December 23, 2019

Provider Memorandum

Ambulance Billing Frequently Asked Questions

Q. How do I submit non-emergent ambulance claims to Molina?
A. Claims can be sent to Molina via Electronic Data Interchange (EDI) or through the secure provider web portal, https://provider.molinahealthcare.com/provider/login.

Q. Will my non-emergent ambulance claims require prior authorization like they did in the past?
A. No, they will not. However, if the claim requires a Physician Certification Statement (PCS) form, it must be submitted for the claim to be considered for payment.

Q. Can attachments be sent, including run papers or the PCS form?
A. At this time, attachments cannot be accepted through EDI, however that enhancement is coming in 2020. Currently the provider portal **does** accept attachments. If the original claim is submitted via the portal, attachments can be included at the point of submission or uploaded later. If the claim is submitted electronically via the EDI clearinghouse, attachments may still be added to an EDI claim via the portal, by searching on the claim number and then uploading the attachment.

Q: How long do I have to submit the PCS form before my claim would be denied?
A: Molina will allow 10 days from the day you submit your claim before the claim would be denied for a missing PCS form.

Q. Is a PCS form required when a non-emergent ambulance claim is being submitted to Molina?
A. Yes, a PCS form is required when the ride is scheduled by a Long-term Care (LTC) facility or a hospital as pursuant to Public Act 100-0646, the Hospital Licensing Act, the Nursing Home Care Act, and the Illinois Public Aid Code, in addition to previous Illinois Department of Healthcare and Family Services (HFS) memos and Molina communications.

Q. Is a PCS form required when there is a hospital to hospital transfer?
A. A PCS form is not required if the transfer is emergent. However, if it is for a non-emergent transfer, the PCS form must be completed, and the hospital to hospital section must be completed.

Q. What happens if the PCS form is not attached to non-emergent ambulance claims?
A. If the claim requires a PCS form and is not present at the time of adjudication, the claim will deny for missing certification form. When the provider receives the PCS form, he or she may then submit a dispute online and include the PCS form for the claim to be reconsidered.

Q. What modifier should I use if the pickup location is a long-term care/nursing facility and the ride is for non-emergent ambulance transportation?
A. At this time, the modifier for non-emergent would be “R” for Residence.

Q. What happens if we are not able to obtain the PCS form from the hospital or LTC provider?
A. The ambulance provider should submit a complaint via the HFS Transportation Provider Portal.

Q. Does “TR” need to be submitted on every claim?
A. Yes, this is a Molina-specific requirement and claims will deny if filled out incorrectly. This requirement applies to ALL Molina emergent or non-emergent billed claims. The “TR” requirement was implemented by Molina

because the NTE segment/Box 19 can contain any type of information in that field. For Molina, the "TR" identifies those elements as the HFS-required transportation-specific data elements when sent. It is not unusual for payers to have additional requirements outside of what is required and is also published in our transportation memo(s).

TIP: Speak to your clearinghouse/claim system vendor on how to default the "TR" entry for only Molina payer id 20934 as the first element in the NTE/Box 19.

Q. Do I have to report the taxonomy code when submitting a claim to Molina?
A. Yes.

Q. Are spaces allowed after commas?
A. No, data elements must be in order. The only exception where spaces are allowed is after the license plate number to ensure character total equals eight before the next comma. (Example: TR,IL,123456spacespace,0000,0000)

Q. I am indicating other notes in the Box 19/NTE segment; will my claims reject if there are other notes after the specific elements?
A. Yes, your claims will reject. HFS also does not allow anything after the specific elements in Box 19/NTE segment for transportation. Please do not include any additional information in Box 19/NTE segment other than what has already been requested.

Q. Will providers be asked to resubmit their claims, or will the claims be reprocessed by Molina?
A. Molina will not reprocess claims that are incorrectly billed. Providers should rebill in accordance with the instructions provided in the transportation provider memorandum. Provider memorandums issued by Molina can be found on the public provider site. Please use the following link for access to memorandums and other provider communications: www.MolinaHealthcare.com.

Q. What if providers rebill without that information?
A. Molina encourages providers to submit claims with the necessary information on their initial claim submission. Claims submitted in accordance with the timely filing requirements of 180 days will adjudicate through Molina's system. However, once the state rejects the encounter for the missing information, Molina will require providers to resubmit corrected claims in accordance with the timely filing requirements of 90 days from the original remittance advice. Failure to respond timely will result in your claims being recouped. Claims that are resubmitted must follow standard corrected claims protocol. The claim frequency, CLM05-3 must be a "7" and the original reference number in the REF*8, box 22 on the 1500 HCFCA, with the provider's original patient control number that was initially denied.

Q. What are common denial issues and how do I correct them?
A. Common denial issues include:

- Remittance Advice Remark Code (RARC) - N745 Missing Ambulance Report (occurs when no NTE segment/Box 19 information sent)
- RARC - N746 Incomplete/invalid Ambulance Report- (occurs when incorrect NTE segment/Box 19 information sent)
- RARC - N519 Invalid combination of HCPCS modifiers (occurs when a missing/invalid transportation modifier and or when 2 RR modifiers are sent on a service line)
- RARC – M22 Missing/Incomplete/invalid number of miles traveled (Occurs when EDI claim is missing CR1-06 numeric value – also see requirements question below)

- RARC- M60, Missing Certificate of Medical Necessity- (Occurs when the PCS form was not attached to the claim)