NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM

DEPARTMENT OF HEALTH AND HOSPITALS

PERFORMANCE AUDIT
ISSUED DECEMBER 2, 2015

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

December 2, 2015

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Charles E. "Chuck" Kleckley,
Speaker of the House of Representatives

Dear Senator Alario and Representative Kleckley:

This report provides the results of our performance audit of the Non-Emergency Medical Transportation (NEMT) program within the Department of Health and Hospitals (DHH). The purpose of the audit was to evaluate whether DHH provides sufficient oversight of the NEMT program.

The report contains our findings, conclusions, and recommendations. Appendix A contains DHH's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of DHH for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/ch

NEMT 2015

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Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Non-Emergency Medical Transportation Program
Department of Health and Hospitals

December 2015

Audit Control # 40140060

Introduction

NEMT
Non-emergency transportation provided for Medicaid recipients to and from a Medicaid medical provider. The program provides transportation when all other reasonable means of free transportation have been explored and are unavailable.

This report provides the results of our performance audit of the Department of Health and Hospitals' (DHH) oversight of the Medicaid Non-Emergency Medical Transportation (NEMT) program. Medicaid participants in NEMT are enrolled in traditional fee-for-service Legacy Medicaid or in DHH's managed care model, Bayou Health. Because we have cited audit findings on potentially improper payments in the NEMT program for seven consecutive years, we conducted this audit to evaluate whether DHH provides sufficient oversight of the program.

From calendar years 2011 through 2014, the program had more than 1.2 million claims[1] involving almost 136,000 recipients, at a cost of more than $83.3 million. Exhibit 1 shows a breakdown by calendar year of the number of unique recipients, total claims, and total costs of the NEMT program.

Exhibit 1
Cost of Rides and Number of Recipients
Calendar Year 2011 through 2014

Year	Unique Recipients	Total Claims	Total Cost
2011	68,961*	397,315	$22,650,282
2012	51,659*	283,968	18,708,668
2013	43,740*	253,373	19,998,524
2014	42,086*	299,552	22,010,743
2011-2014	**135,907****	**1,234,208**	**$83,368,217**

* This represents the number of unique recipients for the year.
** This represents the total number of unique recipients from 2011-2014. Because a recipient may appear in multiple years, the number of unique recipients for the individual years does not equal the total.
Source: Prepared by legislative auditor's staff using Calendar Year 2011-2014 Medicaid data.

[1] The number of claims is less than the number of rides because transportation providers billed capitated (monthly) rides as one claim per recipient. Therefore, what looks like one trip in the data could actually represent anywhere from 1-21 trips. DHH resolved this issue by working with Southeastrans to ensure that providers bill for each ride.

NEMT includes the following two types of transportation:

- **Transportation by non-ambulance transportation providers, which includes non-profit, for-profit, or friends and family providers.** Legacy Medicaid recipients use a broker to schedule NEMT services.[2] Recipients call the transportation broker, give information about their medical appointment, and the broker schedules a ride with the nearest, lowest-cost provider[3] and assigns a prior authorization number[4] for the trip. Rates depend on the type of transportation and the number of miles traveled and range from 36 cents to $1.60 per mile. In calendar year 2014, 231,267 claims totaling $11,116,834 were paid to non-ambulance transportation providers. See Appendix C for the costs, claims, and recipients for these provider types for calendar years 2011 through 2014.

- **Transportation by ambulance providers.** An ambulance can be used when a medical professional deems that it is medically necessary or a non-ambulatory[5] individual cannot be transported in a wheelchair van. These rides are scheduled directly through the ambulance company instead of a broker. The base rate for the use of ambulances is $165.96, while mileage rates are $6.34 per mile. In calendar year 2014, 68,285 claims totaling $10,893,909 were paid to ambulance transportation providers. See Appendix C for the costs, claims, and recipients for this provider type for calendar years 2011 through 2014.

Overall, we found that DHH did not always provide sufficient oversight of the NEMT program. Specifically, DHH has not routinely analyzed all claims data to monitor the program for potentially improper payments. We identified $1,682,286 in NEMT claims paid with no associated approved medical claim on the date of an NEMT claim and $103,258 in payments for transportation that potentially violated NEMT program rules. In addition, DHH no longer conducts on-site monitoring of non-ambulance providers, and it has never monitored ambulance providers to ensure that support exists for their rides. Appendix A includes DHH's response to our recommendations, and Appendix B contains our scope and methodology.

According to DHH, the issues cited in this report will be addressed by the move of NEMT into its managed care model (Bayou Health) on December 1, 2015. The Bayou Health plans, which are administered by five Managed Care Organizations (MCOs), are now responsible for providing transportation for all Medicaid recipients, not just those currently enrolled in Bayou Health. Because of this change, DHH's role in the program changed from administering the program to overseeing the MCO's administration of the program. However, DHH still has the responsibility to properly monitor the MCOs and ensure they implement the recommendations in this report. For example, if MCOs do not conduct data analysis to identify high-risk providers and recipients, such as those identified in this report, the amount of the per member per month (PMPM) fee that is based in part on utilization could be incorrectly inflated.

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[2] Southeastrans became the transportation broker in October 2014. Prior to that, First Transit was the transportation broker for Legacy Medicaid.
[3] However, the recipient is free to choose a different provider, which can result in transportation not always being provided by the lowest-cost provider.
[4] A prior authorization number must be assigned to an NEMT claim for it to be paid by DHH.
[5] Non-ambulatory refers to a person who is not able to walk.

Objective: To evaluate whether DHH provides sufficient oversight of the NEMT program

Overall, we found that DHH did not always provide sufficient oversight of the NEMT program because of the following:

- DHH does not routinely analyze all NEMT claims data to monitor the program for potentially improper payments. We identified 55,474 claims for $1,682,286 that did not have a corresponding medical claim on the same day and $103,258 in payments for transportation that potentially violated NEMT program rules.

- DHH has not conducted on-site monitoring of non-ambulance providers since January 2014. Even when DHH did conduct monitoring, it did not recoup payments from noncompliant providers.

- Although ambulance transportation accounted for $45.8 million, or 55% of payments in NEMT from calendar years 2011 to 2014, DHH has never monitored ambulance providers to determine if support exists for the rides they provided to Medicaid recipients.

These findings are explained in more detail below.

DHH does not routinely analyze all NEMT claims data to monitor the program for potentially improper payments.

DHH does not routinely use data analytics to monitor all NEMT providers for potentially improper payments. NEMT providers electronically submit claims to DHH's contractor (Molina Healthcare, Inc.) for payment. Since the NEMT program provides non-emergency medical transportation for Medicaid recipients to and from a Medicaid medical provider, there should be a corresponding medical claim on the day of the transportation. However, we identified 55,474 claims for $1,682,286 that did not have a medical claim on the date of transportation service in calendar years 2011 through 2014. Not having a medical claim on the same day may indicate that transportation providers are billing for trips that did not occur, that recipients did not actually attend their appointment, or that medical providers did not correctly bill for their services.

Although DHH contracts with Molina to conduct data analysis through its Surveillance and Utilization Review system (SURs), it does not review all NEMT claims on a continuous or routine basis. According to Molina officials, the last time they conducted this kind of analysis was in August 2013 and before that in May 2011. However, this analysis only included for-profit, non-ambulance providers providing rides locally. According to Molina, this analysis resulted in $94,790 in rides being identified as rides without a medical claim. They opened cases on the top two providers in the report, who combined for $10,515 of the costs identified, and recovered $5,422 (52%) of the cost of the rides identified.

To determine whether the non-ambulance trips we identified were supported with documentation, we reviewed 435 claims totaling $9,261 at four non-ambulance[6] transportation providers. Of the 435 claims we reviewed, 194 (45%) did not have a completed MT-3 form, which serves as evidence of the ride occurring. In addition, although we found that 241 (55%) of the rides without a medical claim did have a form, 40 (17%) of the 241 were not completed correctly. Specifically, we found that 13 forms did not include at least one needed signature, and 27 were for rides that were denoted as cancelled or dry-runs.[7] Exhibit 3 shows the results from each transportation provider in our file review.

Exhibit 3
MT-3 Files Not Found*
Calendar Years 2011-2013

Transportation Provider	Files Not Found	Files Found with Errors	Files Reviewed	% of Files Not Found or Found with Errors	Cost Associated with Files with Errors
Provider 1	25	0	70	36%	$481
Provider 2	22	23	86	52%	1,042
Provider 3	88	12	195	51%	2,387
Provider 4	59	5	84	76%	912
Total	**194**	**40**	**435**	**54%**	**$4,822**

* LLA Financial Audit Services (FAS) has had seven consecutive years of findings related to the NEMT program, mostly concerning the lack of required proper documentation to substantiate a trip. Reports related to these findings can be found on the legislative auditor's website at www.lla.la.gov.
Source: Prepared by legislative auditor staff using Medicaid data and MT-3 forms held by transportation providers.

We also identified $103,258 in payments that potentially violated NEMT program rules. According to the NEMT provider manual, transportation to and from a pharmacy is not reimbursable through the NEMT program. However, we found that $90,734 was spent on 3,291 transportation claims where the only medical claim on the date of the transportation was a pharmacy claim.

In addition, nursing homes are responsible for the cost of non-ambulance transportation within 65 miles for their residents, while Legacy Medicaid is responsible for the cost of any ride over 65 miles. However, we identified 386 rides for $12,524 where the ride was less than 65 miles but the non-ambulance transportation was billed to Legacy Medicaid instead of being paid by the nursing home. There were 21 non-ambulance transportation providers that gave these rides for nursing home residents, and one provided 167 (43%) of these rides for a total of $3,116 (25%).

The use of data analytics would also help DHH and the MCOs identify high-risk provider and recipient behavior within the NEMT program. Using the results of our data

[6] This included for-profit and non-profit transportation providers.
[7] Dry-runs are scheduled trips in which no transportation of the recipient occurs and according to program rules are not billable.

analytics, we identified outliers or patterns, which we sent to DHH, to help the department identify providers or recipients most at risk of improper payments. For example:

- *Identifying providers where a significant number of rides did not have an associated medical claim.* For example, we found that 86% of the rides by one transportation provider and 40% of the rides by another provider did not have corresponding medical claims.

- *Identifying recipients where a significant number of rides did not have an associated medical claim.* For example, one recipient received $9,000 in rides from one for-profit transportation provider without associated medical claims. In another example, 95% (105 of 111) of one recipient's rides did not have a medical claim and all of the rides occurred with the same transportation provider.

Recommendation 1: DHH and the MCOs should use data analytics to monitor providers to identify potentially improper payments and identify high-risk providers or recipients.

Recommendation 2: If it is cost-effective, DHH should recoup payments that it finds were paid in violation of program rules.

Summary of Management's Response: DHH agrees with these recommendations. See Appendix A for DHH's full response.

DHH has not conducted any on-site monitoring of non-ambulance NEMT providers since January 2014. Even when DHH did conduct monitoring, it did not recoup payments from noncompliant providers.

DHH began conducting quarterly on-site monitoring, which included ride-alongs with providers and recipients and examining MT-3 forms, as corrective action to a 2012 Louisiana Legislative Auditor finding that found that services billed to the program were not provided in accordance with established policies. DHH's 2013 review found that 1,182 (34%) of 3,514 reviewed MT-3s were noncompliant, meaning the forms were not properly filled out or missing. In addition, DHH's 2014 review found that 62 (11%) of 578 were noncompliant.

Although DHH can sanction, suspend, or exclude NEMT providers for noncompliance, it did not do so; nor did it recoup payments as a result of noncompliance.[8] In addition, DHH has not conducted any subsequent on-site monitoring of the NEMT providers since January 2014, in part because DHH said it needed to re-evaluate the cost effectiveness of ride-alongs. According to DHH officials, the intent was for NEMT program staff to continue conducting audits of MT-3s without the ride-alongs, but complete turnover of the NEMT staff made this impossible. Therefore, using data analytics to identify high-risk providers as recommended in the previous

[8] According to DHH, it did provide education and training to providers to address noncompliance issues.

section of this report would also help DHH target its limited staff to reviewing providers that pose the highest risk of noncompliance.

Standardized storage of MT-3 forms or electronic reporting would improve the ability of DHH and the MCOs to monitor providers. DHH does not receive the MT-3 form unless it conducts a file review. NEMT providers are required to keep MT-3 forms for five years. The files are in paper form and housed at the business location, which can be either a residence or physical business location. In our survey of non-ambulance NEMT providers, we found that storage practices vary widely. For example, some providers store their files on a weekly, monthly, quarterly, and yearly basis, while other providers store their files by participant. In addition, cancelled trips, travel logs, and dry-run MT-3 forms were mixed in with the MT-3 forms where rides actually occurred. Since there is one MT-3 form for each ride, there can be thousands of pieces of paper for certain providers for just one month. The wide range of storage practices among NEMT providers makes it difficult to assess performance and provider compliance. Exhibit 4 illustrates three years of files from one transportation provider.

Exhibit 4
Three Years of MT-3 Files from One Provider

DHH and the MCOs could more efficiently monitor providers using an electronic MT-3 form, which would allow DHH to capture real-time information about each trip. In their survey responses, providers stated that this would eliminate the many boxes of paper they currently have to store, which can become a large expense. Southeastrans, the current Legacy Medicaid transportation broker, stated that it has a system in place that allows for the capture of an e-signature on tablets and mobile devices. This system is currently used in other states, but it is not used in Louisiana. DHH said it is currently researching this technology.

Recommendation 3: DHH should determine if it can recoup payments from providers it identified as noncompliant during its monitoring reviews.

Recommendation 4: DHH should ensure that MCOs conduct sufficient monitoring of providers, which could include using data analytics to create targeted samples.

Recommendation 5: DHH should require MCOs to utilize a uniform storage system for MT-3 forms or move to an electronic MT-3 form.

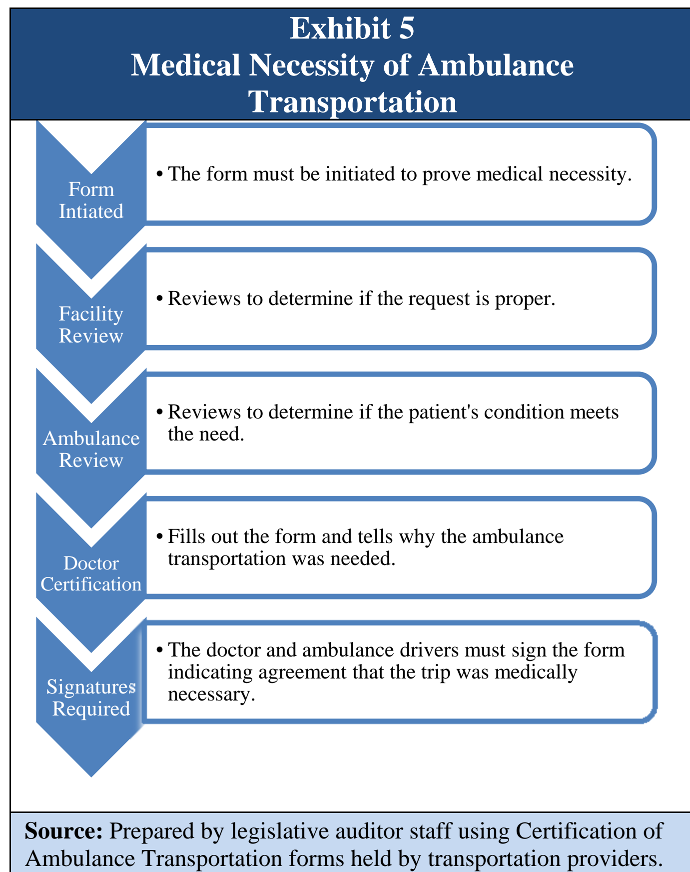
Summary of Management's Response: DHH agrees with these recommendations. See Appendix A for DHH's full response.

Although ambulance transportation accounted for $45.8 million, or 55% of payments in NEMT from calendar years 2011 to 2014, DHH has never monitored ambulance providers to determine if support exists for the rides they provided to Medicaid recipients

As explained earlier, ambulance transportation may be used in the NEMT program if a medical professional deems it medically necessary,[9] meaning that other types of transportation would endanger the health of the patient. From calendar years 2011 to 2014, ambulance transportation accounted for $45.8 million (55%) of the $83.4 million spent in the NEMT program. However, NEMT program staff stated they have never monitored ambulance providers to determine if they have the required form documenting medical necessity.

Unlike non-ambulance NEMT, a prior authorization number is not obtained for ambulance transportation within the NEMT program. Therefore, these trips do not go through a transportation broker. Instead, a medical professional[10] must complete a Certification of Ambulance Transportation Form for each ride to authorize ambulance transportation. This form is the ambulance transportation equivalent of the MT-3 form for non-ambulance providers and is filled out by medical providers to justify the need for ambulance transportation in the NEMT program. Exhibit 5 shows the steps needed to complete the form. On the form there is an option for the doctor to describe why it is medically necessary for the recipient to use an ambulance. However, this information is sometimes illegible or not filled out, and there is no list of conditions on the form that can be checked to justify that ambulance transportation is medically necessary.

Exhibit 5
Medical Necessity of Ambulance Transportation



Source: Prepared by legislative auditor staff using Certification of Ambulance Transportation forms held by transportation providers.

We reviewed the 237 claims of two ambulance companies that provided NEMT services. We conducted a file review of 51 claims at one large provider that stores files electronically and

[9] This usually occurs for Medicaid residents residing in nursing facilities or those recipients receiving dialysis, chemotherapy, and physical therapy services.
[10] The medical professional can be a Medical Doctor, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, or Registered Nurse.

found that a total of 14% (7) of the forms were missing or had errors on them. We also conducted a file review of 186 forms at another smaller provider that uses paper forms and found that a total of 53% (99) of the forms were missing or had errors on them. In addition, although we found that 76.8% (182) of the 237 files we reviewed did have a corresponding form, the form was not always properly filled out. Specifically, 51 (28%) of the 182 forms were not properly filled out, meaning that there was no signature showing that transportation was medically necessary, or other information, such as names, was missing. Exhibit 6 shows file review statistics for these two ambulance transportation providers and the costs associated with the files not found or found with errors.

Exhibit 6
Certification of Ambulance Transportation Form Statistics
Calendar Years 2011-2013

Transportation Provider	Files Not Found	Files Found with Errors	Files Reviewed	% of Files Not Found or Found with Errors	Cost Associated with Files with Errors
Large Ambulance Provider	7	0	51	14%	$1,542
Small Ambulance Provider	48	51	186	53%	20,019
Total	**55**	**51**	**237**	**45%**	**$21,561**

Source: Prepared by legislative auditor staff using information from Certification of Ambulance Transportation forms held by transportation providers.

Monitoring the use of ambulance transportation by nursing homes is especially important because of the way the program is designed. There is a financial incentive for homes to over-utilize ambulance transportation, which has a higher risk when the home's medical staff can authorize this transportation. Approximately $4.7 million (6%) of the $83.4 million spent within the NEMT program from January 1, 2011, through December 31, 2014, was spent on 19,283 ambulance rides for nursing home residents. The NEMT provider manual states that nursing homes are responsible for transportation of their Medicaid residents unless a medical provider determines that an ambulance is medically necessary. Therefore, nursing homes can save money by using ambulance transportation that can be authorized by medical staff at the nursing home instead of providing non-ambulance NEMT services to its residents. We identified two nursing homes in the Medicaid data that used ambulance transportation to transport their residents more than twice as often as any other nursing home in the state. Each of these nursing homes had more than 1,000 rides costing more than $200,000 during calendar years 2011 through 2014.

Requiring a more detailed form would help DHH and the MCOs better monitor ambulance providers. As mentioned above, DHH uses a standardized form that certifies ambulance transport is medically necessary. However, this form does not contain enough information to determine specifically why ambulance transportation is needed. As shown in Appendix D, Medicare uses a Physician Certification Statement that is used for ambulance transportation received by Medicare recipients. As shown on the form, the certifying physician checks the reason(s) why the recipient needs the ambulance transportation, including whether the recipient is bed-ridden, needs an attendant, or has other conditions such as having non-healed

fractures or needing cardiac monitoring during transport. By having more comprehensive information such as this, DHH and the MCOs could better monitor ambulance providers.

Recommendation 6: Similar to non-ambulance NEMT, DHH should ensure that MCOs require prior authorization numbers for NEMT ambulance rides.

Recommendation 7: DHH should ensure that the MCOs develop a process to monitor NEMT ambulance providers to determine whether they have the required Certification of Ambulance Transportation Forms.

Recommendation 8: DHH should consider amending or changing the Certification of Ambulance Transportation form to include more information on why the patient needed ambulance transport, similar to the Medicare form. For example, the form could include whether the patient is bed-ridden or has a condition, such as the need for cardiac monitoring, which requires an ambulance.

Summary of Management's Response: DHH agrees with these recommendations. See Appendix A for DHH's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

November 25, 2015

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

RE: Non-Emergency Medical Transportation 2015 Performance Audit

Dear Mr. Purpera:

The Department of Health and Hospitals (DHH) concurs with the findings in the above referenced performance audit. Many of the issues identified by the auditors are known to and recognized by DHH and were the basis for the decision to transition remaining non-emergency medical transportation (NEMT) operations to the Bayou Health Managed Care Organizations (MCOs) effective 12/1/15. The Medicaid agency will no longer operate a fee-for-service delivery model for NEMT after 11/30/15. Below are the responses to your specific recommendations:

> *Recommendation 1: DHH and the MCOs should use data analytics to monitor providers to identify potentially improper payments and identify high-risk providers or recipients.*
>
> Effective December 1, 2015, Louisiana Medicaid will no longer enroll or manage NEMT providers, contract directly with an NEMT vendor or otherwise operate a fee-for-service delivery system for NEMT services. NEMT services are provided by the Bayou Health MCOs, who are contractually obligated to use surveillance and utilization control programs to safeguard Medicaid funds against unnecessary or inappropriate use of services.
>
> Medicaid administrative staff currently responsible for day-to-day management of the fee-for-service NEMT program will oversee and monitor Bayou Health contract compliance for NEMT services. This will include analysis of NEMT encounter data, review of periodic reports submitted by MCOs, and analysis of monthly member grievances relative to NEMT services. Medicaid staff will use this research to identify potentially improper payments and identify high-risk providers or recipients.

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Recommendation 2: If it is cost-effective, DHH should recoup payments that it finds were paid in violation of program rules.

The LLA identified $103,258 in payments that potentially violated program rules. By July 1, 2016, DHH will determine whether these payments were indeed made in violation of program rules and if so, initiate recovery action.

Recommendation 3: DHH should determine if it can recoup payments from providers it identified as non-compliant during its monitoring reviews.

By July 1, 2016, DHH will determine whether these funds are subject to recovery and if so, initiate recovery action.

Recommendation 4: DHH should ensure that MCOs conduct sufficient monitoring of providers, which could include using data analytics to create targeted samples.

The MCOs are required to use surveillance and utilization control programs to monitor providers. DHH encourages Bayou Health Plans to include data analytics and targeted sampling in order to conduct this monitoring. Medicaid's NEMT staff will also utilize these techniques in overseeing contract compliance, including an annual review of each MCO's NEMT program.

Recommendation 5: DHH should require MCOs to utilize a uniform storage system for MT-3 forms or move to an electronic MT-3 form.

After December 1, 2015, the MT-3 form will be obsolete. One of the Bayou Health MCOs is currently transitioning to electronic trip verification. While other MCOs use standard trip verification logs that are included with each provider's claim submission, their common transportation vendor Logisticare is exploring the feasibility of implementing electronic trip verification.

Recommendation 6: Similar to non-ambulance NEMT, DHH should ensure that MCOs require prior authorization numbers for NEMT ambulance rides.

As of December 1, 2015, all non-emergency ambulance services will be provided through the Bayou Health MCOs, and four of the five 5 MCOs will require prior authorization for non-emergency ambulances. The fifth MCO will not require prior authorization but will monitor utilization to determine the impact when prior authorization is not required. Medicaid NEMT staff will analyze encounters to determine the variability in utilization with and without prior authorization. The Agency believes this is a valuable opportunity to find out the extent to which prior authorization impacts utilization and overall cost to the program. Medicaid will use the results to inform future policy decisions and possible changes to Bayou Health contractual requirements.

Recommendation 7: DHH should ensure that the MCOs develop a process to monitor NEMT ambulance providers to determine whether they have the required Certification of Ambulance Transportation Forms.

Four of the five MCOs will require prior authorization for non-emergency ambulance services, negating the need for the Certification of Ambulance Transportation Form. The remaining MCO will make the determination on the type of authorization and documentation required after an initial period of utilization review. NEMT staff will also review utilization and make a determination on whether amended contract language should be considered.

Recommendation 8: DHH should consider amending or changing the Certification of Ambulance Transportation form to include more information on why the patient needed ambulance transport, similar to the Medicare form. For example, the form could include whether the patient is bed-ridden or has a condition, such as the need for cardiac monitoring, which requires an ambulance.

The Agency will communicate to MCOs by 12/31/15 our expectation that additional information be collected and documented to demonstrate the medical necessity of ambulance transportation, and we will share the Medicare form with them for incorporation into their prior authorization process and/or Form.

On an annual basis beginning in the fourth calendar quarter of 2016, NEMT program staff will make an onsite visit to each Bayou Health Plan to review the areas identified in this performance review, compile a written summary of their findings, and require corrective measures if the need is indicated.

The lead individual responsible for overseeing the Medicaid Transportation program is Mr. Jode Burkett, who can be reached at (225) 342-2094 or jode.burkett@la.gov. John Korduner, Medicaid Program Manager and Chief of Medicaid Program Integrity, will have responsibility for recoupment activity, if applicable.

If additional information is needed, you may contact Mr. Burkett or myself.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK

APPENDIX B: SCOPE AND METHODOLOGY

We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. Our audit covered the time period of January 1, 2011, through December 31, 2014, although some analyses were more limited in scope due to certain program rules. The report objective was:

To evaluate whether DHH provides sufficient oversight of the NEMT program.

We conducted this performance audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. To answer our objective, we reviewed relevant internal controls and performed the following audit steps:

- Researched and reviewed relevant Federal and state NEMT legal statutes and regulations.
- Researched NEMT audits, program models, and practices in other states. Contacted select states to obtain additional information.
- Interviewed relevant staff from DHH. Also interviewed stakeholders for the NEMT program, such as transportation providers and the transportation broker for the Legacy Medicaid population.
- Conducted a survey of all 139 NEMT provides and received 58 responses.
- Obtained and analyzed Medicaid data on claims, recipients, providers, and eligibility between January 1, 2011, and December 31, 2014.
- Used Audit Command Language (ACL) to determine if there was a medical claim for a recipient on the same day that the recipient received NEMT.
- Conducted a file review of NEMT claims that did not have a medical claim on the same day to determine why this occurred.
- Used ACL to determine the prevalence of nursing homes using ambulance and non-ambulance transportation to provide NEMT for their residents.
- Conducted a file review of NEMT claims for nursing home residents to determine if the required documentation was present.
- Discussed the results of our analysis with DHH management and provided DHH with the results of our data analysis.

APPENDIX C: COSTS, CLAIMS, AND RECIPIENTS BY PROVIDER TYPE

Costs, Claims, and Recipients by Provider Type Calendar Years 2011 through 2014						
Provider Type	**Category**	**2011**	**2012**	**2013**	**2014**	**Total**
Ambulance	Cost	$12,873,983	$10,829,744	$11,194,879	$10,893,909	**$45,792,515**
	Claims	86,749	80,091	75,517	68,285	**310,642**
	Recipients*	25,011	21,028	20,993	19,483	**66,886**
Profit	Cost	$7,627,823	$6,468,253	$7,667,166	$9,890,966	**$31,654,208**
	Claims	187,870	129,701	123,007	178,706	**619,284**
	Recipients*	32,858	23,554	19,074	19,643	**58,752**
Non-Profit	Cost	$1,875,956	$1,218,122	$999,762	$1,111,249	**$5,205,089**
	Claims	103,163	61,487	46,643	45,398	**256,691**
	Recipients*	16,670	10,633	6,765	6,682	**25.942**
Friends and Family	Cost	$272,520	$192,550	$136,717	$114,619	**$716,406**
	Claims	19,533	12,689	8,206	7,163	**47,591**
	Recipients*	1,607	1,233	730	535	**2,517**
Total	**Cost**	**$22,650,282**	**$18,708,668**	**$19,998,524**	**$22,010,743**	**$83,368,217**
	Claims	**397,315**	**283,968**	**253,373**	**299,552**	**1,234,208**
	Recipients**	**68,961**	**51,659**	**43,740**	**42,086**	**135,907**

* The number of claims is less than the number of rides because transportation providers billed capitated (monthly) rides as one claim per recipient. Therefore, what looks like one trip in the data could actually represent anywhere from 1-21 trips. This issue has been resolved with Southeastrans.
* This represents the unique number of recipients that used that particular type of transportation.
** This represents the number of unique recipients for each year. The sum of the unique recipient totals for the four provider types listed above does not equal the total unique for the year because a recipient may appear in multiple provider types and in multiple years.
Source: Prepared by legislative auditor's staff using Calendar Year 2011-2014 Medicaid data.

APPENDIX D: MEDICARE PHYSICIAN CERTIFICATION CERTIFICATE

Physician Certification Statement for Non-Emergency Ambulance Services – Version 1.6

SECTION I – GENERAL INFORMATION

Patient's Name: ______________________ Date of Birth: __________ Medicare #: ______________

Transport Date: ______________ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: ______________ Destination: ______________

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? ______________

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: ______________

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: ______________

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition: ______________

2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
   To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
   **Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement
☐ Danger to self/other ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints
☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer
☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport
☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Other (specify) ______________

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:***

____

Signature of Physician* or Healthcare Professional ______________ Date Signed ______________
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)
**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

User bears all responsibility for compliance with all applicable laws and regulations.