

**SECTION 2**  
**POLICIES AND PROCEDURES**

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## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM OVERVIEW

The South Carolina Medicaid program sponsors transportation to Medicaid covered services in three ways: through the Broker model, for non-emergency transportation (ground and air), outside the Broker model, fee-for-service, emergency transportation, Manage Care Organizations (MCOs) and Medical Home Networks (MHNs) for beneficiaries enrolled in a manage care plan. The South Carolina Medicaid program will sponsor only “medically necessary” ambulance transportation.

Ambulance fee-for-service transportation is considered medically necessary if the following conditions exist:

- 911 is called and the beneficiary is transported in an emergency situation (*e.g.*, as a result of an accident, injury, or acute illness), and any other method of transportation is inappropriate.
- The Department of Health and Environmental Control (DHEC) approved Ambulance Run Report justifies the emergency conditions 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 is not transported in any emergency situation, the beneficiary 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.

## **SECTION 2 POLICIES AND PROCEDURES**

### **PROGRAM OVERVIEW**

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## SECTION 2 POLICIES AND PROCEDURES

### 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 (all facilities) – 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.

#### 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.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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).
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>i.e.</i> , DHEC Run Report, 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	<p>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:</p> <ul style="list-style-type: none"><li>• A single line drawn through the error so that the words remain legible</li><li>• The word "error" written above or beside the error</li><li>• The correction entered</li><li>• Signed, initialed, and dated</li></ul> <p>Errors should not be erased or totally obliterated.</p>
Verification of Eligibility	<p>Claims involving retroactive eligibility must be received within six months of the beneficiary's eligibility determination or one year from the date of service delivery, whichever is later. When the date of service is over a year old, claims should be submitted to the program area manager with a DHHS Form 945 (Verification of Eligibility) from the county SCDHHS office verifying the retroactive determination.</p> <p>When a claim involving retroactive eligibility is rejected for edit 510 or CARC 29 (date of service is more than one year old), it is the provider's responsibility to contact the</p>

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### PROGRAM REQUIREMENTS

#### Verification of Eligibility (Cont'd.)

county SCDHHS office to obtain a DHHS Form 945. The form must state when eligibility was added to the system and the dates of eligibility.

Note: Retroactive claims must be submitted to the program area manager within six month from the time eligibility was added to the system. The Transportation Department can only accept retroactive eligibility on a DHHS 945 form; no other forms or printout will be accepted in lieu of the DHHS 945 Form.

## SECTION 2 POLICIES AND PROCEDURES

### 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. <b>The mileage charge should be billed to only one of the beneficiaries transported.</b>

#### TRANSPORTS

##### Advanced Life Support Services (ALS) (A0427)

An Advanced Life Support (ALS) Emergency 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.

NOTE: This is a 911 service call

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### 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 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)

A copy of the DHEC Run Report is located in the Forms section of this manual or a DHEC approved computer generated Run Report may be used in lieu of the DHEC 1050.

##### 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 (ICU ground mileage, per mile) is billed only when X0401 is billed.

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### PROGRAM SERVICES

#### Air Ambulance Emergency Transport (A0430, A0431, A0435)

An Emergency Air Ambulance Transport is a transport that may be billed fee-for-service if the following occurs:

- 911 is called and the beneficiary is transported under emergency conditions only (eg. collision, drowning, fall, etc.).

All air transports require documentation to be attached to the claim. Documentation includes a flight run report (**same as a DHEC Run Report**) 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).

Code A0435 is used for Fixed Wing air mileage, per statute mile. This code is used only to bill air mileage when A0430 is billed.

Note: All fee-for-service air transport claims are subject to review by SCDHHS transportation staff for emergency necessity criteria. All non-emergency air transports should be coordinated with the Broker.

#### Basic Life Support (BLS) Emergency Transport Service (A0429)

A Basic Life Support Emergency Transport provides staff and equipment necessary for beneficiaries that require basic emergency care and treatment during transport.

A Basic Life Support Emergency Transport may be billed fee-for-service when the following occurs:

- 911 is called and the beneficiary is transported in an emergency situation.
- The Run Report call type on the DHEC Report is annotated, dispatched emergent at scene of emergent, and transport is emergent.
- The emergency is identified and documented in the comments section on the DHEC Run Report.

Transport is to or from the site of transfer (*i.e.*, airport or helicopter pad) between modes of emergency air ambulance transports. This is a separate billable service that is reimbursed at the appropriate ground transport rate.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### Unlisted Ambulance Service (A0999) Transport Of Deceased Persons

This code is billed for the 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. All supporting documentation must be submitted.

#### 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. The Comments Section must also be used to document the details of the active, ongoing medical treatment section. For example, you should note the amount of oxygen administered to the patient, details of the suctioning method, etc.

A copy of the DHEC Run Report is located in the Forms section of this manual.

#### 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;

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### Non-Transported Beneficiaries (Cont'd.)

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.

#### 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 emergency transportation, 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 the following:

- **All** non-emergency ambulance transportation to medical appointments and non-emergency ~~BLS~~ transports which are planned/scheduled trips.
- Transports from a nursing home to a physician's office, a nursing home to a dialysis center, or hospital to residence.
- Non-emergency transportation for beneficiaries requiring stretcher or wheelchair service.
- Non-emergency transportation services to beneficiaries traveling out of state for prior authorized medical services, (eg. lodging, meals, etc).
- Non-emergency air transports for both Rotary and Fixed Wing air flights.
- Transportation for beneficiaries who receive retroactive eligibility.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### BROKER ARRANGED AMBULANCE SERVICES (CONT'D.)

NOTE: 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.

Refer to Section 5 for a list of South Carolina Department of Health and Human Services county offices and Non-Emergency Medical Transportation Brokers.

#### MANAGE CARE ORGANIZATIONS AND MEDICAL HOME NETWORKS TRANSPORTATION SERVICES

All transportation services for beneficiaries enrolled in a Manage Care Plan or Medical Home Networks are the responsibility of the MCO. MCOs are responsible for all ambulance transports for Advanced Life Support (ALS) or Basic Life Support (BLS) either emergency or Non-Emergency transports billable by an Ambulance Provider. These trips may be routine or non-routine transports to a Medicaid covered service. The MCO will provide stretcher trips, as well as, air ambulance or medivac transportation.

In the event that an ambulance is called to a location but not used for transport (i.e., the Medicaid MCO beneficiary is not taken to a medical services provider), the MCO is still responsible for payment to the provider. The MCO may review ambulance services; however, the contractual definition of medical necessity must be used as guidance in making determinations. MCOs may require the same level of documentation from the Provider as required by the fee-for-services system. Beneficiaries requiring out-of-state Medical Services are eligible for prior authorized transportation as described below:

- If the MCO authorizes out-of-state referral services and the service is available in-state, the MCO is responsible for all Medicaid covered services related to the referral to include all modes of transportation, escorts, meals and lodging.
- If the MCO authorizes out-of-state services and the service is not available in-state, the MCO will be responsible for the cost of referral services and any ambulance or Medivac transportation.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### 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.**

#### 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 (site/facilities on campus)
- Alcohol related transports, unless the beneficiary is enrolled in a rehabilitation program and is being transported for rehabilitation services.
- 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

## **SECTION 2 POLICIES AND PROCEDURES**

### **PROGRAM SERVICES**

#### **Non-Covered Services (Cont'd.)**

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.