

## Texas Non-Emergency Ambulance Transports Billed With Modifiers RJ/JR

---

Date: (12/30/2011)

Notice ID: [14609](#)

*Applies to Texas ambulance suppliers*

**Note:** This notice is being revised to include instructions effective January 1, 2012.

In July 2011, TrailBlazer implemented automated utilization denials (for more than 12 transports in a year per patient) for non-emergency ambulance transports billed with modifiers RJ/JR in Texas.

**Beginning January 1, 2012**, TrailBlazer will not allow 12 transports per year without the review of medical records.

When claims are submitted, the Medical Review department will request medical record documentation for the first 12 non-emergency ambulance transports per patient billed with modifiers RJ/JR in Texas, to determine if patients meet Medicare's requirements for ambulance coverage and to develop a list of beneficiaries whose documentation meets coverage/benefit requirements.

**Documentation should not be submitted with the initial claim. A Request for Additional Documentation letter will be sent to the suppliers if needed.**

Based on the submitted documentation, those patients who meet the requirements for coverage will be added to a list that will exclude them from the yearly transport restriction (Local Coverage Determination (LCD) utilization guidelines). Claims for patients who are included on this list will bypass the automated utilization denial edit (12 per year). All other claim and LCD requirements have to be met for payment to be allowed.

**Note:** If your patient(s) has been added to the bypass list, you will not receive the request for additional documentation, and the claims will continue to pay. TrailBlazer will not release the names of the patients who are on the bypass list to the suppliers; they will be notified by the payment.

### Documentation Requirements

A detailed description of the patient's condition at the time of transport is necessary to "paint a picture" of the patient's condition. The documentation must include a description of the patient's functional or mental deficits that prevent safe transportation by another means. Please take this opportunity to ensure complete mental and physical assessments are performed and documented on run sheets and the information on the Physician Certification Statement (PCS) is consistent with the information on the run sheet. The physician who completes the PCS should have treated the patient; Medicare should be able to verify this by reviewing the patient's claim history.

When the request for documentation is received, if ambulance providers believe their documentation may have deficiencies, they are encouraged to submit any other supporting information from the patient's attending physician or dialysis facility that helps support the patient's eligibility for ambulance transportation. This information should be dated and signed by the author.

### Denied Transports Due to the Automated Utilization Denials (for more than 12 transports in a year per patient)

Suppliers who have claims denied due to the utilization denial will need to follow the [redetermination process](#).

Based on the submitted documentation during the review, those patients who meet the requirements for coverage will be added to a list that will exclude them from the yearly transport restriction (LCD utilization guidelines). Claims for patients who are included on this list will bypass the automated utilization denial edit (12 per year). All other claim and LCD requirements have to be met for payment to be allowed.