SECTION 2

POLICIES AND PROCEDURES

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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 the Medical Home Networks - Medically Complex Children's Waiver (MCCW) 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. Please visit the SCDHHS Web site at http://www.scdhhs.gov for the current fee schedule.

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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 pay for ambulance services rendered in the South Carolina Medical Service Area (SCMSA), which meet all the requirements in this manual. The 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.

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.

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PROGRAM REQUIREMENTS

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-Code

When billing ambulance transportation services, providers must use a valid diagnosis code from the current edition of the International Classification of Diseases, Clinical Modification (ICD-CM) to reflect the current medical condition/problem that requires the transport. Medicaid requires full ICD-CM diagnosis codes. Refer to Section 3 for more detailed information regarding diagnosis code requirements.

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.

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Legibility

All entries and supporting documentation (*i.e.*, 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

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.

Verification of Eligibility

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.

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 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.

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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) (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.

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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, A0390)

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 A0390 (ICU ground mileage, per mile) is billed only when X0401 is billed.

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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 (*e.g.*, 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 statue 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.

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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; however, only one transports the beneficiary for further medical care. The vehicle that responded but

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Non-Transported Beneficiaries (Cont'd.)

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.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

Effective June 1, 2014, SCDHHS will amend the non-emergency transportation policy for self-administered oxygen dependent beneficiaries discharged from inpatient hospitals or emergency rooms. The policy applies to beneficiaries who are admitted, as an inpatient of a Hospital or Hospital Emergency Room, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. **Hospitals and Ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries.** All provider types and services are subject to post payment review by the Division of Program Integrity.

It is the responsibility of both the Hospital and DME provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the Hospital or Hospital Emergency Room in order for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting hospital facility.

SCDHHS will reimburse for a portable oxygen system, E0443 billed with a U1 modifier (Medicaid Level of Care 1), and the dispensing DME provider will be reimbursed at

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Transportation of Self-Administered Oxygen Dependent Beneficiaries (Cont'd.)

a rate of $20.00 per occurrence. SCDHHS will limit the number of occurrences per patient to no more than three occurrences per calendar month. Services that exceed three occurrences per calendar month will not be reimbursed.

It is the responsibility of EMS providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

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 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, (*e.g.*, lodging, meals, etc).
- Non-emergency air transports for both Rotary and Fixed Wing air flights.
- Transportation for beneficiaries who receive retroactive eligibility.

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 Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us.

The SCDHHS county office listing is located on the website at https://www.scdhhs.gov/site-page/where-go-

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BROKER ARRANGED AMBULANCE SERVICES (CONT'D.)

help. Refer to Section 5 for a list of Non-Emergency Medical Transportation Brokers.

MANAGED CARE ORGANIZATIONS TRANSPORTATION SERVICES

All transportation services for beneficiaries enrolled in a Manage Care Plan or the Medical Home Network-Medically Complex Children's Waiver (MCCW) 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 instate, the MCO will be responsible for the cost of referral services and any ambulance or Medivac transportation.

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

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Scheduling Transports (Cont'd.)

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 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.