

Health Claims Plus

“Elevating your financial future”

2800 Beaumont Ave. • Liberty, TX 77575

Phone: (888) 483-9893 • Fax: (936) 334-9861 • <http://www.healthclaimsplus.com>

1. Ambulance Policy for hospital-to-hospital transports:

- a. A GY modifier will be used for denials
- b. For PTs being taken from Hospital to external rehab location
 - i. Must use hospital to hospital modifier and local necessity

2. Ambulance Local Coverage Determination (LCD) Policy:

- a. Does TB have plans to expand the ICD-9-CM codes on Table 1 and 2?
 - i. No not at this time, LCD Reconsideration process is currently on the website, make recommendations to change and why change needs to occur and submit on website
- b. How long will TB continue to deny the repetitive RJ and JR transports?
 - i. No plan at this time to discontinue
 - ii. If TB sees a beneficiary paying claims consistently, then the PT (Quarterly) will be added to an “always pay list” and that claim will sail on through the system from here on out. This is called the Edit Effectiveness Program.
 1. No clarification was given though if the claim with a PT on “always pay list” will still be auto-denied on the first submittal

3. How long will the audit on transports with the modifier combinations JN, NJ, EJ and JE continue?

- a. The audits are being evaluated quarterly
- b. Why is TB so strict on the documentation requirements for non-emergency transports?
 - i. Paraphrased from Darlene Messina: We are not being strict, your medics are not creating payable narratives. There is nothing in the majority of your reports about “functionality.” Only a couple of vital signs, patient were moved to stretcher, patient was transported by ambulance, and patient was handed over to said person at X facility. You have to include more information about the patient’s functionality and why that patient could not be transported by any other means. Our RN’s review all of the claims at the appeal level and this is the most common reason for denial, there is no information about the patient’s functionality, what is validating their need for medical transport.

4. How long will the appeals take once we receive denials on the non-emergency transports?

- a. 60 days for appeal



5. Why does QIC pay all/most of the transports that TB denies?

- a. Mainly because there is no medical staff making the reviews at the QIC level, only technical staffing. At the QIC level, they fall under category 1861 which does not require them to have medical staffing to review the claims to determine if they are payable or not.
- b. TB is going to have more information on the reason for denial on the initial denial
 - i. This sounds like TB is going to do a better effort to explain why their medical staff is denying the claim, so that when it gets to the QIC level their technical staff can see why the medical staff denied the claim originally. Sounds like they are going to start stacking the deck.
- c. TB – “We rely on the trip record only, not external documentation”
 - i. This brought up the issue of why they are so strict on PCS if they rely on no external documentation and why at the 1st level of appeal when additional medical documentation is submitted the claims sometime get approved.
 1. No real answer was given other than PCS are not going away and your medics need to do a better job of documenting and putting functionality in the narrative.
- d. This also brought up that “theoretically” OIG has told TB that they paid erroneously and providers may have to be ready for repaying CMS.
 - i. This is not supposed to be read into, but is a viable option for CMS after OIG has reviewed claims that were paid in various stages of the denial/appeal process

6. Provider enrollment and Enrollment Issues:

- a. What is the time frame to process an application?
 - i. Currently we have 60 days (and must report to CMS of any applications that extend past the 60 day mark) but currently we are processing at 30-35 days
- b. What are the guidelines on performing site visits?
 - i. 10.10 – Explains ground ambulance guidelines
 - ii. 100.2 – Explains additional guidelines
 - iii. 7350 – General rules
- c. If additional information is required, what is the time frame to receive the information and consequences if not received?
 - i. Must have additional information into TB within 30 days
 - ii. Initial Applicants – will not receive CMS number
 - iii. Established Providers - # may be revoked and payment held
- d. Explain revalidation:
 - i. Complete process details are available in CR75.88



e. Overall explanations of enrollment:

- i. Site Survey – Currently finishing up paperwork for contract with third-party agency to conduct site surveys
- ii. By Mar/2013 – all providers will have to complete revalidation
- iii. If provider is not in PECOS: notice of revalidation was sent to them via mail last Friday
- iv. If Provider is in PECOS: Letter for revalidation will be sent before Mar/2013 to special payment address & correspondence address
 1. If neither address is in PECOS then letter will be sent to Primary Practice address
 - a. If Provider wants to change address, currently at 30-35 days for address change
- v. During revalidation process payments will not be held or delayed, unless provider does not send in request for additional information to TB

Respectfully,

Rodney Reed
Business Development
(C) 832.444.7713
(E) Rodney@hcpplus.com

