DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	8-22-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-090	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR C: Director Keck Cleared 8/1/11, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 8-31-11
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

David Giesen
SC DHHS
Department of Transportation
P.O. Box 8206
Columbia, SC 29202

RE: Appeal of SC Medicaid denial for Ephraim Jones claim number 1115200207813500A

Date: 08/15/2011

Patient: Ephraim Jones
Medicaid number: 0781025600
DOS: 05/17/2011

To David Giesen:

On 5/16/2011, Capital City Ambulance received a request for a long distance transport to New Jersey. We contacted Mumin concerning this transport and were given prior authorization for this transport. We conducted the transport and sent the bill to SC Medicaid for payment. We did not hear from Medicaid and contacted your office and talked with you concerning this transport. You said that you would walk the paperwork through processing so that we would receive payment. We received a remit dated 6/10/2011 with and "S", meaning that the claim was being considered for payment, for this transport. We then received a remit dated 6/17/2011 with an "R" rejecting the claim. We attempted to contact you several times concerning this transport but as of yet have not heard back from you.

We provided ambulance transport for this Medicaid patient based on the prior authorization and the fact that you would walk the paperwork through the processing expediting this claim; and for our efforts we have received a rejection. We request you reimburse Capital City Ambulance for the services provided to your Medicaid patient or at least provide a detailed explanation as to exactly why Medicaid will not reimburse Capital City for a prior authorized transport..

If you have any questions concerning this matter please contact Melissa Hickson at 803-442-9426.

Sincerely,

Melissa Hickson
Office Manager
Capital City Ambulance
Attachments

CC: Anthony E Keck, Director of SC Health and Human Services

TRANSMISSION VERIFICATION REPORT

TIME : 06/12/2011 19:28
NAME : CAPITAL CITY EMS
FAX : 8039290104
TEL : 8039290104
SER.# : 000E5J932832

DATE,TIME	06/12 19:27
FAX NO./NAME	18032558222
DURATION	00:01:09
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

CCN	Amount Billed	Dates of Service	Check Date	Check Number	Payment Type	Total Payment	Claim Status	Claim Status Date	Original CCN
11152002078135 00A	$9268.00	5/17/2011 to 5/17/2011	6/17/2011 12:00:00 AM				Rejected		

PROVIDER ID. 1104818152

000000634
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 06/10/2011

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE DATE(S) MMDDYY	RENDERED PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		051711	A0428	400.00	0.00	R			0HN		0.00	0.00
	02		051711	A0428	300.00	0.00	R			0HN		0.00	0.00
	03		051711	A0425	8568.00	0.00	S			0HN		0.00	0.00
524841	1115200208813500A				648.00	0.00	R	1781116338	P BUTLER				
	01		051911	A0427	600.00	0.00	R			0RH		0.00	0.00
	02		051911	A0425	48.00	0.00	R			0RH		0.00	0.00
									EDITS: L01 989		L02 989		
524961	1115200209813500A				651.60	176.41	P	5402009702	E HOLMES				
	01		051911	A0427	600.00	165.58	P			0RH		0.00	0.00
	02		051911	A0425	51.60	10.83	P			0RH		0.00	0.00
	TOTALS	42			30131.20	2786.66						0.00	0.00

$176.41

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

$0.00

CERT. PG TOT: $0.00
MEDICAID PG TOT: $2,786.66
CERTIFIED AMT: $0.00
MEDICAID TOTAL: $2,786.66
CHECK TOTAL: $2,786.66

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER: 5394857

PROVIDER NAME AND ADDRESS

CAPITAL CITY AMBULANCE INC
ATTN NANCY HICKSON
PO BOX 6365
NORTH AUGUSTA SC 29861

DHHS Claim Submission Tool!

Hide Menu

Eligibility Verification Results

Selection Criteria

Date Of Service:	05/17/2011	**Provider ID:**	**Provider NPI:**	1104818152
SC Medicaid ID:	0781025600	**SSN:**		
Recipient First Name:		**Recipient Middle Initial:**	**Recipient Last Name:**	**Birthdate:**

New Search | Add to Recipient List

Eligibility Verification Information

Subscriber Data

Recipient Name:	EPHRAIM H JONES		
Address:	614 MASON ROAD		
City/State/Zip:	COLUMBIA, SC 29203-3849		
Recipient Medicaid ID Number:	0781025600		
Gender:	MALE		
Birthdate:	07091948	**DOS:**	05172011

Eligibility or Benefit Information

Subscriber is:	ELIGIBLE
Payment Category:	80, SSI
CoPay:	
Limited Benefit:	
Qualification Category	50, DISABLED
Qualified Medicare Beneficiary:	
Home Visits Remaining in the fiscal year:	50
Chiropractic visits remaining in the fiscal year:	6
Ambulatory visits remaining in the fiscal year:	
Mental Health services remaining in the fiscal year:	12

Recipient Special Programs Data

-- RSP Info----

RSP Code: MCCM

BILLING AUTHORIZATION / RESPONSIBILITY FOR PAYMENT & RECEIPT OF PRIVACY

Patient Name: EPHRAIM H. JONES Transport Date: 5/17/11

I understand that I am financially responsible for services provided to me by Capital City Ambulance (CCA) regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on behalf to CCA or its billing agent for any services provided to me by CCA. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services (formerly HCFA) and its carriers and agents, as well as to CCA and its billing agents, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by CCA, in the past, now or in the future. I agree to immediately remit to CCA any payments that I receive directly from any source for the services provided to me by CCA, now or in the future. A copy of this form is valid as the original.

By signing below I also hereby acknowledge that I have been provided with a copy of CCA's Notice of Privacy Practices on this date.

SIGNATURE SECTION:
ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X Ephraim H. Jones 5/17/11
Patient Signature or Mark Date

If the patient signs with an "X" or other mark, someone should sign below as a witness. This can be an ambulance crew member.

X _____ _____
Witness Signature Date

_____
Witness Printed Name

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

- ☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
- ☐ Relative or other person who receives government benefits on behalf of patient
- ☐ Relative or other person who arranges treatment or handles the patient's affairs
- ☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ _____ _____
Representative Signature Date Printed Name of Representative

_____
Representative's Address

SECTION III–AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, and (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason patient incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____ _____
Signature of Crewmember Date Printed Name of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

X _____ _____ _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

Physician Certification Statement For Medicare
Used for determining MEDICAL NECESSITY for Ambulance Transportations

Certification Date *Max of 60 Days ___/___/___ to ___/___/___

Contact Name and Phone Number @Destination _____

Section 1-Beneficiary Information

Patient Name: Ephraim Jones **Medicare #:** _____
Is the patient an inpatient? ☐Yes ☐No

SS# 147 40 7909 DOB _____ SEX: ☒Male ☐Female

Section 2-Transport Information

Transporting To: White House H & R Transporting From: RMP # 1033
Reason for Transport (Must include name of service/treatment/procedure the pt needs at the facility):

Is this service available at originating facility? ☐Yes ☐No Discharge? ☐Yes ☐No
If yes, why is this transport necessary? Admit? ☐Yes ☐No

Section 3-Medical Necessity Information (See reverse side for definition of Medical Necessity)

*Note: **Lack of alternative transportation services does not create a medical necessity for ambulance services.** Describe the patient's condition (not diagnosis) at the time of pickup and/or discharge that necessitated utilization of an ambulance (see reverse for HCFA definition of medical necessity)
Please check all appropriate boxes:

☒Unable to get out of bed without assistance; and ambulate; and unable to sit in a chair, including a wheelchair(~~Bed confined~~)
☐Dementia, ☐Late stage Alzheimer's ☐Severe Altered Mental Status ☐Decreased level of consciousness
☐Frail ☐Debilitated ☐Extreme muscle atrophy ☐risk of falling out of wheelchair while in motion
☐Requires O2 Liters per minute_____
☐Requires airway monitoring or suctioning during transport.
☐IV Maintenance required during transport.
☐Requires trained personnel to monitor condition during transport due to:
☐Comatose ☐Medicated ☐Seizures ☐Other_____
☐Suffers from paralysis or contractures ☐Lower Extremties ☐Fetal
☐Danger to self and others, may require restraints ☐Verbal ☐Chemical ☐Physical ☐Flight Risk
☐Has decubitus ulcers and requires wound precautions ☐Buttocks ☐Sacral ☐Back ☐Hip
What stage Decubitus? _____ ☐Other_____
☐Requires EKG monitoring
☐Needs to remain immobile due to fracture What type of fracture_____ Date of fx:_____
☐Patient's mental status is altered due to ☐Psych ☐Combative ☐Aggressive/Abuse ☐Danger to self/others
(Specify)_____

Section 4-Ordering Physician Information and Signature

Print Name of physician ordering ambulance service UPIN:_____ FAX_____

I certify that the above information is true and correct based on my evaluation of the patient. I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for ambulance service.

[signature] RN Jaynes Dancy 5/17/[illegible]
Authorized Signature *Printed Name* *Date*

Please send to Capital City Ambulance PO BOX 6365 North Augusta, SC 29841 Fax 803-442-9024 Phone 803-442-9426

LogistiCare

DAILY TRIP LOG

Mail Invoices to:

Capital City
Provider Name:

5/21/11
WEEK ENDING:

Susan A. Erwin
DRIVER'S NAME (as it appears on drivers license)

21531
Vehicle Number (Last six of the VIN)

Date of Service	LogistiCare Job # A or B	Recipient's Name	A W S	Pick-up Time	Drop-Off Time	Will Call Time	Total Trip Mileage	Per Trip Billed Amount	Recipient's Signature
5/17/11		Ephraim H. Jones	S	0550			71.4		Ephraim H. Jones

NOTE* *Leg of transport--a leg of transport is the point of pick-up to the destination. Example: Picking recipient up at residence and transporting to the doctor's office would be considered one leg; picking the recipient up at the doctor's office and transporting back to the residence would be considered the second leg of the trip. Each leg of the transport* must be documented on separate lines. A signature is required for each leg of the transport. Pick-up and drop-off times **must** be documented **and** in military time.

Driver's Comments:

I understand that LogistiCare Solutions will verify the accuracy of the mileage being reported and I hereby certify the information herein is true, correct, and accurate.

DRIVER'S SIGNATURE: Susan A. Erwin

RECEIVED 08.22.2011
Dental, DME, Hospital
Transportation

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

David, pls prepare response 2/

TO	DATE
Giese Vaughn	8-22-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-090	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ C: Director Kiele	[X] Prepare reply for appropriate signature DATE DUE 8-31-11 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer)	COMMENT
1.	8/25/11 8/29/11		
2.			
3.			
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF DIRECTOR

ACTION REFERRAL

Claim subm. [illegible] Adjustment for Payment will watch for Payment

TO	DATE
Giese	8-22-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 0011090	[ ] Prepare reply for the Director's signature DATE DUE
2. DATE SIGNED BY DIRECTOR	[X] Prepare reply for appropriate signature DATE DUE 8-31-11
C: ~~Director Keck~~	[ ] FOIA DATE DUE

APPROV... (Only when pr... for director's si...)			...T
1.			
2.			
3.			
4.			

Zenovia — Mr. Padgett called this am to speak w/ Tony, routed to me to handle. Pls call today on my behalf & let me know. - BZ

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

September 1, 2011

Ms. Melissa Hickson
Office Manager
Capital City Ambulance
Post Office Box 6364
North Augusta, South Carolina 29861

Dear Ms. Hickson:

Thank you for your letter regarding issues with Medicaid payments for ambulance transports. I understand that on August 23, 2011, you spoke with Zenovia Vaughn, Program Director for Transportation. I'm pleased that the issues you discussed are being reviewed, and that she followed-up with you on Monday, August 29th.

I have also reviewed your letter to Mr. David Geisen. Your claim for Mr. Ephraim Jones has been submitted for reprocessing. If you do not see the results of that claim within the next 2 payment cycles, please contact Ms. Vaughn for follow up.

If you have additional questions or concerns please contact Ms. Vaughn at (803) 898-2665. We appreciate your continued support and participation of the Medicaid program.

Sincerely,

Melanie "Bz" Giese, RN
Deputy Director

MG/vw

Medical and Managed Care Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-0178 • Fax (803) 255-8235