audit Scope, Objectives, and Methodology***

In accordance with Chapter 11, Section 12, of the General Laws, we conducted an audit of transportation provider claims for the fiscal year ended June 30, 2005. Our audit was conducted in accordance with applicable generally accepted government auditing standards. Our objectives were to determine that transportation claims filed by transportation providers were properly supported with the required documentation, that transportation services were delivered, and that the claims

were complete, accurate and in compliance with applicable laws, rules, regulations, and to determine the extent and effectiveness of the internal controls and oversight of providers by MassHealth.

Our audit was conducted as part of the Office of the State Auditor's ongoing independent statutory oversight of the Commonwealth's Medicaid program. The heightened concern over the program integrity was evidenced in January 2003, when the U.S. Government Accountability Office (GAO) placed the U.S. Medicaid Program on its list of government programs that are at "high risk" of fraud, waste, abuse, or mismanagement. Further, GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. Our previous audit report (No. 2004-1374-3S), issued October 13, 2005, disclosed significant weaknesses in MassHealth's ability and efforts to detect fraud in the Commonwealth's Medicaid program. Our review was conducted to further expand on the results of our previous audit.

We selected 125 fiscal year 2005 transportation claims and conducted field audits of claims at 24 provider locations. Our review included 26 adult day health care transportation claims, 11 regional transportation authority claims, and 88 FFS transportation claims (ambulance and wheelchair vans), and included an examination of the supporting documentation, including Medical Necessity Forms; PT-1 forms; trip logs detailing mileage and the duration of trips, date of service, and origin and destination of trips; and other pertinent information relative to the paid claims. In addition, we compared the information in support of claims to the MassHealth members' medical coverage to determine whether members were entitled to the service. Moreover, we confirmed whether the member received an approved medical procedure at the destination of the trip. We also interviewed provider management and examined driver and vehicle records to determine compliance with regulations. We reviewed applicable state and federal laws, rules, and regulations, as well as MassHealth and the Human Service Transportation Office policies and procedures. We also consulted with various members of the management at MassHealth, EOHHS, and HST.

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## AUDIT RESULTS

### **INADEQUATE INTERNAL CONTROLS AT MASSHEALTH MAY HAVE RESULTED IN SIGNIFICANT OVERPAYMENTS OF TRANSPORTATION CLAIMS DURING FISCAL YEAR 2005**

Our audit indicated that MassHealth's internal controls and policies and procedures over transportation claims processing and payment were not adequate to ensure that the claims are (1) properly supported with the required documentation and (2) complete, accurate and in compliance with applicable laws, rules and regulations. We audited a sample of 125 paid claims totaling \$7,054 in fiscal year 2005 and questioned 72 claims (58%) totaling \$3,870 (questioned claims are defined as claims not in compliance with applicable laws, rules and regulations, not supported by adequate documentation, or appear unreasonable). As indicated in Appendix A, the majority of these questioned claims involved Fee for Services (FFS) providers. MassHealth's overpayment of these transportation claims resulted because MassHealth did not detect overstated provider claims, review supporting claims documentation, discover duplicated provider claims, identify paid ancillary services related to denied non-emergency transportation claims, detect shared rides paid as sole passengers, or confirm that transportation actually occurred. We also obtained confirmation from three providers, who acknowledged receiving overpayments in excess of \$200,000 and advised us of the difficulties encountered attempting to return the funds to MassHealth.

Our audit sample of claims disclosed a questioned claims rate of 58%. Transportation claims for providers totaled \$76 million during fiscal year 2005 and there could be millions of dollars in questioned claims or potentially fraudulent payments to transportation providers. Our audit found that the highest risk was with FFS Providers, who accounted for 24% of the claims paid and 49% of the amount paid (\$36.9 million). Because of the inadequate system of internal controls, policies, and procedures that require the transportation provider to maintain supporting documentation for claims, and the lack of post audits of transportation provider claims, the risk of questionable and fraudulent claims is significant. As indicated in our prior audit report (No. 2004-1374-3S) on the oversight of the Medicaid program, the Government Accountability Office (GAO) and health insurance industry sources have estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. The GAO estimate, along with our audit results of a 58% error rate in

claims processing, indicates a high risk of the payment of questionable transportation claims that could be fraudulent.

All non-emergency transportation, other than public transportation, provided to MassHealth members requires pre-approval. MassHealth officials indicated that MassHealth's prior authorization process is the primary means by which it provides oversight of the non-emergency FFS transportation to ensure that the member uses the most appropriate mode of transportation. The required prior authorization documents are maintained at the FFS transportation providers' place of business, in accordance with state regulations, but are not reviewed by MassHealth. In fact, MassHealth has not conducted an on-site review of FFS transportation providers in at least 10 years, yet this is the location for the most essential supporting documentation for the payment of a claim. Without reviewing the primary supporting documentation of transportation providers, MassHealth cannot determine whether an approved medical service was provided to the member at the trip's destination and that a trip actually occurred. Moreover, our review indicated that the internal control activities and the existing Medicaid Management Information System (MMIS) procedures within MMIS did not prevent the payment of ancillary billing for denied claims, the payment of overstated mileage, or the duplication and double payment of round-trips. Moreover, as there is no regular post-payment review of transportation claims, there is potential for fraud and abuse.

In its publication "Internal Control – Integrated Framework," the Committee of Sponsoring Organizations (COSO) of the Treadway Commission, a private organization that offers guidance on financial reporting, effective internal controls, and corporate governance states that monitoring and control activities ensure that internal controls continue to operate efficiently, and that a monitoring and control activities process should be in place, as follows:

*Internal control systems need to be monitored – a process that assesses the quality of the system's performance over time. This is accomplished through ongoing monitoring activities, separate evaluations or a combination of the two. Ongoing monitoring occurs in the course of operations. It includes regular management and supervisory activities, and other actions personnel take in performing their duties.... (COSO, pp. 5, 69)*

*Control activities are the policies and procedures that help ensure management directives are carried out ... Control activities should include preventative controls, detective controls, manual controls, computer controls and management controls. (COSO, pp. 49)*

During our audit, we determined that many of the claims reviewed had multiple exceptions, including the following: (a) duplicate round trip claims were paid; (b) mileage was paid for denied transportation; (c) payments possibly made to incorrect provider type, may have resulted in significantly higher costs; (d) services could not be confirmed for 34% of claims audited; (e) overstated mileage paid; (f) claims were paid without required special authorization, (g) shared rides were billed as sole-passenger trips, resulting in claim overpayments; (h) there was a lack of oversight in type and mode of transportation; (i) transportation claims were inadequately documented; and (j) providers experienced difficulty in returning overpayments. The details of our review follow:

**a. MassHealth's Payment System Duplicates and Pays Round-Trip Claims Twice**

We audited five claims paid to a Fee for Service (FFS) provider of wheelchair van services and found three duplicate round trip payments. We then researched all claims paid to this provider in fiscal year 2005 and found 2,860 duplicate round trip and mileage claim payments totaling in excess of \$98,000. We contacted the provider, who acknowledged that the overpayments were received and that they must be repaid to MassHealth. The provider stated that it reported the receipt of duplicate payments to MassHealth in September 2004, but that MassHealth indicated that it was a computer system error that would be corrected and advised the provider to keep billing using the same method. We then researched fiscal year 2005 transactions and discovered that 11 other transportation providers may have received similar duplicate payments. One provider may have received an excess of \$40,000 during the period July 1, 2004 through November 10, 2004 alone. This provider, who has acknowledged receiving a total of approximately \$100,000 in overpayments, also stated that it had notified MassHealth about the problem and of its desire to repay the amounts in question, but that it was experiencing difficulty with MassHealth's required repayment procedure. Another provider, who returned \$32,659 in overpayments after two years of correspondence with MassHealth, similarly stated that it was filing the claims according to MassHealth's standard procedure, but that the MMIS was overpaying its claims. (See Subsection (j) "Providers Experience Difficulty in Returning Overpayments").

A MassHealth official indicated that he was unaware of these duplicate payments or any system error that may have caused it. The providers who have not repaid their overpayments indicated

that MassHealth has not contacted them since the issue was reported, and they continue to hold the overpayments. We estimate, based on a review of the other 10 providers, that in fiscal year 2005 there was approximately \$200,000 of duplicate round trip and mileage claims paid to transportation providers. A preliminary review indicates that duplicate round trip payments were also made in periods prior to and subsequent to fiscal year 2005. The 130 Code of Massachusetts Regulations (CMR) 450.235 defines overpayments as follows:

*Overpayments include, but are not limited to, payments to a provider: (C) in excess of the maximum amount properly payable for the service provided, to the extent of such excess; (G) for services billed that result in a duplicate payment.*

An adequate internal control system would include regular post payment review of claims and application controls designed to prevent the duplication of payment. In addition, an appropriate control environment would require the prompt investigation of overpayments received and reported to MassHealth by providers. COSO's publication, Internal Control – Integrated Framework, states, in part:

*Application controls are designed to control application processing, helping to ensure the completeness and accuracy of transaction processing, authorization and validity. Particular attention should be paid to an application's interfaces, since they are often linked to other systems that turn need control, to ensure that all inputs are received for processing and all outputs are distributed appropriately. (COSO, pp. 54)*

#### **b. Mileage Was Paid for Denied Transportation**

Our audit disclosed that payments were made for mileage on denied transportation claims. There are two elements to a transportation claim, the base charge (a fixed amount) and the mileage (miles multiplied by a rate per mile). Some MassHealth member types are limited to emergency transportation services, and claims submitted by them under non-emergency codes are denied. We found four basic transportation claims from two providers that were denied by MassHealth because the members were not eligible for non-emergency transportation services; however the mileage was paid.

We requested that MassHealth review the extent of the mileage overpayment on denied transportation and the cause of the problem. MassHealth's review, which was limited to ambulance services, discovered that 2,410 non-emergency ambulance claims paid to 87 providers during the period July 2004 to December 2005 were denied and not paid; however, \$96,274 was paid for mileage associated with these claims. Subsequent to the MassHealth review, we

revisited an ambulance company that reported having received \$32,659 in overpayments for such claims from 1999 to 2002, which the provider refunded in two installments (December 31, 2004 and March 29, 2005). Another ambulance company, whose claims were not a subject of this audit but were discovered in our expanded review of duplicate round-trip payments, acknowledged that it has overpayments from denied claims where they received payment for mileage, but reported having difficulty refunding these payments to MassHealth. As of the end of our audit field work, repayment had not been made. (See Subsection (j) "Providers Experience Difficulty in Returning Overpayments.")

MassHealth stated that the overpayments for mileage occurred because the procedure code for both non-emergency and emergency transportation is identical and MMIS could not identify and therefore deny the improper payment. As a result of our audit, MassHealth is considering creating separate codes for non-emergency and emergency mileage.

MassHealth's review found that the \$96,274 in mileage overpayments was limited to non-emergency ambulance trips. However, we also found one claim for a denied wheelchair van trip with paid mileage. We suggested that MassHealth expand its review to include denied wheelchair van services with paid mileage and to extend the review period of overpayments for mileage charges on denied basic transportation claims to cover the periods prior to July 2004 and after December 2005 in order to measure the magnitude of the problem.

The regulation governing the eligibility of members to receive transportation services and the restrictions on services depending on members' type are as follows:

130 CMR 407.403: Eligible Members

*(A)(1) MassHealth Members. The Division covers transportation services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.*

130 CMR 407.411: Transportation Utilization Restrictions

*(A) Covered Services. The Division pays for transportation services only when such services are covered under the member's MassHealth coverage type and only when members are traveling to obtain medical services covered under the member's coverage type.*

An adequate internal control system would include regular post-payment review of claims and controls designed to prevent the payment of ancillary claims associated with basic claims which have been denied. In addition, an appropriate control environment would require the prompt investigation of overpayments received and reported to MassHealth by a provider.

**c. Payments Made to a More Costly Provider Type May Have Resulted in Significantly Higher Costs**

MassHealth paid 67 claims directly to FFS providers when payment if made to Regional Transit Authorities (RTAs), would have resulted in lower cost. Regulations are unclear as to whether it is a requirement that members use RTAs for their transportation rather than going directly to a FFS provider. MassHealth's current policy may conflict with its own regulations. MassHealth indicated that current RTA contracts do not grant exclusive rights to regional RTAs to provide all transportation in specific areas, and the Office of Medicaid regulations permit, but do not require the agency to direct all MassHealth members in a particular region of the state to a certain transportation provider.

The incremental amount paid to the FFS providers compared to that which would have been paid to RTAs on the 67 claims varied from 1% to 50% per claim. A MassHealth official estimated that the differential in the cost of services paid to FFS providers over RTAs is 10%. In fiscal year 2005, \$12,791,951 was paid directly to FFS providers for wheelchair van services that, if provided by and paid to RTAs, could have generated substantial savings. Assuming that the MassHealth official's estimate of the rate differential is correct, the program could have saved in excess of \$1 million.

All transportation providers must comply with 130 CMR 407, Transportation Manual Program Regulations. The 130 CMR 407.432(A) indicates that payment to providers for transportation services be made directly to providers of services except in areas of the state where a selective contract with a transportation broker is in effect. MassHealth has had selective contracts for transportation brokerage services with RTAs administered by the Human Service Transportation Office (HST) throughout all of Massachusetts since calendar year 2000. The 130 CMR 407.432(A), Payment to Providers for Transportation Services, states that payments be directly made to providers of services, except in areas where there is a selected contract, as follows:

*(A) Amount of Payment: Payment for transportation is made directly to providers of services except in the circumstances specified in 130 CMR 407.431<sup>1</sup>, or in areas of the state where a selective contract with a transportation broker is in effect. Where such a contract is in effect, payment is made in accordance with the terms of the contract.*

Moreover, MassHealth is required by 130 CMR 407.407, Selective Contracting, to communicate to its members regarding the required use of the RTAs, as follows:

*(C) Members in regions where selective contracts are in effect are notified by the Division of the transportation available to them under the terms of such contracts.*

An example of this communication can be found in MassHealth's Web site, which has the following Frequently Asked Question and Answer:

*"I would like to travel with a specific cab company because I like them the best. Can I do that?"*

*"No. MassHealth transportation is done through the lowest bidder system, meaning that rides are assigned based on vendor's rates. For that reason MassHealth cannot assign a specific company or driver to a specific MassHealth Member for every ride."*

The lower bidder system is the RTA program.

Also, in the case of ambulance and wheelchair van transportation with a FFS transportation provider, the provider is to judge and advise the members if the transportation is covered by MassHealth. The 130 CMR 407.411, Transportation Utilization Restriction, indicates the transportation provider's responsibility is as follows:

*(2) In the case of ambulance and wheelchair van transportation not provided through a selective contract with a transportation broker, it is the responsibility of the transportation provider to judge which medical services are covered by MassHealth and to advise the member in cases where transportation is requested to a service that, in the providers judgment may not be or is not covered by MassHealth. If a member is in doubt as to whether or not a medical service is covered by MassHealth, the member should contact the Division.*

MassHealth's position is that their policy does not restrict the member's use of an RTA and that they need to be flexible. A MassHealth official stated the following:

*MassHealth members may receive their transportation from a Fee-For-Service provider. The regulations do not specify that RTAs must be used but that MassHealth may provide transportation service through selective contracts. Federal law requires that MassHealth ensure that members have transportation to medically necessary services and the*

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<sup>1</sup> 130 CMR 407.431: Reimbursement to Members for Transportation Expenses

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*MassHealth regulations are intended to provide MassHealth with flexibility to ensure that members have transportation when it is needed.*

In support of its stance that MassHealth members do not necessarily have to use RTAs, MassHealth refers to 130 CMR 407.407, Selective Contracting, which states, in part:

*(A) In some regions the Division may provide transportation services through selective contracts with regional transit authorities or other transportation entities. In areas of the state where a selective contract with a transportation broker is in effect, services are provided in accordance with all applicable MassHealth regulations and the terms of the contract.*

However, this regulation does not govern the provider of the service, but rather refers to Selective Contracting, and that MassHealth may have selective contracts with RTAs or selective contracts with other transportation entities. There are transportation entities other than RTAs that can and do provide selective contracting services.

Further, a MassHealth official stated that it is impractical for the agency to comply with the regulation governing the use of Regional Transit Authorities (RTAs) instead of FFS providers.

The official reported that the reality of the marketplace is that transportation service companies and institutions (hospitals and nursing homes) have long standing or contractual relationships. Additionally, some of these institutionalized patients require assistance from bedside to the vehicle. Also, the RTAs do not offer ambulance services (neither emergency nor nonemergency). As a result, literal compliance with the regulations is not practical.

MassHealth does not have a consistently applied policy that will maximize the feasible use of RTAs for non-emergency non-ambulance transportation. At one time the policy mandated that all non-emergency non-ambulance transportation of members that were not institutionalized be exclusively transported via the RTAs and not FFS providers. This policy takes advantage of the many benefits of the RTA program. It enhances the oversight of providers, as MassHealth and HST regularly meet with the RTAs and review their operations, and the RTAs oversee and perform field inspections of their subcontractors. Mileage would be monitored because RTAs enter trips into a routing system that calculates miles per trip through an interface with Geocoding and map software. Duplicate trips may be prevented, RTAs are required to obtain special authorization for the second and succeeding wheelchair van round trips provided to a member in the same day. Finally, there will be a valid form of prior approval, because the RTAs

must submit a prescription for transportation (PT-1) form to MassHealth for authorization prior to rendering any transportation services.

The benefits are most directly realized in member transport by wheelchair vans. Our review disclosed that it may have been possible for MassHealth to save in excess of \$1 million in fiscal 2005, if the use of RTAs was maximized with a policy requiring their use in specific circumstances.

An adequate system of internal controls would require that MassHealth amend its regulations to comply with its current policies. COSO's volume on Internal Control – Integrated Framework states, in part:

*Control activities usually involve two elements: a policy establishing what should be done and, serving as a basis for the second element, procedures to affect the policy. (COSO, pp. 51)*

**d. Services Could Not Be Confirmed for 34% of Claims Audited**

Our audit disclosed that the MMIS system pays claims without a system cross edit to confirm that the trip actually occurred. In order to confirm that transportation services were provided as claimed, we obtained information from the MMIS system to determine that the system contained a payment for medical service at the destination of the trip on the date of transportation. We found that MassHealth could not produce electronic evidence that a medical procedure was performed on the day of transportation service in 42 of the 125 (34%) claims examined.

The 130 CMR 407.411, Transportation Utilization Restrictions, requires that MassHealth pay for transportation claims only when members are traveling to obtain medical services at the destination of the trip, as follows:

*(A) Covered Services. The Division pays for transportation services only when such services are covered under the member's MassHealth coverage type and only when members are traveling to obtain medical services covered under the member's coverage type.*

Since MassHealth does not conduct a regular post-payment review of transportation claims, medical treatment for transportation members is rarely verified. MassHealth indicated that it relies on the provider trip logs and the Medical Necessity Forms as evidence of the propriety of

the transportation claims. We found that, in most cases, this documentation exists at the provider's place of business, as required by regulation. However, MassHealth does not visit FFS providers or examine this documentation before or after payment of a claim. RTAs, however, do submit an electronic PT-1 form, which could be cross-checked by the MMIS prior to payment. As a result, it is possible for transportation providers to submit claims for transportation that never occurred because MassHealth does not have a system to verify claims.

The 42 Code of Federal Regulations (CFR) 455.20, Recipient Verification Procedure, states, in part:

*(a) The agency must have a method for verifying with recipients whether services billed by providers were received.*

Proper internal controls would require MassHealth to have a procedure within MMIS that denies payment of a transportation claim without verification of medical services at the destination facility and to conduct a post-payment review of the documentation of paid claims at provider locations.

#### **e. Overstated Mileage Paid**

MassHealth paid transportation providers for mileage which was overstated. We audited mileage claimed utilizing MapQuest® to compare actual mileage between locations with the mileage billed by the provider. We found nine instances where the mileage was overstated from 10% to over 100%. For example, we found a trip from Sudbury to Boston billed at 70 miles round trip, MapQuest® calculated the roundtrip as 42 miles. The mileage was billed at \$1.30 per mile, resulting in a \$36.40 overpayment. While the amount overstated may not be for a large dollar amount per occurrence, several of the transports were for members traveling to dialysis treatment on a regular basis, often three to four days per week every week for years.

MassHealth's internal control on mileage billed by FFS transportation providers is limited to an edit in MMIS that requires a review if the mileage is in excess of 250 miles. A MapQuest® query of the driving distance from Provincetown to Pittsfield indicated a distance of 242 miles. We find this 250-mile control inadequate because few, if any, trips will reach this limit. We also found that the origin and destination of the trips are not always included on the claims submitted by the provider, and, accordingly, the mileage on those claims cannot be entered into

MMIS. As a result, overstated mileage could go undetected by the system, and all excessive mileage under the 250-mile benchmark could be undetected and paid.

The relevant state regulations describing unacceptable billing practices, which could result in overpayments, are as follows:

130 CMR 450.307: Unacceptable Billing Practices

*(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method; (B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden: (2) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more-comprehensive service for which a single rate of payment is established*

130 CMR 450.223: Provider Contract: Execution of Contract

*(C) The following provisions are a part of every provider contract whether or not they are included verbatim or specifically incorporated by reference. By executing any such contract, the provider agrees; (2) that the submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that; (e) the information submitted in, with, or in support of the claim is true, accurate, and complete*

An adequate system of internal controls would require a post-payment review of the documentation of paid claims at provider locations and a method of verifying the mileage from origin to destination of a trip within the MMIS system.

**f. Claims Were Paid without Required Special Authorization**

Our audit disclosed that seven claims were paid (five to the same provider) for members who were transported, without the required approval by MassHealth, outside of their locality for a service that was readily available within the locality. As a result, the payment for transportation was at a substantially higher cost than if transported locally. Out-of-locality transport requires special authorization from MassHealth.

The 130 CMR 407.411, Transportation Utilization Restrictions, requires that transportation to medical care be within the member's locality (defined as the town or city in which the member resides and to immediately adjacent communities) or to the nearest medical facility in which treatment is available, as follows:

*(C) Locality Restrictions. The Division pays for an eligible member to be transported to sources of medical care only within the member's locality, unless otherwise authorized by the Division. Locality refers to the town or city in which the member resides and to immediately adjacent communities. However, when necessary medical services are unavailable in the member's locality, transportation to the nearest medical facility in which treatment is available is covered by MassHealth. Medical transportation originates from the member's home and proceeds to the location of the medical appointment. Other points of origin, such as from one doctor's office to another, require approval from the Division.*

The five trips serviced by the same provider involved transporting members from Boston, Cambridge, Belmont, and Medford to a physician's office in Canton for physical therapy. We noted that these members were traveling to this location on a regular basis and that physical therapy is available in their localities. If MassHealth does not enforce the regulation governing locality restrictions, transportation costs will be excessive.

An adequate system of internal controls would require a post-payment review of the documentation of paid claims at provider locations and a method of verifying the appropriateness of the charges within the MMIS system.

**g. Shared Rides Were Billed as Sole-Passenger Trips, Resulting in Claim Overpayment**

Our audit disclosed evidence that the provider that transported the five members out of locality (see Subsection (f), "Claims Were Paid without Required Special Authorization") without approval was transporting the members in a shared ride and billing at the higher rate of single passenger ride. This provider transports multiple members regularly to Canton for physical therapy. One claim, similar to all others, was for transporting a member and billed at \$40 for the round trip and \$26 for mileage totaling \$66. If the claim had been billed as a shared ride, the cost would have been \$20 with no mileage allowed. Hence, the \$66 payment was overpaid by \$46. Additionally, this was a trip that should have been provided by a RTA, whose billing rate at the time was \$7 for a shared ride, which would result in a \$59 overpayment. Although the provider claimed that the members were transported separately, our examination of the provider's trip logs indicated that the members were in a shared wheelchair van.

The 130 CMR 407.411, Transportation Utilization Restrictions, is specific regarding two members traveling to the same locality, as follows:

*(G) Shared Ride. (1) When two or more members are traveling to the same locality at the same time, they must share transportation when such arrangements are made by the Division, transportation provider, transportation broker, or medical provider.*

Moreover, in accordance with Subchapter 6 of the Transportation Manual used by MassHealth, no mileage fee is allowed for extra patients or passengers in non-emergency wheelchair van transportation.

We discovered the shared-ride issue as a result of our reviewing the trip logs of the provider. MassHealth, however, is unable to determine sole passenger rides that should be claimed as a shared rider because the system of internal control does not require provider visits. An adequate system of internal controls would require post payment review of the documentation of transportation claims at provider locations, as well as controls designed to detect non-compliant provider practices.

#### **h. Lack of Oversight in Type and Mode of Transportation**

Because MassHealth does not review the prior authorized forms (e.g., Medical Necessity Form) for FFS providers, it has inadequate assurance that the least expensive mode of transportation has been used. As a result, MassHealth may be paying for more expensive transportation than necessary. The 130 CMR 404.411(E) requires that personal transportation or public transportation if available must be used before private transportation is covered, as follows:

*Members must use personal transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a member must use public transportation, if available in the member's locality and suitable to his or her medical condition. Private transportation is covered by MassHealth only when public transportation suitable to the member's medical condition is unavailable.*

In response to this issue, MassHealth officials stated:

*"MassHealth's prior authorization process is the primary means by which it provides oversight of the non-emergency transportation to ensure that the member uses the most appropriate mode of transportation. MassHealth reviews the documentation provided to ensure that members utilize travel appropriately, including using personal transportation and subway or bus transportation, before resorting to a taxi, for example."*

However, our audit disclosed that MassHealth does not use the prior authorization document to confirm that the least expensive means of transportation is being utilized, because its system of internal control does not require post-payment review of the documentation in support of a claim at the provider's location, where the documentation is required by regulation to be on file.

### **i. Inadequate Claims Documentation**

Our review indicated that Medicaid payments for transportation were made for 42 claims that were not supported by complete and accurate documentation. As outlined by 130 CMR 407.421, Authorization for Transportation, all non-emergency transportation requires prior authorization, except public transportation, and it is the responsibility of the provider to retain documentation of the authorization, as follows:

*(A) Types of Authorization. (1) All forms of transportation except public transportation require prior authorization from the Division. The authorization must consist of one or more of the following: (a) verbal authorization for transportation; (b) a Prescription for Transportation (PT-1) completed by a physician, physician assistant, nurse midwife, dentist, nurse practitioner, or managed-care representative; or (c) a completed Medical Necessity Form.*

FFS transportation providers use Medical Necessity Forms to authorize non-emergency ambulance and wheelchair van trips, whereas RTAs utilize PT-1 forms. Of the 84 FFS claims in our sample that required a Medical Necessity Form (MNF), we found that 35 MNFs were incomplete and five were missing. Some forms did not include an answer to the question regarding the medical necessity for the transportation or, in the case where the forms were signed by a physician's designee, note the physician's name and the authority of the designee. Moreover, we reviewed 11 RTA claims that required a PT-1 and found two with inaccurate information.

The 130 CMR 407.421, Authorization for Transportation, states the information that is required on the PT-1 and Medical Necessity Form, when the forms are to be used, who is required to sign the form, the provider's responsibilities, and other pertinent information, as follows:

*(C) Prescription for Transportation. (2) A completed PT-1 must contain the following information: (a) the member's social security number, name, and address; (b) the specific physical or mental disability that prohibits the use of public transportation; (c) the medical condition for which treatment is sought; (d) the medical care that will be received; (e) how often transportation is needed (specific dates or specified number of trips per week for the duration of treatment); (f) destination of the trip (the name and address of the location of the service covered by MassHealth); (g) the expected duration of the need for transportation (specific time period not to exceed six months for acute illness and one year for chronic illness); (h) the date on which the prescription is written; (i) the signature of the physician, physician assistant, nurse midwife, dentist, nurse practitioner, or managed-care representative; (j) if the member is residing in a nursing facility, the medical services or equipment that are needed and cannot be obtained in the facility; and (k) if the treatment destination is outside the member's locality, the medical services or equipment that are needed and cannot be obtained locally. (D) Medical*

*Necessity Form. (1) Purpose. The Medical Necessity Form is used to authorize medical necessity for nonemergency ambulance and wheelchair van trips. The member's medical record must support the information given on the Medical Necessity Form. (2) Required Signature. Only a physician, physician's designee, physician assistant, nurse midwife, dentist, nurse practitioner, or managed-care representative may sign a Medical Necessity Form. The Medical Necessity Form may be signed either at the trip's origin or destination. If the Medical Necessity Form is signed by a physician's designee, the physician's name and the authority of the designee must be noted on the Medical Necessity Form where designated. (3) Transportation Provider's Responsibility. (a) The transportation provider must obtain a signature on the Medical Necessity Form from one of the individuals specified in 130 CMR 407.421(D)(2). (b) Transportation providers are responsible for completeness of Medical Necessity Forms. The completed Medical Necessity Form must be kept by the transportation provider as a record for four years from the date of service.*

In response to the issue, a MassHealth official stated:

*The regulations do not limit MassHealth's discretion to determine (despite an incomplete MNF) whether there is sufficient information to conclude that the transportation was (1) requested by an authorized prescriber, and (2) medically necessary. The claims you identify included sufficient information (i.e., trip logs, medical service claims) for MassHealth to make those determinations, and pay for the claims.*

However, as previously noted, MassHealth does not visit providers; therefore, the sufficiency of their documentation was not examined by MassHealth before or after the payment of these claims. Furthermore, we find that the regulations do limit discretion and are specific in the recordkeeping and documentation requirements. Specifically, 130 CMR 450, All Provider Manuals, states in part,

*The Division will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for.<sup>2</sup>*

*All records, including but not limited to those containing signatures of medical professionals authorizing services, such as prescriptions, must, at a minimum, be legible and comply with generally accepted standards for recordkeeping within the applicable provider type as they may be found in laws, rules, and regulations of the relevant board of registration, professional treatises, and guidelines and other information published, adopted, or promulgated by state or national professional organizations and societies. All accounting records must be maintained in accordance with generally accepted accounting principles. In those instances where MassHealth regulations identify specific recordkeeping requirements for particular types of providers, such regulations constitute an additional standard against which the adequacy of records will be measured for the purposes of 130 CMR 450.205. In no instance will the completion of the appropriate*

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<sup>2</sup> 130 CMR 450.205(A)

*MassHealth claim, the maintenance of a copy of such claim, or the simple notation of service codes constitute sufficient documentation for the purpose of 130 CMR 450.205.<sup>3</sup>*

*The following provisions are a part of every provider contract whether or not they are included verbatim or specifically incorporated by reference. By executing any such contract, the provider agrees that the submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that the information submitted in, with, or in support of the claim is true, accurate, and complete;<sup>4</sup>*

*Overpayments include, but are not limited to, payments to a provider for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts.<sup>5</sup>*

Proper internal controls would require, at a minimum, post-payment review of claims in order to ensure compliance with regulations, and to emphasize to the provider community the importance of complete documentation in support of claims filed.

#### **j. Providers Experience Difficulty in Returning Overpayments**

We interviewed three providers who confirmed that they had received overpayments. One had refunded \$32,659 in overpayments, whereas the second and third, while acknowledging the amounts owed, had not as yet refunded approximately \$100,000 and \$98,000, respectively. There are potentially more overpayments with other providers whose claims were not subject to our review.

Transportation providers can refund overpayments to MassHealth either electronically or by paper. In either case, however, the provider does not submit a check, but rather a negative amount will appear on future remittance advices until the overpayment is recovered. If the overpayment requires that the full amount of the claim be refunded, the provider performs a “Void and Replace Transaction” in which the original overpaid claim is voided and a replacement claim is submitted. This procedure must be performed for each claim individually. Where a replacement claim requires attachments and is filed electronically, MassHealth will suspend the claim for review and issue a Claims Attachment Form (CAF) to the provider. The provider will return the CAF with the appropriate attachment and the electronic claim and paper attachment will be processed together. To return a partial overpayment, the provider must

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<sup>3</sup> 130 CMR 450.205(D)

<sup>4</sup> 130 CMR 450.223(C)

<sup>5</sup> 130 CMR 450.235(E)

submit an “Adjusted Claim” and prepare a new claim form for each claim line with the correct information. If the original submission required documentation, it must be attached to the Adjusted Claim. MassHealth allows 90 days from the date of service to submit the initial claim to MassHealth, and claims submitted after this will be denied. A resubmitted claim that never met the original 90-day billing deadline requires providers to follow procedures to obtain a waiver of the requirement. If a provider initially submitted a claim within 90-days of the date of service and is denied, they have an opportunity to resubmit the claim without obtaining a waiver in most circumstances.

These providers informed us that they do not have the qualified billing staff to perform this procedure in addition to their normal workload, and that it would be much more efficient to submit a check for the total amount with a worksheet in support of the detail. One provider described that in the past it had voided and replaced claims, but because the replacement claim was beyond the 90-day limitation for claim submittal, it was denied and the process to have the denial reversed was a complex and time-consuming procedure. Moreover, some providers stated that on many occasions MassHealth lost the paper documentation that was submitted in the process, and that the entire claim had to be redone and resubmitted.

The provider who refunded the overpayments reported to us that during the period 1999 to 2002, it received 516 overpayments totaling \$39,604. During this period, and extending to September 2004, the provider had submitted a void and replace request for each claim. However, for unknown reasons, most were not processed, and the majority had to be submitted more than once. Finally, the provider sent a letter on September 24, 2004 to the Director of Medicaid that stated in part:

*“As you will agree, this process of correcting overpayments made by Medicaid is extremely time consuming and costly for both parties. Thus, in an attempt to reconcile this in the most cost effective way for both of us, I would like to submit one check for the amount of \$39,604 which would be reflective of the total overpayments made to [the provider] to date from the years 1999, 2001, 2002. I realize this is not typically allowed and vendors must submit voids individually, however from our point of view, we have previously complied with your policy and it has not been successful.”*

According to the provider, MassHealth reviewed the provider’s detailed list of overpayments but only could confirm that \$32,659.07 was to be repaid, a difference of \$6,404.93. The provider

issued two checks in the amount of \$10,318.31 and \$22,340.76 on December 31, 2004 and March 29, 2005, respectively.

As the average transportation claim in fiscal year 2005 was \$27.85 (\$76,087,427 transportation payments/2,731,218 transportation claims), the provider with \$100,000 in overpayments would have to perform approximately 3,600 (\$100,000 in repayments/\$27.85 average transportation claims) Void and Replace Transactions in order to comply with the MassHealth's refund protocol. The provider with \$98,026.60 in overpaid claims (2,860 claims) stated that it reported the overpayments to MassHealth in September 2004, and that MassHealth responded that it was aware of the situation, was working to resolve the issue, and would contact the provider once the issue was resolved. However, the provider was not contacted until we informed MassHealth of the situation in September 2006.

The pertinent regulations pertaining to overpayments are as follows:

130 CMR 450.235 Overpayments

*Overpayments include, but are not limited to, payments to a provider: (C) in excess of the maximum amount properly payable for the service provided, to the extent of such excess.*

130 CMR 450.238: Sanctions: General

*(B) Instances of Violation. Instances of violation include, but are not limited to: (7) failing to return credit balance funds to the Division within 60 days of their receipt;*

An effective system of internal control and sound business practices would recognize the environment in which MassHealth providers are operating and design internal control systems that facilitate the return of overpayments. In addition, an appropriate internal control environment would require the prompt investigation of overpayments received and reported to MassHealth by a provider. Internal controls are not solely limited to financial matters, but involve controlling and monitoring policies for their efficacy in the achievement of management's objectives. COSO's volume on Internal Control – Integrated Framework, states, in part:

*Control activities are policies and procedures that help ensure management directives are carried out. Control activities usually involve two elements: a policy establishing what should be done and, serving as a basis for the second element, procedures to effect the policy. (COSO, pp. 51)*

A procedure that encourages prompt refunds of overpayments would benefit MassHealth, the providers, and the federal government. There are federal regulations for the recovery of Medicaid overpayments that require states to return the federal share of overpayments within 60 days of the date of discovery. The legislation is codified in 42 CFR, subpart F, “Refunding of Federal Share of Medical Overpayments to Providers”:

*Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers*

*Source: 54 FR 5460, February 3, 1989, unless otherwise noted.*

*Section 433.300 Basis.*

*This subpart implements – (a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under Title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made. (b) Section 1903(d)(2) (C) and (D) of the Act, which provides that a State has 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 60 days, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectible. (c) Section 1903(d)(3) of the Act, which provides that the Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.*

Our prior audit report (No. 2004-1374-3S) on the extent of oversight of the Commonwealth’s Medicaid program disclosed that MassHealth has neither the resources nor the internal controls in place to effectively detect and deter fraud, losses, thefts, or misuse of Medicaid funds. In response to the audit, MassHealth indicated that it “emphasizes aggressive management of its front-end program processes to ensure that services provided are medically necessary, provided by qualified health care providers, provided to eligible residents of the Commonwealth and that payments are appropriately made.” Also, MassHealth stated that “sophisticated information systems support MassHealth’s efforts to detect inappropriate billings before payment is made and to ensure that eligibility determinations are accurate. With the focus of our program on front-end detection of waste, fraud and abuse, MassHealth avoids making inappropriate expenditures and deters providers inclined towards fraud from attempting it. Most notably, our current MMIS processes provider claims and contains a significant number of sophisticated edits, rules and other program integrity checks and balances.” However, as noted in our report,

some edits and checks do not exist in the MMIS, and improvements to the current system and assurances are needed that the new MMIS would have the appropriate edit and checks.

The Massachusetts Executive Office of Health and Human Services (EOHHS) contracted with Thomson Medstat to conduct a gap analysis (a formal study of what a business or organization is doing and where it wants to go in the future) of program integrity efforts in MassHealth. Within the gap analysis one of the key findings where improvements could be made was in the area of pre-payment procedures (edits). The report stated that “current pre-payment edits are limited in number ... and have not been audited recently to determine their effectiveness and estimated \$25 - \$50 million in incidental annual cost avoidance with effective edits.” The report indicated that the new MMIS will improve on the current system’s pre-payment edits, however, MassHealth should audit the current MMIS edits to identify opportunities for short-term recoupment and cost avoidance. This will assist in determining the type of edits that are most important in the new system and provide a baseline measurement against which to assess the performance of the new system.

MMIS enhancement would certainly reduce the number of inappropriate payments; however, an ongoing, continuous, and systematic approach to transportation provider audits and reviews (for all provider types) would mitigate inappropriate provider claims and result in the accurate payment of the claim. Since the internal control system and the policies and procedures in place rely on the providers to maintain the supporting documentation that can validate that the claim is accurate, proper, and in compliance with MassHealth’s laws, rules, and regulations, it is essential that provider audits be conducted.

***Recommendation***

Based on the results of our audit, MassHealth should strengthen its internal controls and oversight over payments to transportation providers to ensure that transportation claims are properly supported with the required documentation, services were delivered, and claims were complete, accurate and in compliance with applicable laws, rules and regulations. We recommend that MassHealth:

- Conduct regular, systematic post-payment reviews of paid claims, at provider locations, in order to ensure compliance with laws, rules and regulations, since the present internal control system and policies and procedures rely on the providers to maintain documentation

in support of transportation claims. This activity will not only be valuable in detecting potential abusive billing practices, but also deter providers from submitting inaccurate transportation claims, and will have a sentinel effect on the provider community.

- Develop a series of edits and procedures within the MMIS billing system that not only will prevent the duplication and payment of claims, the payment of mileage, and other ancillary changes on denied claims, but also the verification of mileage claims as well as provide electronic confirmation of the delivery of the medical service to the member at the treatment location. In addition, MassHealth should appoint an IT professional to conduct periodic audits of these edits in order to evaluate their continued effectiveness and ensure that these edits are incorporated into the new MMIS system currently under development.
- Consider implementing or amending its existing policy to require FFS providers to adopt the policies and procedures currently in effect at RTAs for non-emergency transportation in order to take advantage of the many benefits beyond regulatory compliance. In addition, MassHealth should consider the feasibility of implementing the same rate payment structure for both RTAs and FFS providers in order to generate cost savings within the program. This will enhance the oversight of providers, as MassHealth and HST regularly meet with the RTAs and review their operations, and the RTAs oversee and perform field inspections of their subcontractors. Mileage would be monitored because RTAs enter trips into a routing system that calculates miles per trip through an interface with Geocoding and map software. Duplicate trips may be prevented, as RTAs are required to obtain special authorization for the second and succeeding wheelchair van round trips provided to a member in the same day. Finally, there will be a valid form of prior approval because the RTAs must submit a prescription for transportation (PT-1) form to a MassHealth vendor for authorization prior to rendering any transportation services. This effort should be combined with an effort to amend the existing legislation, 130 CMR 407.432(A) and other applicable regulations.
- Establish a series of policies and procedures that require an immediate investigation of a report of overpayment from a provider; a “user friendly” system at MassHealth for the return of overpayments from providers, including, if necessary, a repayment schedule that is not burdensome to the providers; and the establishment of provider council to exchange ideas on billing system issues with MassHealth.
- We reaffirm our recommendation contained within our audit report on the oversight of the transportation provider and enrollment process (No. 2005-1374-3S1), wherein we acknowledged that MassHealth has begun a process which will result in the recredentialing of all providers. It is a three year activity, and therefore we concur with the Thomas Medstat recommendation that *“MassHealth identify a set of high risk providers for immediate and comprehensive review”*, and further recommend that transportation providers be included in the set of high risk providers.
- Establish a task force within MassHealth, reporting directly to the Director of Medicaid, composed of program managers and financial and IT professionals to take corrective action on the audit results and implement the recommendations in the report. Also, to the extent practical, MassHealth should conduct a review of prior and current claims to determine the

extent of transportation provider overpayments and to establish a system to collect the amounts owed and to refund the federal funding portion to the United States government.

- Obtain immediate reimbursement for the overpayments identified in the Audit Results section of this report.
- Review and make the necessary adjustments and enhancements that are being developed for the new MMIS in light of the edits that are not in the current MMIS and disclosed in this report.

### ***Auditee's Response***

*The Executive Office of Health and Human Services (EOHHS) appreciates the opportunity to comment on the State Auditor's Office (SAO) Report on MassHealth Transportation Providers' Claims. EOHHS accepts the recommendations made by the Auditor for streamlining and strengthening internal controls, including efforts to conduct post-payment reviews of paid claims; to develop edits and procedures within electronic systems to prevent errors; and to examine current practices for collection of overpayments in an effort to identify a way to simplify them.*

*While we agree that we can improve internal controls and that audit findings indicate a need to do so, it is important to note, as the Auditor does, that this audit involved a small percentage of all transportation claims and focused in particular on one segment of transportation services, namely the Fee-for-Service transportation system. In fiscal year 2005, MassHealth processed 2.7M claims for transportation services. This audit tested 125 (.003%) of these claims. Of the claims tested 88 (70%) were from fee-for-service transportation providers. However, fee-for-service transportation providers submitted only 24% of all transportation claims in 2005.<sup>1</sup> Furthermore, Office of Medicaid staff and leadership disagree with Auditor's conclusions regarding many claims that HST has identified as appropriately paid, but that the Auditor found questionable.*

*In general, however, the Office of Medicaid agrees that this audit identifies areas where we could strengthen our processes, and we began to develop plans for doing so prior to conclusion of the audit.*

*The Auditor's report focused on ten findings, (a) – (j). Below is a response to each of those ten findings. For each, the Office of Medicaid provides additional information regarding the finding, and, where appropriate, outlines methods for addressing the finding through internal control and audit procedures.*

*We request that you append this response, in full, to the SAO Final Report. We understand that your doing so does not in any respect indicate that the SAO agrees with the statements it contains.*

*(a) Duplicate round trip claims.*

*The Office of Medicaid acknowledges that several claims reviewed by the Auditor were duplicates. Of note is that the duplicates were not generated by the Office of Medicaid's payment system; rather, they were generated by a particular billing software program used by 6 providers. The duplicate trip error occurred in providers' software prior to the point of entry into the Massachusetts Medicaid Management Information System (MMIS).*

- *The Office of Medicaid has contacted these providers to ensure that they either fix their billing software or discontinue using it.*

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<sup>1</sup> The fee-for-service claims account for 72% (63/88) of the questioned claims and 83% (93/112) reported exceptions. However, of the 2.7 million claims paid for transportation in 2005, 76% were for RTA and ADH transportation and only 24% were for fee for service transportation. The Adult Day Health transportation program had only one reported exception.

- *The Office of Medicaid is implementing systems edits within MMIS and procedures within the transportation provider community to prevent duplicate claiming going forward.*
- *The Office of Medicaid, in coordination with the Office of the Attorney General, will be taking appropriate action to recover any overpayments.*

*(b) Mileage paid for denied transportation.*

*The Office of Medicaid is in the process of recovering the inappropriately paid mileage claims noted under this finding. These mileage claims were paid in error due to the lack of an emergency/non-emergency indicator on the transportation mileage procedure code. The Office of Medicaid is exploring the feasibility of implementing systems edits and coding improvements for MMIS and improved business procedures to reduce the potential for this error to occur in the future.*

*In the interim, we plan to monitor and adjust related activity on a monthly basis.*

*(c) Payments made to a more costly provider type may have resulted in significantly higher costs.*

*Non-emergency transportation services are provided through MassHealth through two systems. Transportation for members covered under a MassHealth MCO [Managed Care Organization] or the PCC [Primary Care Clinician] plan is brokered through a system of Regional Transit Authorities (RTAs). Transportation for members covered under the Fee-for-Service program can be arranged directly with authorized providers or through the brokerage system. In light of the Auditor's comments, EOHHS plans to clarify these regulations.*

*The Center for Medicare and Medicaid Services has reviewed and approved the Massachusetts State Plan for Medicaid services, including but not limited to the transportation program. The State Plan provides that "Payment is made to providers of ambulance, chair car, taxi and common carrier services who are participating in the Medical Assistance Program" and that "Payment is also made as an administrative expense to Regional Transit Authorities, or other entities, under contract with the Department."<sup>2</sup> In order to restrict members to RTAs, EOHHS would have to obtain federal approval to change the existing State Plan.*

*Accordingly, current RTA contracts do not grant exclusive rights to regional RTAs to provide ALL transportation in specified areas, and the Office of Medicaid regulations permit, but do not require, the agency to direct all MassHealth members in a particular region of the state to a certain transportation provider ("selective contracting"). 130 CMR 407.407.*

*In general, the Office of Medicaid does share the Auditor's interest in the potential cost efficiency and enhanced internal controls of RTA-brokered services. However, the analysis cited by the Auditor which identifies the apparent cost-efficiency of the RTA system requires further exploration before cost-efficiency can be confirmed. This is because, as the Auditor notes, in many cases a more intensive level of care is provided via the FFS system. It is possible that the apparent potential efficiencies*

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<sup>2</sup> See, Massachusetts State Plan under Title XIX of the Social Security Act, Attachment 3.1-D.

*may actually be due to a less intensive level of service provided by the RTAs rather than management efficiency.*

*Regardless, the Office of Medicaid will review cost and intensity of service factors to determine the most efficient and cost effective transportation. Pending the outcome of this analysis, management changes may occur in this area. The procurement documents for the RTA brokerage system to be released in December 2006, are designed to address this possibility.*

*(d) Services could not be confirmed for 34% of the claims audited. (25% of detail test exceptions relate to this issue)*

*There are several circumstances under which data systems reviewed by the OSA would not confirm definitively that a medical service was provided for every transportation claim. For example, systems reviewed by OSA would not have captured all medical services delivered to dually-covered by Medicare and Medicaid, or covered by another third party payer. Additionally, although it appears that the claims in question did not include MCO claims, a similar situation would be relevant to such claims, for which encounter data on medical services delivered is stored in the EOHHS Data Warehouse and not in the MMIS.*

*The existence of both a signed medical necessity form authorizing the transportation, and a trip log kept by the provider demonstrating that the transportation was provided is generally sufficient evidence to support a payment to the transportation provider. If, ultimately, the member accepted the ride but did not keep the appointment with the medical provider who authorized the transportation, the issue is not with the transportation provider, but with the member and potentially the medical provider authorizing the transportation.*

*The Office of Medicaid recognizes the need to conduct post payment reviews of claims to identify instances where medical services cannot be confirmed. These reviews are planned to include:*

- Third party liabilities and billing data to examine alternative sources of information on medical services billed to third parties;*
- Transportation provider billing patterns, to identify providers for whom there is a disproportionate number of transportation claims with no corresponding medical claim;*
- Medical provider authorizations for transportation, to identify medical providers who authorize a disproportionate number of transportation claims for which a corresponding medical service cannot be identified;*
- Members requesting transportation services, to identify specific members whose transportation utilization frequently does not have a corresponding medical claim.*

*Each of these post audit activities will identify potential system abuse or fraud and would result in appropriate action by the Office of Medicaid.*

(e) Overstated mileage paid.

*It is unclear to what extent providers may have overstated mileage. Without the data that underlies this conclusion, the Office of Medicaid cannot assess the significance of any apparent overstatements of mileage. MapQuest® may be useful for a raw comparison, but does not provide sufficient information from which to draw a conclusion – particularly when the differential between MapQuest® and the mileage reported is low. There is no requirement that the transportation provider take the shortest route or the same route each time. In the event that the driver had to pick up other riders, the route would unlikely be the shortest available; such trips would be recorded as shared rides. MapQuest® is not foolproof, and cannot respond to short-term detours necessitated by road conditions, traffic or other considerations.*

*The Office of Medicaid has reviewed its present edits for mileage limitations and will adjust the current limit down per the OSA recommendation. Mileage claims beyond the limit will be suspended pending review and approval. Also, the new MMIS, that is currently being built, does include geo-coding of member and provider addresses. This will enhance current mileage review capability.*

(f) Claims were paid without required special authorization.

*It appears from the OSA report that this finding is based primarily on review of a small number of transportation providers who were found to make frequent trips outside of members' geographic area. The Office of Medicaid is reviewing the records of these 3 providers.*

*Once an appropriate medical professional signs either of the Office of Medicaid's transportation authorization forms (the PT-1 or the Medical Necessity Form), the transportation provider (either FFS or RTA based) is authorized to transport the member to the medical service.*

- 1) All transportation delivered via the brokerage system requires completion of a PT-1 form by the medical provider. Any out-of-locality services recorded via the PT-1 form are reviewed by the MassHealth Customer Service Team prior to forwarding it to the RTA.*
- 2) Transportation delivered via the FFS system requires completion of a Medical Necessity Form (MNF) signed by the medical provider. As long as the trip is within locality and has a corresponding, appropriately completed MNF, prior authorization is not required. Based on the recommendations of the Auditor, the Office of Medicaid will begin systematic post payment review of documentation for out-of-locality FFS transportation claims to ensure that transportation services are appropriate.*

*As stated elsewhere in this response, the Office of Medicaid is reviewing the business and policy issues associated with incorporating segments of the FFS system within the RTA brokerage system. Should the Office of Medicaid determine this to be the right management strategy, the PT-1 review process would be extended to cover additional transportation services.*

(g) Shared rides billed as sole passenger trips.

*This finding is attributable to the same provider mentioned in (f) above whose records are being reviewed. The Office of Medicaid will conduct post payment reviews regarding this issue. As stated above, the Office of Medicaid will further review management policies and regulations regarding fee-for-service transportation and the role of Brokered services and make changes to the current management model if analysis, program integrity and business needs demonstrate the benefit of doing so.*

(h) Lack of oversight in type and mode of transportation.

*The Office of Medicaid will conduct post payment reviews of the Medical Necessity Form and the Provider's Trip Logs and will further review its' management policies and regulations regarding fee-for-service transportation and the role of its' Brokered services. Less than 7% of all MassHealth members used Medicaid-funded transportation services in 2006. This is due in part to success in encouraging providers and RTAs to require use of public or personal transportation resources wherever possible.*

*Nevertheless, the Office of Medicaid will review the present content of the Medical Necessity Form and update those sections where appropriate and necessary.*

(i) Transportation claims were inadequately documented.

*As noted in "h," the transportation provider must produce a signed medical necessity form and a trip log in order to support the claim. The Office of Medicaid will review the present Medical Necessity Form and update where necessary. The Office of Medicaid will conduct additional post payment reviews to identify adequate claims documentation.*

(j) Providers experience difficulty in returning overpayments.

*The Office of Medicaid has always had policies and procedures regarding return of provider overpayments. Prior to November 1997, MassHealth transportation providers, among others, were indeed permitted to return overpayments via check. That process created a number of problems for us; most significantly to the integrity of claims history, since it was difficult to match a payment to particular claims for audit and other purposes. In addition, it was a labor intensive process for us and complicated adjustments to Federal Tax Forms 1099. In November 1997, we discontinued the practice of permitting return of overpayment by check and instructed providers to void the claim.<sup>3</sup>*

*Subsequently, the Health Insurance Portability and Accounting Act of 1996 (HIPAA) became effective, requiring Medicaid and all health providers to comply with electronic data exchanges (EDI) standards. That standard includes specific implementation guidelines that providers who submit claims electronically must use to correct and report any overpayments; that is, a void or void and replace transaction to off-set future payments to the provider. Currently, 87% of our providers submit claims electronically, and are subject to the HIPAA standard transaction requirements.*

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<sup>3</sup> See, Provider Bulletin 107, November 1997.

*New MMIS will simplify the return of overpayments for all providers – those that submit claims on paper and those that submit electronically -- by permitting the provider to correct a claim online through a web portal. In the meantime, we are considering options to streamline the process for transportation providers to assist their return of overpayments.*

*Thank you for the opportunity to comment.*

***Auditor's Reply***

We are pleased that MassHealth has taken our audit results into consideration and has either taken corrective action, will take corrective action, or will further evaluate the feasibility of implementing the recommendations contained in our report. With regard to MassHealth's disagreement with our conclusions regarding many of the questionable claims in the audit sample, our audit objectives and methodology consisted of a determination of whether transportation claims were properly supported with the required documentation; transportation services were delivered; claims were complete, accurate and in compliance with applicable laws, rules, and regulations; and the extent and effectiveness of the internal controls and oversight of providers by MassHealth. As noted in our audit report, we identified claims that were not in compliance with applicable laws, rules and regulations; claims that were not supported by adequate documentation; and claims that appeared to be unreasonable. Notwithstanding Mass Health's objection that the audit involved a small percentage of claims and focused primarily on FFS providers, the audit identified a significant questionable claims rate of 58% that, when combined with the internal control weaknesses, supports our conclusion that the risks of questionable claims being paid is clearly significant. Therefore, MassHealth should continue to take the necessary corrective actions to improve its internal controls and claims processing for transportation providers.

## APPENDIX A

### Summary of OSA Sample of Transportation Provider Claims Fiscal Year 2005

#### *Claims Audited by Type of Service Provided*

Type of Service	Claims Reviewed	Amount of Claims Reviewed	Questioned Claims Paid	Percentage of Questioned Paid Claims	Amount of Questioned Paid Claims	Percentage Amount Questioned Paid Claims
Adult Day Health Care	26	\$1,009.30	1	4%	\$ 30.00	3%
Ambulance Non-Emergency	17	2,418.06	11	65%	1,430.71	59%
Ambulance Emergency	4	680.76	1	25%	225.69	33%
Wheelchair Van	73	2,844.38	55	75%	2,103.75	74%
Other – Ambulatory Transportation	5	101.24	4	80%	79.69	79%
Total	<u>125</u>	<u>\$7,053.74</u>	<u>72</u>	<u>58%</u>	<u>\$3,869.84</u>	<u>55%</u>

#### *Claims Audited by Type of Transportation Provider*

Type of Provider	Claims Reviewed	Amount of Claims Reviewed	Questioned Claims Paid	Percentage of Questioned Paid Claims	Amount of Questioned Paid Claims	Percentage Amount Questioned Paid Claims
Adult Day Health Care	26	\$1,009.30	1	4%	\$ 30.00	3%
Regional Transit Authority	11	279.26	8	73%	200.28	72%
Fee for Service	88	5,765.18	63	72%	3,639.56	63%
Total	<u>125</u>	<u>\$7,053.74</u>	<u>72</u>	<u>58%</u>	<u>\$3,869.84</u>	<u>55%</u>

#### *Total Claims Paid by Type of Transportation Provider in Fiscal Year 2005*

Type of Service	Claims Paid	Percentage	Amount of Claims Paid	Percentage
Adult Day Health Care	443,980	16%	\$14,091,782	18%
Regional Transit Authority	1,624,627	60%	25,074,527	33%
Fee for Service	662,611	24%	36,921,118	49%
Total	<u>2,731,218</u>	<u>100%</u>	<u>\$76,087,427</u>	<u>100%</u>

## APPENDIX B

Summary of Audit Sample - Exceptions by Provider  
Fiscal Year 2005

				Questionable Claims								
Provider	Provider Type	Quantity of Claims Reviewed	Amount of Claims Reviewed	Duplicate Round Trip Billings Paid	Inadequate Claims Documentation	Mileage Was Paid for Denied Transportation	Overstated Mileage Paid	Services Cannot Be Confirmed	Claims Paid Without Required Special Authorization	Shared Rides Billed as Sole Passenger	Total Questionable Items	Amount of Questionable Claims
A	FFS	5	\$ 346.38	-	1	2	-	1	-	-	4	\$ 64.28
B	FFS	5	897.75	-	2	-	-	1	-	-	3	474.60
C	FFS	5	631.83	-	-	2	-	2	-	-	4	349.73
D	FFS	5	379.30	-	5	-	1	-	1	-	7	379.30
E	FFS	5	206.80	-	2	-	-	-	-	-	2	86.80
F	FFS	5	210.96	-	5	-	-	5	-	-	10	210.96
G	FFS	6	139.00	-	5	-	-	3	-	-	8	119.00
H	FFS	5	467.10	-	3	-	-	2	1	-	6	387.10
I	FFS	5	303.20	-	-	-	-	-	-	-	-	-
J	FFS	5	194.40	3	3	-	3	2	-	-	11	194.40
K	FFS	5	163.69	-	2	-	-	3	-	-	5	160.00
L	FFS	5	175.60	-	-	1	3	2	-	-	6	95.60
M	FFS	5	959.17	-	-	-	-	3	-	-	3	507.79
N	FFS	6	240.00	-	6	-	-	1	5	5	17	240.00
O	FFS	6	240.00	-	-	-	1	5	-	-	6	200.00
P	FFS	5	120.00	-	1	-	-	3	-	-	4	80.00
Q	FFS	5	90.00	-	5	-	-	2	-	-	7	90.00
R	ADH	5	134.00	-	-	-	-	-	-	-	-	-
S	ADH	5	114.30	-	-	-	-	-	-	-	-	-
T	ADH	5	135.30	-	-	-	-	-	-	-	-	-
U	ADH	6	480.00	-	-	-	-	1	-	-	1	30.00
V	ADH	5	145.70	-	-	-	-	-	-	-	-	-
W	RTA	6	155.54	-	2	-	-	2	-	-	4	98.11
X	RTA	5	123.72	-	-	-	-	4	-	-	4	102.17
Totals		125	\$7,053.74	3	42	5	8	42	7	5	112	\$3,869.84
				2.4%	33.6%	4.0%	6.4%	33.6%	5.6%	4.0%		54.9%

