



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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Office of Inspector General  
Office of Audit Services

Region IX  
50 United Nations Plaza, Rm. 171  
San Francisco, CA 94102  
(415) 437-8360 FAX (415) 437-8372

July 30, 2003

Report Number: A-09-03-00037

Jay Martinson  
Executive VP and Chief Operations Officer  
Noridian Administrative Services  
4510 13th Avenue SW  
Fargo, North Dakota 58121-0001

Dear Mr. Martinson:

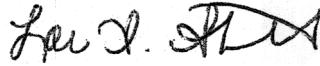
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General Report entitled "Review of Medicare Part B Payments to Emergency Medical Services System" for the period January 1, 2000 to December 31, 2001. A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Report Number A-09-03-00037 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand".

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Enclosures – As stated

**Direct Reply to HHS Action Official:**

Ms. Cassie Undlin  
Chief Financial Officer  
Centers for Medicare and Medicaid Services  
2201 Sixth Avenue  
MailStop/RX 40  
Seattle, WA 98121-2500

cc: Emergency Medical Services System

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PART B  
PAYMENTS TO EMERGENCY  
MEDICAL SERVICES SYSTEM**



**JULY 2003  
A-09-03-00037**

# *Office of Inspector General*

<http://oig.hhs.gov/>

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## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.





July 30, 2003

Report Number: A-09-03-00037

Jay Martinson  
Executive VP and Chief Operations Officer  
Noridian Administrative Services  
4510 13th Avenue SW  
Fargo, North Dakota 58121-0001

Dear Mr. Martinson:

This final report presents the results of our audit of Medicare Part B payments to Emergency Medical Services System (EMSS) for the period January 1, 2000 to December 31, 2001. During the audit period, EMSS received \$5,008,670 of Medicare Part B payments for 21,773 ground ambulance transports.

## Objective of Audit

The objective of our audit was to determine whether EMSS was paid by the Medicare program for transporting beneficiaries to allowable facility destinations as defined by the Centers for Medicare & Medicaid Services' (CMS) Carriers Manual coverage guidelines.

## Summary of Finding

Our audit disclosed that EMSS incorrectly billed the Medicare program for transporting beneficiaries to unallowable facility destinations on 41 of 200 sample claims reviewed. Based on a projection of the sample results, we estimated that EMSS claimed and received \$19,929<sup>1</sup> of unallowable Medicare reimbursement. The claims for unallowable services were processed and paid by Noridian Administrative Services (Noridian) because EMSS used incorrect destination modifiers on its Medicare claims.

We discussed our finding with the EMSS program manager. The manager did not agree that the Medicare beneficiaries were transported to unallowable destinations. We recommend that Noridian (i) recover the \$19,929, and (ii) educate EMSS on the Medicare guidelines for allowable ground ambulance destinations and the correct use of destination modifiers.

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<sup>1</sup> Based on a statistical sample, we are 95 percent confident that EMSS claimed at least \$19,929 of unallowable Medicare reimbursement.

In its written response to our draft report, Noridian officials did not agree completely with the findings and recommendations presented in the report. We considered Noridian's comments and concluded that our audit findings on the unallowable facility destinations are still valid. We have summarized Noridian's comments and the Office of Inspector General's (OIG) response to those comments at the end of this report. The full text of Noridian's comments is included as an appendix to this report.

## **Other Matters**

During our review, we also noted that EMSS (i) did not always properly bill for services it provided to beneficiaries under a Medicare managed care plan, and (ii) provided ambulance transports to ambulatory beneficiaries who may not have been in need of such services. These issues are discussed in more detail in the OTHER MATTERS section of this report.

## **INTRODUCTION**

### **Background**

As a branch of the State of Hawaii Department of Health, EMSS administered, maintained and operated a comprehensive emergency medical services system throughout Hawaii. It provided emergency ground ambulance transport services by contracting either with a private contractor or county emergency services. The EMSS electronically submitted its ambulance billings for services provided to beneficiaries to Noridian, the Medicare Part B carrier for processing and payment.

In general, Medicare allows for ground ambulance services provided when (i) the ambulance provider was a Medicare approved supplier, (ii) the transportation was medically appropriate, and (iii) the destination was to an allowable facility. In addition, the CMS Carriers Manual, Part 3 Chapter II Coverage and Limitations Section 2120.3 stated that: "As a general rule, only local transportation by ambulance is covered. This means that the patient must have been transported to a hospital or a skilled nursing home..." Section 2125.3 further stated that: "Ambulance service to a physician's office or a physician-directed clinic is not covered."

The Noridian Medicare Ambulance Manual, dated April 1999, states that: "Twenty Four Hour walk-in Clinics and Emergency Care Centers are considered by Medicare as physician based or physician directed clinics, and like physician offices, they are not acceptable destinations for coverage..."

The Noridian Medicare Ambulance Manual also instructs suppliers to report both the appropriate origin and destination of the ambulance transport through the use of modifiers on its claim form. The following are examples of modifiers to be used on the forms: (i) an ambulance trip from the beneficiary's residence to the hospital would be coded as "RH," and (ii) an ambulance trip from the scene of accident or acute event to the hospital should be coded as "SH."

## **Objective, Scope, and Methodology**

### **Objective**

The objective of our audit was to determine whether EMSS was paid by the Medicare program for transporting beneficiaries to allowable facility destinations as defined under the CMS's Carriers Manual coverage guidelines.

### **Scope and Methodology**

For the 2-year period January 1, 2000 through December 31, 2001, EMSS received Medicare Part B payments totaling \$5,008,670 for 21,773 ground ambulance claims. We conducted computer analyses using the CMS National Claims History (NCH) file of fee-for-service Medicare Part B claims to identify EMSS ambulance billings with "RH" (residence to hospital) and "SH" (scene of accident or acute event to hospital) modifier codes. We matched these claims against the NCH file of fee-for-service hospital claims in order to identify the EMSS ambulance services that had no related hospital admission or emergency room service. Based on our computer analyses, we identified 2,007 EMSS claims totaling \$517,600 of Medicare payments. In order to review the 2,007 claims, we divided them into two strata:

- Stratum No. 1 consisted of 1,779<sup>2</sup> EMSS claims totaling \$458,490 of Medicare payments that did not have a matching hospital admission or hospital outpatient claim with an "RH" (residence to hospital) or "SH" (scene of accident or acute event to hospital) modifier code. For this stratum, we randomly selected a sample of 100 claims totaling \$25,420 for our review.
- Stratum No. 2 consisted of 228 EMSS claims totaling \$59,110 of Medicare payments. Our computer analyses indicated that these claims did match to hospital outpatient billings with no emergency room charges or non-hospital treatment facility billings. For this stratum, we randomly selected a sample of 100 claims totaling \$25,856 for our review.

Appendix A presents additional details of our sampling methodology.

Our review included visits to EMSS, selected hospitals, and non-hospital treatment facilities. For each sample claim, we reviewed EMSS's supporting ambulance report files to identify the destination of the ambulance transport. We contacted the facilities listed on the ambulance reports to verify that the sample beneficiaries received either inpatient treatment and/or emergency room care. Since our audit objective was limited to determining the ground ambulance transport destination, we did not perform any medical review on the sample claims.

Our review was conducted in accordance with generally accepted government auditing standards. We did not review the overall internal control structure of EMSS since such a review

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<sup>2</sup> The NCH inpatient data is stored by date of discharge. Since the 2002 NCH was not available at the time of the audit, 195 of the selected ambulance claims for services provided in December 2001 were excluded from review.

was not necessary to accomplish our audit objective. Our audit fieldwork was conducted from January 2003 through April 2003.

## FINDING AND RECOMMENDATIONS

### Review of EMSS Claims

Our review of EMSS and hospital records for 200 sample claims for ground ambulance services disclosed that Medicare was billed in error on 41 claims. Based on the statistical sample, we are 95 percent confident that EMSS claimed at least \$19,929 (\$543 + \$19,386) of unallowable Medicare payments. The claims for unallowable services were processed and paid by Noridian because EMSS used incorrect destination modifiers on its claim forms. For the remaining 159 claims, we found that the Medicare beneficiaries were transported to allowable facility destinations. The details of our review by strata are shown below:

**Stratum No. 1.** We reviewed 100 sample claims totaling \$25,420. Based on computer analyses, these EMSS claims appeared not to have any matching hospital admission or hospital outpatient claim. However, our review of records disclosed that only two of the claims, totaling \$543, were unallowable for Medicare reimbursement.

Unallowable Claims. Two of the sample claims did not comply with Medicare guidelines since the beneficiaries were transported to unallowable facility destinations. The two beneficiaries were transported to community health centers. In both cases, EMSS billed Medicare using the wrong destination modifier code which incorrectly indicated that the beneficiaries were transported to hospitals. We did not project the two unallowable claims for \$543 found in Stratum No. 1 to the universe of 1,779 claims because the number of non-zero values did not meet the minimum required by OIG internal policy.

Allowable Claims. Ninety-eight of the sample claims, totaling \$24,877, complied with the Medicare guidelines. The beneficiaries were transported to allowable facility destinations. We found that the majority of these claims were for beneficiaries that EMSS submitted fee-for-service claims to Noridian. However, the hospitals submitted their claims to either a Medicare Managed Care Organization (MCO) plan or a non-Medicare insurance plan that did not appear in the NCH system.

**Stratum No. 2.** We reviewed 100 sample claims totaling \$25,856. These EMSS claims did have matching hospital outpatient billings with no emergency room charges or non-hospital treatment facility billings. Our review disclosed that 39 of the claims were unallowable for Medicare reimbursement. Based on the projection of the sample results, we estimated with 95 percent confidence that EMSS received overpayments totaling at least \$19,386 for ambulance transports. The details of our sample projection are included in Appendix B of this report.

Unallowable Claims. Thirty-nine of the sample claims, totaling \$10,086, did not comply with Medicare guidelines. The beneficiaries were transported to unallowable facility destinations. Thirty-eight of the beneficiaries were transported to a community health center. As in Stratum No. 1, EMSS billed the wrong destination modifier code that incorrectly indicated that the beneficiaries were transported to hospitals. The remaining beneficiary was transported to an emergency room. However, the emergency room personnel found the patient not to be in need of emergency services and sent the patient directly to a physician office located at the hospital facility.

Allowable Claims. Sixty-one of the sample claims, totaling \$15,770, complied with Medicare guidelines. The beneficiaries were transported to allowable facility destinations, such as (i) a hospital emergency room, or (ii) a hospital or non-hospital treatment facility to obtain diagnostic or therapeutic services not available at the skilled nursing facility where the beneficiaries were inpatients. We attempted to determine why the 61 emergency room services were not listed in the NCH data. We found that for most claims, the hospitals either (i) did not bill for the services provided, or (ii) billed other private insurances or Medicaid for the emergency room services.

### **Finding Discussed with EMSS Official**

We discussed our finding with the EMSS program manager. The manager did not agree that the Medicare beneficiaries were transported to unallowable destinations. However, the manager could not provide any specific Medicare guidelines to support this position.

### **Recommendations**

We recommend that Noridian:

1. Recover the \$19,929 of unallowable Medicare Part B payments, and
2. Educate EMSS on the Medicare guidelines for allowable ground ambulance destinations and the correct use of destination modifiers.

### **Noridian's Comment**

In a letter dated June 30, 2003, Noridian agreed that EMSS incorrectly used the destination modifier H for beneficiaries being transported to community health centers. However, it pointed out two exceptions to the 1999 ambulance manual guideline which stated "Twenty-four hour walk-in clinics and emergency care centers are considered by Medicare as physician based or physician directed clinics, and like physician offices, they are not acceptable destinations for coverage..." The exceptions are as follows:

1. Where stops are made at one of these entities in order to stabilize or because of a patient's dire need for professional attention, and immediately thereafter, the ambulance continues enroute to the hospital; or
2. When a skilled nursing facility (SNF) or nursing home inpatient is transported round-trip for specialized services to the nearest hospital or non-hospital treatment facility, i.e., clinic, therapy center of physician's office to obtain necessary diagnostic and/or therapeutic services (such as CT scan or radiation therapy) **not available** at the institution where the beneficiary is an inpatient. However, this benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient. Ambulance transfers to a physician's office for evaluation and management services (in the absence of any specialized services, i.e., tests or procedures that could not be brought to the patient) **are not** covered.

Noridian recommended that a medical review be done prior to projecting the sample results to the universe especially as it relates to the exception of ambulance transports stops to clinics made enroute to a hospital. Noridian further believed that Medicare coverage is determined by the patient's actual condition at the time of transport.

Noridian concurred with our recommendation to educate EMSS regarding the Medicare guidelines for allowable ground ambulance destinations and the correct use of destination modifiers. In addition, it will look at EMSS's claims submission on a pre-payment basis to ensure compliance with Medicare guidelines for proper reimbursement or denial of claims. The full text of Noridian's comments is included as Appendix C to this report.

## OIG's Response

Our audit findings did consider the two circumstances where 24 hour walk-in clinics and emergency care centers could be treated as acceptable destinations for coverage. Therefore, our recommended recovery of \$19,929 in unallowable Medicare Part B payments was not adjusted based on Noridian's comments.

In Stratum No. 1, the two unallowable claims were for ambulance transports to community health centers. In both cases, the community health centers were final destination stops by EMSS. In addition, the beneficiaries were not SNF or nursing home inpatients.

For Stratum No. 2, we found 38 beneficiaries were transported to unallowable community health center destinations. Of these 38 claims, there were 3 instances where the beneficiaries were first taken by EMSS to the community health centers for treatment then taken by a second ambulance provider to a hospital. We confirmed that the second ambulance provider billed a separate ambulance charge for transport to the hospital destination. Since there was a separate billing for the hospital transport, this circumstance would not meet the exception of ambulance transports stops to clinics made enroute to a hospital. We did allow four claims in Stratum No. 2 where we found evidence that EMSS transported SNF or nursing home inpatients to either a hospital or a non-hospital treatment facility for specialized services.

Since our audit objective was limited to determining the ground ambulance transport destination, we did not perform any medical review on the sample claims. However, if Noridian does perform medical review on the sample claims, we will be available to calculate a revised sample projection if warranted.

## **OTHER MATTERS**

During our audit review, we noted that EMSS (i) did not always properly bill for services it provided to Medicare MCO beneficiaries, and (ii) provided ambulance transports to ambulatory beneficiaries who may not have been in need of such services.

### **Medicare MCO Plan**

We found 21 instances where EMSS improperly submitted fee-for-service claims to Noridian for services provided to Medicare MCO beneficiaries. Noridian paid EMSS for the primary coverage and the MCO plan paid the patient share. Since EMSS was a participating provider with the Medicare MCO plan, it should have submitted these claims directly to the MCO plan.

### **Ambulatory Beneficiaries**

For 25 of our sample claims, the ambulance reports indicated that the beneficiaries were ambulatory and their medical conditions were minor. The Noridian Ambulance Manual, dated April 1999 stated, “Medicare Part B will only pay for services that are medically necessary. This means that Medicare will pay for your transport in an ambulance only if you could not be safely transported any other way.” Since our audit objective was limited to determining the ground ambulance transport destination, we did not perform any medical appropriateness review on the sample claims. However, the ambulatory status and the minor medical conditions of the beneficiaries may indicate the lack of medical necessity for these services.

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG reports issued to the Department’s grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Page 8 – Mr. Martinson

To facilitate identification, please refer to Report Number A-09-03-00037 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Enclosures

# **APPENDICES**

### Sampling Methodology

#### Review Objective

The objective of our audit was to determine whether EMSS was paid by the Medicare program for transporting beneficiaries to an allowable facility destination as defined by the CMS's Carriers Manual coverage guidelines.

#### Population

We conducted computer applications using the CMS National Claims History (NCH) file of fee-for-service Medicare billings in order to identify EMSS ambulance claims with "RH" and "SH" origin and destination modifiers. We matched these claims against the NCH file of fee-for-service hospital claims in order to identify the EMSS ambulance services that had no related hospital admission or emergency room service. Based on our computer analyses, we identified 2,007 EMSS claims totaling \$517,600 of Medicare payments. In order to review the 2,007 claims, we divided them into two strata: Stratum No. 1 consisted of 1,779 claims totaling \$458,490 in Medicare payments that did not have a matching hospital admission or outpatient claim; and Stratum No. 2 consisted of 228 EMSS claims totaling \$59,110 that matched hospital outpatient claims with no emergency room charges or non-hospital treatment facility claims.

#### Sampling Unit

The sampling unit was an EMSS ambulance claim shown on the NCH with a provider payment amount greater than zero.

#### Sampling Design

A simple random sample was used for both strata.

#### Sample Size

We selected 100 sample units for both strata.

#### Source of Random Numbers

Department of Health and Human Services, Office of Inspector General, Office of Audit Services Random Number Generator.

#### Estimation Methodology

For Stratum No. 1, we did not project the sampling errors to the universe of 1,779 claims because the number of non-zero values did not meet the minimum required by Office of Inspector General internal policy. For Stratum No. 2, we used the Office of Audit Services' Statistical Software Variables Appraisal program for simple random sampling to project the amount of unallowable service costs to the total population of 228 claims.

**Projection of Unallowable Costs**

For Stratum No. 2, we reviewed 100 randomly selected EMSS claims totaling \$25,856. We found that 39 of the claims totaling \$10,086 were not allowable. These claims were for transporting beneficiaries to unallowable facility destinations. We projected the results of our review to the population of 228 claims. The results of the projection are:

Point Estimate of Differences: \$ 22,995

At the 90% Confidence Level:

Precision Amount: \$ 3,610

Lower Limit: \$ 19,386

Upper Limit: \$ 26,605



4305 13th Avenue South  
Fargo, ND 58103-3373

## Medicare

June 30, 2003

Lori A. Ahlstrand, Regional Inspector General  
Office of Inspector General  
Office of Audit Services  
Region IX  
50 United Nations Plaza, Rm. 171  
San Francisco, CA 94102

Dear Ms. Ahlstrand:

Noridian Administrative Services, LLC. (NAS) is responding to your audit entitled "Review of Medicare Part B Payments to Emergency Medical Services System." The report number is: A-09-03-00037. We would like to give rebuttal on your findings in the report.

NAS agrees that using the modifier H when being transported to a community health center is incorrect. This report quotes a NAS Ambulance Manual from 1999, "Twenty-four hour walk-in clinics and emergency care centers are considered by Medicare as physician based or physician directed clinics, and like physician offices, they are not acceptable destinations for coverage..." However, there are exceptions to this guideline as follows:

- A. Where stops are made at one of these entities in order to stabilize or because of a patient's dire need for professional attention, and immediately thereafter, the ambulance continues enroute to the hospital; or
- B. When a skilled nursing facility (SNF) or nursing home inpatient is transported round-trip for specialized services to the nearest hospital or non-hospital treatment facility, i.e., clinic, therapy center or physician's office to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or radiation therapy) **not available** at the institution where the beneficiary is an inpatient. However, this benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the patient is **less costly** than bringing the service to the patient. Ambulance transfers to a physician's office for evaluation & management services (in the absence of any specialized services, i.e., tests or procedures that could not be brought to the patient) **are not** covered.



In the above situation, the destination modifier of H would be inappropriate. However, NAS would recommend that medical review be done prior to projecting the sample results to the universe. Medicare coverage is determined by the patient's actual condition at the time of the transport. In one of the cases, it stated the patient was transported to the emergency room and then the emergency room found the patient not to be in need of emergency services and sent the patient to a physician office located in the hospital facility. If the patient's condition was uncertain the transport may be medically necessary even if it was then determined that a clinic could care for the patient. Consider the following: [REDACTED] received a visit in the ER and then had a leg cast applied in the clinic. Another of the beneficiaries, [REDACTED], was seen at the clinic and then continued on and was admitted to the hospital. [REDACTED] also received another transport on the same date and was seen in the ER. Again the inappropriate modifier was used but the service may have been medically necessary. Noridian would recommend medical review to see if this satisfied the exception where stops are made at one of these entities in order to stabilize or because of a patient's dire need for professional attention, and immediately thereafter, the ambulance continues enroute to the hospital.

We will educate this facility regarding the Medicare guidelines for allowable ground ambulance destinations and the correct use of destination modifiers. We will look at their ambulance claims on a pre-payment basis to ensure compliance with the Medicare guidelines regarding submission of claims for ambulance and to ensure proper reimbursement and or denial of the claims as appropriate.

Thank you for the opportunity to respond to this audit.

Please contact our Manager of Part B Medical Review, Bryan Danielson at 701-282-1190 with your questions.

Sincerely,

  
Jay Martinson  
Executive Vice President & COO  
Noridian Administrative Services

**OIG NOTE:** References to beneficiary names have been omitted from Noridian's response letter.

# ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Douglas Rennie, *Audit Manager*

Warren Lum, *Senior Auditor*

Linda Siu, *Auditor*

Mabel Yeung, *Auditor*

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