

**SC Department of Health and Human Services
Transportation/Ambulance Workshop
Questions & Answers
07/10/08**

Note: This is a record of questions asked and answers given during the South Carolina Department of Health and Human Services' Medicaid Basics workshops. It is intended as a rough guide to topics covered during those sessions. For program-specific policy information, you should always contact your program representative and/or refer to your program manual.

Question 1: If an RN has not seen the service, can a random RN sign the 216?

Answer: *When a non-emergency ambulance service is provided, the person requesting the service is authorized to sign the 216 Form. An attending physician, physician's assistant, nurse practitioner, clinical nurse specialist or registered nurse at the requesting facility must co-sign the 216 Form, if the requestor is not authorized to document medical necessity.*

Question 2: Are we responsible for filing an emergency on a non-emergency beneficiary?

Answer: *You should use the billing code that most accurately describes your services during the transport. However, if a beneficiary has indicated an emergency situation that in fact is not, the ambulance provider can inform the beneficiary in writing prior to the transport that he/she is not being accepted as a Medicaid patient. This will allow the provider to bill the person directly for any services rendered.*

Question 3: What happens if you cannot find the Medicaid ID# (Whether using the WT on IVRS, but the beneficiary does not have Medicaid)?

Answer: *For Broker transports, if a beneficiary is not Medicaid eligible on the date of transport, a transportation service should not be billed. For fee-for-service transports, when a beneficiary becomes Medicaid eligible, a provider may bill retroactively for service if a member meets medical necessity criteria.*

Question 4: If the beneficiary is coming from the residence, how do you get a signature? Who needs to sign it? What if the facility does not want to sign it – Form 216?

Answer: *Neither the beneficiary nor the patient's family is authorized to sign the 216 forms. When it is known that a beneficiary whose medical condition is such that transport by any means other than ambulance is detrimental, the attending physician, physician's assistant, nurse practitioner, a clinical nurse specialist, or RN must request the*

transport. The required information (signature, title, condition, and mileage) must be legibly documented on the form. If the above conditions are not met, the service should not be billed to Medicaid. The transportation provider should verify authorization with the attending facility prior to transporting the beneficiary.

Question 5: If you are rendering a non-emergent service, will documentation suffice if we cannot get a signature? (The 216 form)

Answer: No, the signature of the attending physician, physician's assistant, nurse practitioner, clinical nurse specialist, or RN must be present to certify that a beneficiary's medical condition is such that transport by any means other than ambulance is detrimental to the beneficiary.

Question 6: Can we bill the patient for non-covered Medical service?

Answer: If the beneficiary was initially accepted for Medicaid covered transportation services, the provider cannot bill the beneficiary. However, as stated above in Question 2, the beneficiary can be held responsible if the ambulance provider informs the person prior to transport that they are not accepting him/her as a Medicaid beneficiary.

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07/11/08**

Question 1: How many Brokers do you have? How many regions?

Answer: Two (2) Brokers: LogistiCare and MTM. The Broker network is divided into six (6) regions. LogistiCare covers 4 regions, including the Midlands, the Lowcountry, and the Pee Dee areas. MTM covers two regions, including the Upstate area.

Question 2: If you are having a problem with the Broker?

Answer: Contact the Transportation Department at (803) 898-4614.

Question 3: Assisted living facilities often do not have providers who can sign the DHHS 216. How do we handle when none are on staff?

Answer: When a non-emergency ambulance service is provided, only the person requesting the service is authorized to sign the 216 Form. An attending physician, physician's assistant, nurse practitioner, clinical nurse specialist or registered nurse at the requesting facility must co-sign the 216 Form in order for the claim to be paid.

Question 4: Can we use the original form that the LPN has signed, and have the RN sign it in order to file?

Answer: Yes

Question 5: From and To on Form 216 is not a covered service; residence needs to be listed on Form 216.

Answer: From and To are headers for location only. See Medicaid Bulletin, dated November 20, 2007, for current version of DHHS Form 216.

Question 6: On Web Tool, if you have a crossover claim (Medicare and Medicaid), what do you need to do?

Answer: *Medicare claims no longer crossover to Medicaid, effective 10/20/2001. Providers will need to submit claims to Medicare before submitting to Medicaid.*

Question 7: Is oxygen required for transport? Brokers have not been signing off on it?

Answer: *When beneficiaries have self-administrated oxygen, Broker sponsored transportation is appropriate. When self-administrated oxygen is not available, but medical necessity criteria is met, DHHS Form 216 may be used to authorize the transport. The ambulance transport unit must provide continuous oxygen and monitoring during the transport and DHHS form 216 must be authorized by the appropriate medical personnel.*

Question 8: Does any wheelchair transport get oxygen v. an ambulance transport? The beneficiary does not have the oxygen with them and need transport to provide oxygen?

Answer: *See previous question.*

Question 9: If Medicare is primary what do you do?

Answer: *Contact the Broker to arrange non-emergency, follow Medicare's policy and procedures and bill as appropriate.*

Question 10: If we send in all three forms, why do we need an edit correction form (ECF) before we get paid? We are getting the 216 again and we are getting a timely filing denial.

Answer: *Reimbursement is based on full compliance with Medicaid Ambulance policies and procedures.*

Question 11: If all information/documentation is correct, we are going to get paid, right?

Answer: *See previous question.*

Question 12: Do all non-emergent transports have to go through the Broker?

Answer: *Yes, all non-emergent transports should be first coordinated with the Broker.*

Question 13: The Broker called about a patient seven months ago, but Medicaid is saying that it will not pay? Beneficiary is a high blood pressure patient and we have all the paper work.

Answer: *If the beneficiary's medical condition (at the time of transport) did not meet medical necessity criteria, Medicaid will deny reimbursement for the claim.*

Question 14: In order to transport from the residence to the physician's office, do we need the 216?

Answer: *If the beneficiary's medical condition meets medical necessity criteria, a DHHS Form 216 must be completed to authorize the non-emergency transport.*

Question 15: We are an EMT (clean crew) at @ 5 PM the beneficiary is sitting in the doctor's office and we get called to take the patient home. Do we have to take the beneficiary home? DHEC says we don't have any choice but to go.

Answer: *Contact the Broker before transporting the beneficiary. If this situation occurs frequently, it should be reported to the Fraud and Abuse Hotline at 1-888-364-3224 since this is an inappropriate request for transportation services.*

Question 16: Why can't we just submit the claim form instead of scanning the paper because hard copies are sent anyway? Why are we sending claims this way?

Answer: *Claims along with appropriate documentation may be submitted to DHHS for payment on a CMS 1500 either electronically or paper (hard copy).*

Question 17: Why can't we send in the paper automatically instead or electronically? Wouldn't that save money? Why can't we do that?

Answer: *See question above.*

Question 18: What manual are you talking about? There is no ambulance manual at this time.

Answer: *The most recent manual is in the process of being revised and updated, with an expected release date in the near future.*

Question 19: Why does the provider have to correct the processor's errors when the form was sent without errors?

Answer: *All processing errors must be corrected before claims are paid.*

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07/15/08**

Question 1: Do you want the EOB attached to the 216?

Answer: *The EOB should be attached to the initial claim. The insurance information from the EOB must be entered on the claim form in the appropriate sections.*

Question 2: How long can a claim stay in suspended status?

Answer: *A claim may remain in suspended status at least 30 days.*

Question 3: What do you suggest providers do in the meantime?

Answer: *When a claim is in suspended status no action can be taken by the program area or the provider.*

Question 4: How long do you estimate the new staff getting up to speed with claims processing?

Answer: *Additional staff has been crossed trained to assist with the claim processing review to speed up the processing time.*

Question 5: Let's talk about the 920 and 921 edit codes—is there a system in place where we can get the broker to honor the edits on the claim form?

Answer: *Edits 920 and 921 are to alert providers that non-emergency transports are covered by the Broker. However, all non-emergency transports may or may not be a broker responsibility. Claims that receive these edits are reviewed by appropriate staff for medical necessity criteria.*

Question 6: There remains a lot of confusion about when a patient is a LogistiCare patient or a 216 patient. Are we to assume the list at the bottom of the form will provide us with the proper guidelines?

Answer: *The checklist summarizes some medical conditions that may qualify a beneficiary for ambulance transport. Other more specific qualifying conditions may be listed under "Other". All non-emergency ambulance transports submitted fee for service must be reviewed by appropriate staff to determine medical necessity.*

Question 7: What are we to do when we are called at the last minute and we know the patient should be contacting LogistiCare?

Answer: *Refer the beneficiary back to LogistiCare.*

Question 8: What about patients who are on self-administered oxygen and the broker denies assistance?

Answer: *Since self-administered oxygen is not a reason for denial, beneficiaries should be referred back to the Broker for assistance. The provider should document the time, date and reason for denial. Please include a Transportation staff person at DHHS if this problem persists.*

Question 9: Is the state considering looking at reimbursing the providers for fuel prices considering the high cost of fuel?

Answer: *The state has not considered reimbursing providers due to rising fuel cost.*

Question 10: Wound Care—who is responsible for transporting a patient from the nursing home to the wound care facility?

Answer: *Depending on the condition of the beneficiary, transportation may be provided by the Broker or ambulance provider.*

Question 11: How do we file TPL when Medicaid is secondary or tertiary?

Answer: *Claims should be filed with other insurance providers before submitting to Medicaid. Appropriate sections for TPL should be completed on the CMS 1500.*

Question 12: Is LogistiCare responsible or does the DRG include a patient's transport from an acute care setting to a swing-bed setting? Example: McLeod Regional, an acute care facility, to McLeod Darlington which is a swing-bed facility, and each has its own provider number, but both are in the same building—who is responsible? All of the patients are bedridden/require stretchers.

Answer: *Hospital to hospital transports must be arranged through the Broker unless medical necessity is met for the DHHS Form 216. The DRG does not include patient transports.*

**SC Department of Health and Human Services
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07/22/08**

Question 1: Why is an acceptable signature not a social worker or a discharge planner?

Answer: *Medicaid's standard for an acceptable signature is based on CMS guidelines consistent with Medicare requirements.*

Question 2: Why is it (signature) required as currently stated?

Answer: *See previous question.*

Question 3: Is there a time limit if a claim is suspended, but reviewed, in which a response is given?

Answer: *A claim may remain in suspense at least 30 days. Once the claim is reviewed by the program area, it will be processed and returned to Medicaid Claim Control System for processing.*

Question 4: Why would a claim deny for timely filing if you, (DHHS) have it and it is suspended?

Answer: *If a claim is presented to the processing system and paid before 1 year, it will not be rejected.*

Question 5: Does that (transport) also include any other equipment such as Foley catheters? (Transporting non-emergent w/oxygen).

Answer: *Contact the Broker before transporting the beneficiary.*

Question 6: Why can't Medicaid send out a list of what the state pays for and what it does not? (What does Medicaid pay vs. the state/other insurer)? If there is a list, we need the denial code to bill the broker.

Answer: *Medicaid will reimburse for transportation to approved medical services. If a patient meets medical necessity criteria, a provider may submit the DHHS Form 216 for reimbursement.*

Question 7: Where and when do we need a Form 216?

Answer: *See previous question.*