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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

The South Carolina Medicaid program sponsors ambulance transportation to Medicaid covered services in two ways: through the Broker model and outside the Broker model. The South Carolina Medicaid program will sponsor only "medically necessary" ambulance transportation.

Ambulance transportation is considered medically necessary if the following conditions exist:

- The beneficiary is transported in an emergency situation (*e.g.*, as a result of an accident, injury, or acute illness).
- The beneficiary is transported in a non-emergency situation as warranted by the patient's condition and any other method of transportation is inappropriate.
- The Department of Health and Environmental Control (DHEC) Ambulance Run Report justifies the condition and/or treatment of the level of service billed.

Payment will not be made for ambulance service in a case where another means of transportation could be utilized without endangering the beneficiary's health. For example, if a beneficiary does not meet medical necessity criteria, he should be instructed to contact the broker.

The South Carolina Medicaid program will reimburse for ambulance services using the lower amount of the provider's actual submitted charges or the established program fee schedule.

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PROGRAM OVERVIEW

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

Enrollment

Providers wishing to participate in the South Carolina Medicaid program must contact SCDHHS at the following address to request an enrollment package:

SCDHHS
SC Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

Providers must complete the enrollment form and return it to SCDHHS.

Licensing

The Department of Health and Environmental Control (DHEC) Code of Regulation 61-7, South Carolina Code of Laws of 1976, Statutory Authority Section 44-61-150, sets forth the current minimum standards for ambulance operations in South Carolina. South Carolina Medicaid will only reimburse ambulance providers who are in compliance with all current DHEC regulations, including revisions, for the services rendered. Out-of-state providers must be licensed and certified by their respective states.

South Carolina Medical Service Area (SCMSA)

The South Carolina Medicaid program will sponsor ambulance services rendered in the South Carolina Medical Service Area (SCMSA). SCMSA includes all of South Carolina and area(s) within 25 miles of the South Carolina Border. If any part of the metropolitan area of the city such as Charlotte, Augusta, Savannah, etc., is within 25 miles of the state border, the entire metropolitan area is considered to be within the SMCSA. Any ambulance services rendered outside of the SCMSA requires prior approval from the SCDHHS Ambulance Provider representative. The following six locations are pre-approved destinations:

1. Emory University Medical Center – Atlanta, GA
2. Henrietta Eggleston Hospital – Atlanta, GA
3. Duke Medical Center – Durham, NC

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PROGRAM REQUIREMENTS

South Carolina Medical Service Area (SCMSA) (Cont'd.)

4. University of North Carolina School of Medicine - Chapel Hill, NC
5. Wake Forest University, Bowman Gray School of Medicine – Winston-Salem, NC
6. Pinehurst Hospital – Pinehurst, NC

Note: This list is not all-inclusive. Refer to the SCMSA section in the Appendices.

Out-of-State Transport

The South Carolina Medicaid program will sponsor ambulance services rendered outside the South Carolina Medical Service Area (SCMSA) in the following situations:

- A medically necessary service is provided to a SC beneficiary traveling outside the SCMSA. The provider providing the services, must:
- Be licensed and/or certified by the state in which it operates,
- Be enrolled in the South Carolina Medicaid program, and
- Follow all of the rules outlined for the transportation service that was rendered.
- A referral is made for an ambulance service provided outside of the SCMSA, and the service is not available within the state.
- A request is made for air ambulance service out of the SCMSA.

All ambulance services provided out of the SCMSA, with the exception of emergency services, **must have prior approval from SCDHHS.** Prior approval can be obtained by contacting the SCDHHS Physician Services Provider Representative at (803) 898-2660.

If the need to transport a beneficiary falls outside of the normal working hours (*i.e.*, weekends or after 5 p.m. Monday thru Friday) and there is no time to obtain prior authorization before making the transport, then the approval must be requested from the Physician Services Provider Representative the next business day.

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PROGRAM REQUIREMENTS

DOCUMENTATION REQUIREMENTS

Documentation is necessary to show evidence that billed services were provided and were medically necessary. If during a review sufficient documentation is not available to support the paid claims filed by the provider, then Medicaid funds could be subject to recoupment.

Transport/Trip

A transport or trip is defined as a pickup and transport to or from a Medicaid service.

DHEC Run Report

Each time an ambulance service responds to a call, South Carolina law requires that a DHEC approved Ambulance Run Report be completed to document the trip. The Ambulance Run Report is a medical document that can be used to record a patient's treatment and must be maintained in the beneficiary's record for all ambulance transports. Refer to the Forms section for an example of the DHEC Ambulance Run Report.

Client Record

There must be a record for each client/patient that includes sufficient documentation of services rendered to justify Medicaid participation. The record should be arranged in a logical manner so that services can be easily and clearly reviewed and audited. All clinical records must be kept in a confidential and safeguarded manner as outlined in Section 1.

Additional Documentation

Additional documentation justifying medical necessity and vehicle odometer readings supporting mileage charges for the transport should be included in the beneficiary's record. All paid claims are subject to post-payment review to verify program compliance and the appropriate level of care billed.

ICD-9 Code

When billing ambulance transportation services, providers must use a valid diagnosis code to reflect the current medical condition/problem that requires the transport.

Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) must be filed in the beneficiary record if the beneficiary has other health insurance. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3).

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PROGRAM REQUIREMENTS

Abbreviations and Symbols

Each provider must maintain a list of approved abbreviations and symbols used in a patient/client record documentation.

Legibility

All entries and supporting documentation (*i.e.*, DHEC Run Report, DHHS Form 216, EOB) must be in ink or typed, legible, and in chronological order. Entries must be dated and signed with the staff person's name and title. Copies of documents must be clear and readable.

Error Correction

The beneficiary's record is a legal document and should be corrected with caution. Each provider must have a document error correction policy in place. At a minimum, single entry errors should be corrected as follows:

- A single line drawn through the error so that the words remain legible
- The word "error" written above or beside the error
- The correction entered
- Signed, initialed, and dated

Errors should not be erased or totally obliterated.

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PROGRAM SERVICES

COVERED SERVICES

Mileage

Mileage is paid from the point of pickup to the point of destination.

Supplies

All supplies and drugs are included in the ambulance transport fee.

Extra Attendant

An extra certified ambulance attendant will be covered if needed. The DHEC Run Report must explain the necessity for using an additional attendant.

Waiting Time

Ambulance waiting time may be billed when an ambulance transports a beneficiary to receive services. It is billed in one half hour increments (the first half-hour is not reimbursable). Waiting time charges cannot exceed the return trip charges. The DHEC Run Report must support any waiting time billed.

Multiple Beneficiaries in a Single Trip

Ambulance providers may transport more than one beneficiary at the same time. A multiple beneficiary transport may be either an emergency or a non-emergency service. Separate documentation for each beneficiary that is transported is required. The claim should include the appropriate base rate. **The mileage charge should be billed to only one of the beneficiaries transported.**

TRANSPORTS

Advanced Life Support Services (ALS) (A0426, A0427)

An Advanced Life Support (ALS) transport provides the staff and equipment necessary to beneficiaries that require an advanced level of care during the transport. The transport must be properly documented on a DHEC Run Report. DHHS will use the Call Type section to determine if the transport was an emergency.

Documentation

DHEC Run Report

The Advanced Procedures section is used to denote advanced medical procedures rendered during the transport. The comments section of the DHEC Run Report

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

DHEC Run Report (Cont'd.)

should further document the advanced procedures rendered at the scene and during the transport.

In addition to the Advanced Procedures section and the Treatment Procedures section, the Drugs Used section and the Revised Trauma Score section may be needed to describe the care provided at the scene or during transport. Again, the comment section of the DHEC 1050 Run Report should further document the procedures/treatments rendered at the scene and during the transport.

The primary and/or secondary attendant's signature(s) and certification number must be documented. The attendant's certification number should begin with 8 or 9 to designate the following

8 – Paramedic

9 – Intermediate Emergency Medical Technician (EMT)

Neonatal Transport (A0225)

A Neonatal transport is an advanced life support (ALS) transport that provides the staff and equipment necessary to treat and transport a fragile neonate. This transport is used when transporting a fragile neonate that is less than one month old. All supplies and mileage are included in the basic transport rate.

Intensive Care Unit (ICU) or Special Neonatal Transport (X0401, X0402)

An ICU transport is used when transporting beneficiaries that require a high degree of care. The transport requires a vehicle licensed by DHEC and highly specialized equipment. A nurse, a doctor, or a specially trained paramedic is necessary for treatment and transport. All supplies are included in the basic transport rate.

Code X0402 is used for ICU ground mileage, per statue mile.

Air Ambulance (A0430, A0431, A0435)

All air transports require documentation to be attached to the claim. Documentation includes a flight run report **(same as a DHEC Form 1050)** and any other appropriate documentation. The reimbursement rate for rotary air ambulance transportation (A0431) is inclusive of the cost for air mileage and supplies for the rotary air transport. When code A0431 is used, mileage should not be billed separately.

Code A0430 is used for Ambulance Service, Conventional Air Services Transport, One Way Fixed Wing (FW).

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PROGRAM SERVICES

Air Ambulance (A0430, A0431, A0435) (Cont'd.)

Code A0435 is used for Fixed Wing air mileage, per statue mile.

Ground transport to and from the site of transfer (*i.e.*, airport) is a separate billable service that is reimbursed at the appropriate ground transport rate.

Basic Life Support (BLS) Transport Service (A0428, A0429)

A Basic Life Support (BLS) transport provides the staff and equipment necessary for beneficiaries that require basic care and treatment during transport. A BLS transport may be a broker sponsored service or billed fee for service. **Scheduled or planned non-emergency BLS transports must be coordinated with a transportation broker before the transport.**

BLS ambulance transportation services may be an emergency service or non-emergency service. When billing an emergency claim, a claim form and a DHEC Run Report are required. A BLS non-emergency transport may be billed fee for service if:

- A beneficiary's <u>current</u> medical condition is such that it requires active medical care or intervention by emergency medical technicians (EMTs) during the transport **AND** a claim form with a DHEC Run Report and a 216 Form are filed.

For the purpose of this manual, active medical care is defined as interventions required to maintain or return the beneficiary to a steady state of health. The intervention must be necessary to keep the beneficiary stable during the transport. Examples of interventions are noted on page 1 of the DHEC Ambulance Run Report in the Treatment Procedures Section.

Monitoring/checking the beneficiary's vital signs (blood pressure, pulse, respirations) and continuing assessment of the beneficiary's health status (checking vital signs, visual checks of condition) during transport are considered integral parts of beneficiary care and are not considered active medical care.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Documentation

DHEC Run Report

The DHEC Run Report includes the following: Type of Incident, the Call Type, the Patient Status, and any Treatment Procedures. The Drugs Used Section may be completed if ambulance personnel administered medication during the transport. The Comments Section must support all care provided at the scene and during transport and show a detailed account of the amount of physical effort required to transport the beneficiary.

DHHS 216 Form

When a beneficiary requires active medical care during a non-emergency transport, the DHEC Run Report and the DHHS 216 Form must be submitted with the claim.

- The DHHS 216 Form:
  1. Must be the correct version of the form. (Revised 11-07)
  2. Must denote where the beneficiary is being transported to and from.
  3. Must choose at least one item from the list of []. If none of the boxes are appropriate, the ambulance requestor must specify a medical condition on the line provided.
  4. The ambulance requestor must certify that it is necessary for the beneficiary to be transported by ambulance by signing the 216 Form under the certification statement. The requestor's complete name and title are used. The requestor must then print the name and title below the signature. **Only physicians, physician assistants, nurse practitioners, clinical nurse specialists, or registered nurses are authorized to sign the 216 Form.** Forms that are illegible or do not have a valid signature authority will cause the claim to reject.
  5. Odometer readings.

All non-broker BLS claims are reviewed by SCDHHS for level of care and medical necessity.

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PROGRAM SERVICES

BLS Return Trip

All return trips to the beneficiary's original place of pickup must be billed using code A0999 – Return Trip regardless of the number of dispatch orders issued.

NOTE: BLS return trips must meet 216 criteria <u>and</u> receive active medical care during transport.

Non-Transported Beneficiaries

Ambulance providers may bill for services rendered to beneficiaries at a scene even if it is determined that transport is not required. The following instances are examples of situations where providers may provide care at the scene but not transport.

- The ambulance is called and medically necessary services are provided; however, the beneficiary refuses to be transported or transportation is no longer necessary. Services should be billed using Procedure Code A0998 (Treatment/No Transport).
- Two vehicles respond to the same emergency call and both provide medically necessary services; however, only one transports the beneficiary for further medical care. The vehicle that responded but did not transport, may bill the A0998 procedure code and one-way mileage (*i.e.,* for a major accident, and when multiple vehicles are called).

Transport of Dually Eligible Beneficiaries

Medicare rates for Skilled Nursing Facilities (SNF) may include costs for transporting residents of the facility. If transportation is not specifically excluded from the SNF Rate, the cost of transportation is the responsibility of the facility if the transportation is medically necessary. If transportation is excluded from the SNF Rate and the beneficiary meets the medical necessity criteria, the transportation provider must bill Medicare. Refer to the chart in the Appendices section.

Transport of Deceased Persons

Transport of deceased persons is covered under the following conditions:

- When a beneficiary is pronounced dead after an ambulance transport is requested but before the ambulance arrives.
- When a beneficiary is pronounced dead in route to or upon arrival at the transport destination.

Services should be billed using the appropriate procedure.

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PROGRAM SERVICES

Transport of Deceased Persons (Cont'd.)

All supporting documentation must be submitted when billing for the service.

BROKER ARRANGED AMBULANCE SERVICES

This information should assist providers to answer telephone calls from beneficiaries who are not eligible for ambulance services outside of the Medicaid Broker. If a beneficiary does not meet the criteria for transport outside of the broker **(the criteria = requires active medical care or intervention during transport)**, they should be instructed to call the non-emergency transportation broker in the county in which they reside. The broker will provide Medicaid transportation services for routine non-emergency ambulance transportation to medical appointments and non-emergency BLS transports which are planned/scheduled trips (*i.e.,* transport from a nursing home to a physician's office, a nursing home to a dialysis center, or a hospital to residence). The broker will also provide non-emergency transportation for beneficiaries requiring stretcher or wheelchair service. Refer to Section 5 for a list of South Carolina Department of Health and Human Services county offices and Non-Ambulance Medical Transportation Brokers.

Scheduling Transports

For Medicaid beneficiaries of all ages, South Carolina Medicaid covers necessary non-emergency transportation to and from South Carolina Medicaid covered services for eligible beneficiaries. It is also the responsibility of the Broker to:

- Receive the transportation request (beneficiary name, date transport needed, and other pertinent beneficiary and appointment information necessary to arrange/schedule the transport).
- Determine the appropriate method of transport, book the transport, and inform the beneficiary and medical facility (if applicable) of the transport information.
- Ensure transportation requests include weekends and holidays, if necessary.

The beneficiary or a person designated by the beneficiary to act on their behalf (*i.e.,* a neighbor, a hospital, a social worker, etc.) must make the request for transportation through the **non-emergency transportation broker in the county in which they reside.**

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PROGRAM SERVICES

Scheduling Transports (Cont'd.)

Note: The Medical Transportation Broker will determine when transportation request meet medical necessity criteria and require a higher level of care for transport. (Refer to DHHS 216 Form section of the manual.) If the broker denies a non-emergency transport, the file should be documented with the date of the denial, time denied, reason for denial, and name of the person denying the transport.

Non-Covered Services

The following ambulance transports are not covered:

- When a beneficiary is pronounced dead before the ambulance transport is called.
- When the ambulance transport is to a coroner's office, a morgue, a funeral home, or any other non-medical facility.
- Free ambulance services
- Convenience Transports
- Intra-facility Transports
- Inpatient Hospital Services (offsite) – when a beneficiary remains an inpatient of the hospital, all services rendered to the beneficiary including ambulance transports are included in the hospital DRG payment. (e.g., if a member remains on the census as an inpatient at Hospital A and is only traveling to Hospital B for a diagnostic test or procedure not available at A, the DRG Facility is responsible). Ambulance providers and the hospital facility should determine payment procedures when rendering services to an inpatient beneficiary.

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