Claims Manual

Medi Trans Claims Policy and Procedure	
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Authorized Approval	Leah Begnaud, Chief Operating Officer
Approving Signature	

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Medi Trans ensures that the claims process meets, at a minimum, the required guidelines as outlined in this policy for filing, verification, processing, and all other claims-related activities in adherence to State, Federal, or Regulatory requirements. Claims are processed using the ~~Salesforce~~ NovusMed or Salesforce systems.[VG1][LB2]

Timely Claims Filing

A. Medicaid claims must be filed within three hundred sixty-five (365) days of the date of service.

B. Claims involving third-party liability shall be submitted within 365 days from the date of service.

C. Timely filing exception regarding retroactive eligibility.

   1. Medi Trans must not deny claims submitted in cases of retroactive eligibility for timely filing if the claims are submitted within one hundred and eighty (180) days from the member's linkage to MediTrans.

   2. The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to MediTrans by the latter of the three hundred and sixty-fifth (365) calendar day from the date of service or one hundred and eighty (180) days from the member's linkage to MediTrans.

Receipt of a Claim

The receipt of a claim is established, and date stamped, for:

A. Paper Claims – Upon the date received claims are stamped and scanned into our system to prevent loss by Medi Trans

B. Electronic Claims – Upon the successful transmission to Medi Trans[VG3][LB4]

Claim Receipt Verification

As per claim receipt verification requirements, all claims that have a receipt of claim established will be reportable in addition to the capability to provide both on-line and over-the-phone status information.

Timely Claims Processing

All claims must be processed expeditiously. The following minimum guidelines or standards exist to ensure timely processing and prompt payment:

A. Process and pay or deny, as appropriate, at least Ninety percent (90%) of all clean claims for each claim type, within fifteen (15) calendar days of the receipt.

~~A. 90% of clean claims of each provider [VG5][LB6]will be paid within 15 calendar days of the date of receipt~~

B. Process and pay or deny, as appropriate, one hundred percent (100%) of all clean claims for each claim type, within thirty (30) ~~c~~Calendar days of the date of receipt.~~100% of all claims of each provider type must be paid within 30 calendar days of the date of receipt~~[VG7][EH8]

C. Within five (5) business days of receipt of a claim, MediTrans shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication

D. The date of payment is the date of the check or other form of payment

~~D.~~E. Fully adjudicate (pay or deny) ~~all~~one hundred percent (100%) of ~~p~~Pended ~~c~~Claims within sixty (60) calendar days of the date of receipt[VG9].

~~E.~~F. At a minimum, MediTrans shall run one (1) provider payment cycle per week, on the same day each week, as determined by MediTrans

Rejected Claims Process

A. Medi Trans may reject claims for missing or incomplete information.

B. Rejected claims will:[VG10][LB11]

1. Be held in rejected status for the remainder of the alotted 365 days from date of service in order to give the provider time to submit a clean claim for payment:

   a. The status and reason for this status can be found on the provider portal.

2. Not appear on the Remittance Advice (RA) because it will not have entered the claims processing system

   Note: All electronic claims processed through Medi Trans Trip Management software will provide immediate notice of acceptance or rejection of a claim to the Transportation Provider[VG12][LB13]. All paper claims will provide notice as soon as they are processed in the system.

Dispute Claims

For disputed claims:

A. Medi Trans will process all disputed claims to a paid or denied status within 30 business days of receipt of the disputed claim

B. Providers have one hundred eighty (180) calendar days from the date of denial to dispute a denied claim.

~~C. Adjudicate all claims, including disputed claims, within 24 months [VG14]of the date of service~~

Interest Payment on Non-timely Processing

A. Medi Trans will pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline.

B. Interest owed to the provider must be paid on the same date that the claim is adjudicated and reported on the encounter submission to the Financial Institution as defined in the Systems Companion Guide.

Non-Contracted Claims Process

A. MediTrans does not delegate any lines of business to non-contracted providers.

Reprocess Claims

A. If Medi Trans, or any third-party sub-contractors, discover errors made by MediTrans when a claim was adjudicated, MediTrans must:

1. Make corrections and reprocess the claim within fifteen (15) calendar days of discovery

2. If needed or circumstances exist that prevent Medi Trans from meeting the above time frame, a specified date will be provided by Medi Trans

3. Automatically recycle the impacted claims and shall not require the provider to resubmit the impacted claims

4. Pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean Claim remains unpaid beyond the fifteen (15) Calendar Day Claims reprocessing deadline.

Explanation of Payment (EOP)/ Remittance Advice (RA) Requirements

In conjunction with its payment cycles, Medi Trans must ensure:

A. Each remittance advice generated to a provider complies with the provisions of LA-R.S. 46:460.71

B. Adjustments and Voids appear on the RA under “Adjusted or Voided claims” either as Approved or Denied

C. The following statement is included on each remittance advice sent to providers: “I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.” in accordance with 42 CFR §455.18 and §455.19

Policy Management

Governance

Senior Management is responsible for setting the structure for creation, modification, review, approval and publishing of Medi Trans's policies and procedures. In addition, the Senior Management team provides guidance and support to department heads or subject matter experts (SMEs) across all areas of policy development and ownership.

Development

New policies and procedures, and those that require amendments or changes, must be coordinated with Senior Management. The Senior Management team, department heads and SMEs are collectively responsible for developing policies that adhere to the following guidelines:

A. Policy documents are consistent with Medi Trans standards and required regulations
B. Policy documents do not duplicate or conflict with existing policies
C. Areas of overlap must be carefully reviewed
D. Appropriate cross-references must be used to avoid confusion
E. A Functional Policy and Procedure must conform and not conflict with law or regulation
F. Policy documents reflect Medi Trans's risk management principles, include the relevant legal and regulatory requirements, and provide the governance framework necessary to ensure compliance with the policy
G. Policy documents indicate the key risks of non-compliance and articulate how risks are controlled and managed

H. Policy documents clearly and specifically identify responsibilities for implementing key elements of the policy, controls that support the policy and individuals accountable for the day-to-day oversight and administration of the policy
I. Policy documents are vetted with key SMEs, stakeholders and control functions when appropriate
J. Policy documents are reviewed and approved through the proper processes and approvals are tracked for audit purposes
K. Policy documents are stored in Medi Trans cloud-based servers and assigned review dates (at least annually) for review according to requirements
L. All policy and procedure must contain:
    1. An Original Effective date
    2. The Date of last Revision
    3. A Review date
    4. Identification of authorized authority and individual, role, or department designation

Approval

Approval is required by the Health Plan (including LDH when necessary) and by executive-level Medi Trans management when policy and procedure documents are created, updated, and retired.

Review

A. All policy and procedure documents must accurately reflect underlying legal and regulatory requirements.
B. Policy and procedure documents are reviewed annually unless determined differently (more than once annually) by Senior Management or a business need. [VG15][LB16]The revision date (date of last review) and next review date are located at the top of the document.

The annual review is in addition to normal updates that occur due to business changes.

Claims, Documents and Correspondence Intake

A. Claims, documents or correspondence may be received by:

    1. Electronic submission [VG17][LB18]via Medi Trans Trip Management system ~~(MediRoutes)~~

    2. Mail

    3. ~~Other physical~~ [VG19][LB20]~~or electronic means~~

B. All incoming claims, documents or correspondence are:

    1. Reviewed and sorted daily

2. Stamped or dated with the date of receipt

   Note: All Paper and electronic claims received by 5:00 pm (local time) must be considered as received on that date.

3. Consecutively numbered or tracked

4. Routed to the correct department for handling within 48 hours

C. Day claims are transmitted directly or received by the clearinghouse, and is the claim Date of receipt, even if the claim is not uploaded or received by Medi Trans until a later date.

D. Medi Trans ensures that:

1. Any Member, Provider, and all other grievances are identified, and notification is sent to the Health Plan in ~~a timely manner~~[VG21][LB22]within the timeframe allotted by each health plan contract

2. Claims are acknowledged

3. Medical records are handled expediently

4. Claims are processed timely

Misdirected Claims, Documents and Correspondence

Fast Adjudication Process

Claims that are pre-date stamped and are nearing the end of, or have passed the compliance period, are identified in Medi Trans's fast adjudication process and routed with prioritization for immediate:

A. Processing
B. Finalization
C. Payment, if applicable

Tracking and Handling Misdirected Claims, Documents, or Correspondence

Medi Trans ensures that any misdirected claims, documents or correspondence are easily:

A. Identified
B. Have the proper ownership established
C. Re-directed to the proper payor within 10 days of receipt

Claim Submission and Claims Data Entry

Claim Submission

All claims submitted must utilize Medi Trans's most up-to-date forms, including those sent to a Clearinghouse.

The Provider will be notified by email when claims are not submitted with all of the required or mandated information including the exclusion of the "alternative statement", as approved by the Regional CMS Administrator.

Required Alternative Statements (must be in Bold Face Type)

A. "This is to certify that the foregoing information is true, accurate, and complete"
B. "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws"

Claims Data Entry

To ensure acknowledgment of claim receipts:

A. Paper Claims are entered into the claims processing system within 5 days of receipt of the claim
B. Electronic Claims are entered into the claims system immediately upon receipt

General Claims Policies, Procedures and Documents

Disseminating Claims Information

When requested or otherwise required, Medi Trans will securely provide claim information to our internal Claims Specialists. All claims for processing are sent electronically via Medi Trans' cloud-based Trip Management system. Any changes in policy required by the Health Plan or LDH for the processing of clean claims are conveyed through in-person meetings, or via internal secure email. After in-person meetings, any paper documents containing PHI are collected by the Claims Administrator and all extra copies are shredded. Acknowledgement signatures from each employee will be submitted to the Director of Human Resources[VG23][LB24]. All original meeting minutes and agenda items are then scanned and stored in Medi Trans' cloud-based server.

Clean Claim

Medi Trans defines a "Clean Claim" as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claims must have the following criteria to be considered a clean claim:

Provider Name
Date of Service

Driver Name
Last four digits of VIN
Member Name
Medicaid ID
Trip ID number
Pick up time
Drop off time
Member Signature
Driver Signature [VG25]

Improper Claims Payment Identification

A. Medi Trans systems contain extensive validation to minimize the acceptance of many improper claims, as well as to implement training and develop best practices to avoid future issues. Claims tracking data will be monitored and any consistent concerns will be addressed by process improvement, training, or software modification.
B. A Weekly Error Report process provides additional validation of claims that have been accepted and checks for issues that have been identified after claims processing.
C. Medi Trans performs regular eligibility verification that is based on provided eligibility files to identify claims that may have been submitted an incorrect payor.

Coordination of Benefits Process

Medi Trans must make reasonable efforts to collect funds from any insurance or benefit plan that is the primary payer to Medicaid. Reasonable efforts include, but are not limited to:

A. Questioning the member to identify any other insurance so that a claim to the primary payer can be filed
B. Checking the States website for insurance coverage on the member so that a claim to the primary payer can be filed
C. Questioning the member regarding any updates to the coverage(s) shown on the State's website
D. Filing a claim with the known primary insurance(s) prior to filing with Medicaid
E. The discount amount reported on the EOB from the primary payer

Medi Trans takes into account many factors when determining the amount of payment on a Medicaid COB claim. Factors include, but are not limited to the:

A. Payment amount from a primary payer
B. Medicaid maximum allowable amount for a specific covered service
C. Discount amount reported on the EOB from the primary payer

Third Party Liability

Medi Trans must provide the following information to the Providers on the Provider Remit or separate letter:

A. Carrier name
B. Carrier address
C. Effective dates
D. Termination dates

Overpayment Process

It is Medi Trans' responsibility to ensure that all overpayment of claims be identified, addressed, and corrected in a timely and effective manner. To achieve this, Medi Trans applies the following standards to all claims submitted:

B. Claims submitted are reviewed and entered into Medi Trans system for payment.
C. Any claim identified as a duplicate or showing payment above appropriate amount for the trip are marked accordingly and sent to Medi Trans Finance Department to be processed through Accounts Payable/Accounts Receivable within 60 days of discovery.
D. Medi Trans will then notify the recipient of the overpayment of the findings via certified mail and offer a 30-day Reconsideration window in which the recipient may appeal the notice of overpayment.
E. If overpayment is based on SIU findings, provider has 60 days to submit an appeal with supporting documentation for reconsideration.
F. If the overpayment appeal is found to have valid, supporting evidence, then recoupment of payment will not take place.
G. If overpayment notice is found to be valid, Medi Trans will notify the recipient of the findings, and of expected repayment dates within thirty (30) days
H. Repayment may be taken from recipient's payment distributions incrementally.

Claims Re-opening and Revised Process

Claims may be re-opened for good cause as defined by:

E. New and Material Evidence
F. Clerical Error
G. Error on the Face of the Evidence

If a claim is re-opened and the decision or determination is revised, a letter will be mailed to all involved parties.

Any adverse determination must clearly state the rationale and basis for the reopening and include appeal rights.

Claims Appeal Process

Claims may be appealed:

Provider has ~~365~~ 180 days from the date of denial to correct and resubmit denied claims. A request for claim reconsideration review must be received from the provider within 180 calendar days of the Remittance Advice paid date or original denial date. A determination will made by the broker within 30 days of receipt.

For HBLA, Humana, and ABHLA trips, ~~P~~provider has 90 calendar days from the date on the determination letter, from the original request for claim reconsideration, to submit a claim appeal.[VG26][LB27]

For LHCC trips, provider has 180 calendar days from the date on the determination letter, from the original request for claim reconsideration, to submit a claim appeal.

Claim System Inventory and Reporting Functionality

Claim System Inventory and Reporting Functions

Medi Trans utilizes the following claim reports:

A. Days Receipt on Hand Report (DROH)/Inventory on Hand Report
B. Misdirect/Misroute Claims Report
C. Monthly Timeliness Report (MTR),
D. Provider Dispute Resolution Report
E. Direct Member Reimbursement (DMR)

Claims encounters are submitted weekly.

Reports are submitted to the Health Plan via sFTP and include the following information:

A. Member ID
B. Provider Name
C. Claim Number
D. Provider Contract Status
E. Claims Status (e.g. paid, denied, pending)
F. Date of Service
G. Receipt Date
H. Paid/Denied Date
I. Check/Denial Mail Date
J. Adjustment Reason

Claims Monitoring and Auditing

Claims are continually monitored through monthly quality reviews, reports and internal auditing.

Audits are conducted monthly on all Claims employees by the Claims Administrator using the Timely Filing Guidelines in this document.

The Claims Administrator gauges company competency by:

A. Reviewing 1% of claims monthly for payment accuracy based on amount paid
B. Reviewing 1% of claims monthly based on clean claims accuracy
C. Reviewing 1% of claims monthly based on benefit eligibility

Upon completion of monthly audit, the Claims Administrator will provide feedback and/or coaching to each Claims Agent and will report all findings and report to Executive Management Team for appropriate actions to be taken. If any audit metrics fall below 99% for any one agent or the Claims Department as a whole, performance improvement action will be taken as follows:

I. Performance coaching and improvement plan by management team (30 days with no improvement)
J. Written notice (60 days with no improvement)
K. Staff re-evaluation (90 days with no improvement)

Payments to Providers after System Error or Glitch

Should MediTrans discover a system error or “glitch” that might affect provider payments, MediTrans:

A. Shall notify providers within five (5) business days of discovery of a system error or “glitch” that impacts their reimbursement.
B. The notification will outline the process of resolution, including time frames, and be posted on the provider portal, on the MediTrans’ web page, and sent to providers via email and/or fax blast.
C. Will provide its provider call center staff with the relevant information immediately after discovery of the system error or “glitch” occurs in order to ensure that staff will be able to properly answer provider questions.

Provider Payment Disputes (PPD)/Provider Payment Reconsideration (PPR)/ Provider Dispute Resolution (PDR)

Medi Trans defines PPD, PPR and PDR as:

A. Provider Payment Disputes PPD - A provider dispute (for contracted ~~and non-contracted providers~~[VG28][LB29]) is a provider's written notice to Medi Trans challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or a contract dispute or disputing a request for reimbursement of an overpayment of a claim.
B. Provider Payment Reconsideration PPR – A provider resubmission/reconsideration is defined as a claim originally denied because of missing documentation, incorrect coding, etc., which is now being resubmitted with the required information.
C. Provider Dispute Resolution PDR – Methods taken to resolve disputed claim between provider and Medi Trans. Methods and responsibilities of PDR are listed below.

Medi Trans maintains a fast, fair, cost-effective Provider Dispute Resolution (PDR) process for contracting and non-contracting providers per Medicare guidelines of the Centers for Medicare and Medicaid Service (CMS). Providers wishing to file a dispute are not subject to discrimination or retaliation. In processing provider disputes, Medi Trans does not charge the provider for costs incurred and does not reimburse for expenses incurred by the disputing provider. All provider disputes must be received in writing and must be filed timely per Medicare guidelines.

A. Submission, Receipt, Processing and Resolution Must:
    1. Provide the claim dispute be submitted using the original claim number
    2. Be processed and tracked in a manner allowing linkage with the original claim number
    3. Inform the provider of the availability of the PDR mechanism whenever contesting, adjusting or denying a claim, and the procedures for obtaining forms and instructions for filing a dispute including the mailing address.
B. Disputes Regarding a Claim, or a Request for Overpayment Return Must:
    1. Clearly identify the disputed item
    2. Include the date of service (DOS)
    3. Provide clear explanation of the basis for the provider's reasons that the payment, request for overpayment return, request for additional information, contest, denial or adjustment is incorrect
    4. Include disputing provider's name, identification number and contact information.
C. For Contract Providers Only, If Dispute is Not Regarding a Claim or Request for Overpayment Return (i.e. a Contractual Issue) It Must Include:
    1. Clear explanation of the issue
    2. Provider's position thereon
D. If Dispute is Submitted on Behalf of the Enrollee(s), Medi Trans Will Forward the Member Grievance to the Corresponding Health Plan Within 3 Business Days via email; Unless Delegated, Medi Trans Will Follow Pursuant to State Law and Regulations. It Must Include:
    1. The name and identification number of the enrollee(s)
    2. A clear explanation of the disputed item(s)
    3. The DOS

4. The provider's position thereon

E. Medi Trans Verifies the Enrollee(s) Authorization to Proceed with the Grievance Prior to Submitting Through the Member Grievance Process.
   1. When a dispute is submitted on behalf of the enrollee(s), the provider is deemed to be joining with or assisting the enrollee(s) with the meaning of regulations.

F. Provider Dispute Deadlines for Submission:
   1. A deadline is imposed for receipt of provider disputes. The deadline is 90 calendar days from the last date of action on the issue, or in the case of inaction, will not be less than 90 calendar days from the most recent time for contesting or denying claims has expired.
   2. If not received by the defined deadline, the dispute will be upheld and an untimely filing closure letter will be mailed to the provider.

G. Acknowledgement of Provider Disputes:
   1. Provider Disputes are acknowledged in writing within 15 working days of receipt for paper claim disputes and 2 working days for EDI claim disputes.

H. Dispute Resolution Time Frames:
   1. Incomplete Provider Disputes:
      a. Will be returned to the provider for more information within ~~45~~ 30 working days of receipt[VG30][LB31][LB32].
      b. Will clearly identify missing information needed to resolve the dispute.
      c. Cannot ask for claim documentation already submitted (unless returned to the Provider)
      d. Provider has 30 working days to submit additional information requested.
      e. If additional information is received timely, Medi Trans will process as a completed provider dispute within ~~45~~ 30 working days[VG33][LB34]
      f. If additional information is not received or not received timely, the provider dispute will be closed.
   2. Completed Provider Disputes:
      a. Medi Trans will make written determination of the dispute within ~~45~~ 30 working days
      b. Determination will state pertinent facts.
      c. Determination statement will provide explanations for the decision.

I. Disputes Decided in Whole or Part on Behalf of the Provider:
   1. Payment, including any applicable interest/penalties due will be made within 5 working days of the determination. The resolution letter will be printed and mailed 3 days prior to the date of payment and/or on the date of payment.

J. Good Will Payments
   1. Payment, including any applicable interest/penalties due will not be made to Medi Trans payments as payments are based on project status of claims.

K. Provider Right of Appeal:

1. If the provider dispute involves an issue of medical necessity or utilization management (UM, the provider has an unconditional right to appeal the determination to the corresponding Health Plan within 60 working days from Medi Trans's Date of Determination.

L. Interest:
   1. Interest and penalties are applied on completed PDRs after 45 working days from the date of receipt of a COMPLETE claim. (If the original claim was received complete/clean, interest will be applied from the original receipt date of the first submission.)
   2. Interest and penalties will not apply to "Good Will" payments.

M. Retention of Records:
   1. All records will be kept for a period of ten (10) years.

Provider Explanation of Payment (EOP)/ Remittance Advice (RA)

Check Payments and Stale Check Procedure

A. Checks payments are created in Sage system every Wednesday to be distributed on Friday. If the distribution day falls on a holiday both the printed checks and EFT payments are made the day before.
B. If needed, check will be voided and re-issued for payment.
C. All checks issued for payment are validated as "cashed" utilizing systemic reporting and stale checks will become void after 180 days.
D. Checks are mailed the same day they are printed.
E. If after 180 days, a check is not negotiated, the check is considered stale and is voided.
F. MediTrans will use all contact information available to try to locate the payee.
G. If contact is made with the payee, contact information will be updated and a new check issued.
H. For any payee that we are unable to get in contact with, MediTrans maintains a reserve account for the funds to assure that upon request, the funds are available to reissue payment.

Claims Telephone Inquiries and Communication

For Claims Inquiries, Medi Trans's:

A. Hours of operation are: 9am to 5pm
B. Claims Customer Service # is: 844-349-4326 option 9

Agents will be available during all operational hours to communicate:

A. Provider Payment Disputes (PPD)/Provider Payment Reconsideration (PPR)/Provider Dispute Resolution (PDR) rights, where and how to submit a PPD/PPR/PDR.
B. Member Grievances and Appeal rights
   Note: Agents will ensure that Member Grievances and Appeals are forwarded to the Health Plan or proper department, within 48 hours.

Additionally, Medi Trans:
A. Tracks and Trends Calls, such as:
   1. Number of Calls
   2. Type of calls (e.g. Member Grievance calls and Provider Payment Disputes (PPD)/Provider Payment Reconsideration (PPR), Provider Dispute Resolution (PDR) calls)
B. Audits and monitors call quality and accuracy
C. Utilizes all available means in an effort to implement an effective quality improvement process through the use of training, meetings and job aid materials.

Claims Document Storage and Retention

A. Medi Trans stores:
   1. ~~Claims history, in the Claims system, for a minimum of eighteen (18) months~~[VG35][LB36]
   1. Claims and Documents for a minimum of ten (10) years and longer if under legal or regulatory review
B. Medi Trans has the ability to:
   1. Retrieve Claims and Documents within three (3) days of request
   2. Produce an original paper copy of an electronically submitted claim

Claims Sub Delegates

All items related to Claims are performed by Medi Trans. Medi Trans does not subdelegate any Claims processing or functions to any other entities.

Disaster Recovery Plan

All MediTrans' systems are cloud-based and therefore continuously backed up and not subject to prolonged outages or lost data in the event of unforeseen event, such as an outage, flood, or cyberattack.

A. MediTrans' systems are mobile and can be activated prior to a disaster to avoid disruption or restored within minutes of losing power after a disaster event.
B. The Medi Trans Leadership team are notified of and declare a disaster and activates this contingency plan. The following are the contacts for the leadership team and their responsibilities in the Disaster Recovery Plan:
   a. Chief Operations Officer, Leah Begnaud- Personal Cell (337) 515-1909
      i. The COO will have the responsibility of declaring and initiating the Disaster Recovery and the initial communication to the Health Plan.

   ii. The COO will serve as the point person for communications and updates to the Health Plan after the initial notice.
b. Chief Technology Officer (CTO), Kelly Russell- Personal Cell (337) 519-8318
   i. The CTO will serve as the main point of contact between communications and software vendors.

C. All MediTrans systems are cloud-based and therefore continuously backed up to multiple, secure storage sites across the United States, creating multiple backup components to prevent loss of service.

Program Integrity Fraud, Waste and Abuse

A. All reviews shall be completed within ten months (300 calendar days) unless an extension is authorized. Requests for extensions to investigations are to be e-mailed to LDH as needed.
B. MediTrans reports all audits, overpayments identified, and recoveries by the company and its subcontractors, including subcontractors that pay claims (e.g., PBMs, transportation brokers)
C. MediTrans adjusts encounters when it discovers the data is incorrect or no longer valid or that some element of the claim needs to be changed.
D. When overpayments associated with fraud, waste, and abuse are identified, MediTrans will gather data and provide all supporting information to the Health Plan's fraud investigation unit for review. MediTrans will then await approval from the state and Plan to suspend payments if the allegation is found to be true. MediTrans will then suspend payments to the suspected entity until a final resolution has been made. If LDH or MediTrans determines that the provider should be removed from the Medicaid Transportation program, MediTrans will reroute all trips associated with the provider, suspend all payments, make the provider inactive so that no new trips can be accepted, and formally remove the provider from network via an official "cease and desist" notice sent to the business owner.
E. When overpayments associated with fraud, waste, and abuse are identified, MediTrans shall start the process of voiding or adjusting claims and encounters within 14 days of being considered final, regardless of recovery status. Overpayments are considered final when all appeals and grievances have been exhausted. All voids should be completed within 45 calendar days of the overpayment being considered final. A 45-calendar day extension will be allowed for those overpayments involving 500 or more claim lines.
F. All provider and enrollee fraud and abuse must be reported to the health plan. The health plan will report to the appropriate agencies as follows:

   1. Provider (confirmed) reported to Health Plan SIU via preferred report template
   2. Provider (suspected) reported to Health Plan SIU via preferred report template
   3. Enrollee (confirmed or suspected) reported to Health Plan SIU via preferred report template

G. Unless prior approval is obtained from LDH, Meditrans must not employ extrapolation methods to derive an overpayment in a provider audit. LDH follows published CMS guidelines used by Medicare recovery contractors to determine whether an extrapolation is permissible.

H. Monthly and quarterly reporting regarding tips, overpayments, billing/claims issues, disclosure of audits, and recovery statuses will be provided to the Health Plans per contractual reporting requirements.

Sanction and State Exclusion Reviews

All MediTrans staff and sub-delegates are checked against the OIG/SAM/State/National exclusion list on a monthly basis using Streamline Verify[VG37][LB38]. All exclusion reports are available upon request for audit purposes.

Staff and sub-delegates that are identified on the exclusion list are handled in accordance with standards outlined in Medi Trans's background check policy. Should a match be found, MediTrans will notify the health plans within 3 business days.

No claims will be paid to individuals found to be excluded from the program.

Ambulance Claims

Ambulance providers shall submit claims using the CMS 1500 Health Insurance Claim Form (paper) or the 837P (electronic)

Medicaid will not make payment on any claim denied by Medicare as not being medically necessary. For trips that are not covered by Medicare but are covered by Medicaid, payment will not be made unless the claim is filed with the Medicare explanation of benefits (EOB) attached stating the reason for denial by Medicare. For claims that fail to cross over electronically, a hard-copy claim may be filed up to six months after the date of the Medicare EOB, provided that the claim was filed with Medicare within a year of the date of service.

When billing for procedure codes A0425 ~~A0429, A0433-A0434~~, A0426, A0428,~~,~~ and ~~A0436~~ A0434 for ambulance transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit procedure code[VG39]. Different modifiers may be used for the same procedure code. The approved destination modifiers are: D, E, G, H, J, N, P, and R. -Spaces will not be recognized as a valid part of the 2-digit modifier.~~modifier for those procedures requiring a~~ modifier[VG40][LB41][LB42].