GROUND AMBULANCE SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Ground ambulances must be licensed by the Department of Health under ARSD Ch. 44:05:04 and ground ambulance vehicles must meet Department of Health requirements. Out of state providers must be licensed and enrolled with their home state's Medicaid agency.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitation described in this chapter and in the table below:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the Recipient Eligibility manual for additional information regarding eligibility.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary; and
- The recipient must be eligible.

The manual also includes non-discrimination requirements providers must abide by.

Ground Ambulance Coverage
Ground ambulance services are limited to:

- Medically necessary transportation of a recipient locally or to the nearest medical provider that is equipped or trained to provide the service if the use of any other method of transportation is contraindicated;
- Medically necessary services provided at the pick-up point if an ambulance has been dispatched, but the recipient is not transported; and
- Loaded mileage, which is mileage driven while a recipient is being transported. Loaded mileage may not be billed for more than one recipient per trip.

Service Type
Services must be billed based on the level of medically necessary services furnished, not the vehicle used. Even if a local government requires an ALS response for all calls, payment is made only for the level of medically necessary service furnished.

Basic Life Support (BLS)
Services are reimbursable at a BLS level when services provided include basic, non-invasive interventions to reduce the morbidity and mortality associated with a medical response, including those procedures described in the EMS Scope of Practice as outlined by the South Dakota Board of Medical and Osteopathic Examiners. Nebulizer treatment is considered a BLS level procedure.

Transportation of a recipient to or from the air transport with the air transport team is considered a BLS service. In addition, medically necessary services provided at the pick-up point when the recipient is not transported is considered a BLS service.

Advanced Life Support (ALS)
Services are reimbursable at an ALS level when performed by advanced life support personnel licensed under SDCL Ch. 36-4B and the services consist of basic life support procedures plus at least one advanced service that can only be performed by advanced life support personnel as described in the South Dakota Board of Medical and Osteopathic Examiners EMS Scope of Practice.

Advanced Life Support Level 2 (ALS2) (effective December 1, 2024)
Services are reimbursable at an ALS2 level when performed by advanced life support personnel licensed under SDCL Ch. 36-4B and the services consist of basic life support procedures plus at least three advanced services as listed above in the ALS requirements.

For a transport to qualify for the ALS2 level of payment, medications must be administered intravenously (IV). Medications administered by other routes, such as intramuscularly, subcutaneously,

orally, sublingually, or nebulized, do not qualify for ALS2 payment. IV medications must be given in standard doses as directed by local protocol or online medical direction. Fractional administration of a single dose in order to meet ALS2 criteria is not acceptable.

The administration of an intravenous drug by infusion counts as one IV dose. For instance, treating atrial fibrillation with two boluses of diltiazem followed by an infusion qualifies as three IV administrations, thus meeting the ALS2 criteria. However, fractional administration, such as giving a single 1 mg dose of IV Epinephrine in increments, does not qualify for ALS2 payment. According to American Heart Association (AHA) protocols, administering Epinephrine in 1 mg increments every 3 to 5 minutes is required. Likewise, administering Adenosine in non-standard doses does not meet ALS2 criteria. Adhering to local protocols and administering appropriate doses within the specified time frames is essential for ALS2 qualification. Endotracheal (ET) intubation, including monitoring and maintaining an ET tube, qualifies for ALS2 payment without considering medications administered by the ET route.

Specialty Care Transport (SCT) (effective December 1, 2024)
Services are reimbursable when performed by advanced life support personnel licensed under SDCL Ch. 36-4B and when the interfacility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. This higher level of care is necessary when ongoing treatment by health professionals with specialized training, such as in emergency or critical care nursing, respiratory care, or cardiovascular care, is required. Only if additional personal is required for the transport can this level of care be applied.

Allowable Destinations
An ambulance transport is covered to the nearest appropriate facility to obtain medically necessary services as well as the return transport if medically necessary. Medicaid covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:

- Airport
- Hospital including Critical Access Hospital;
- Nursing facility;
- Recipient's home; and
- Dialysis facility.

Ambulance transportation is limited to the nearest appropriate facility equipped to treat the recipient. If two or more facilities located in the same city meet the destination requirements and can treat the recipient appropriately, then the full mileage to any one of the facilities to which the recipient is taken is covered.

Institution to a Recipient's Home
Ambulance service from an institution to the recipient's home is covered if medically necessary and the home is within the city of the institution or the recipient's home is outside of the city of the institution but the institution, in relation to the home, was the nearest one with appropriate facilities.

Institution to Institution

Occasionally, the institution to which the recipient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the recipient is then transported to a second institution having appropriate facilities. In such cases, transportation by ground ambulance to both institutions is covered as long as other ground ambulance requirements are met.

Transport to and From Medical Services for Non-Inpatients

Ambulance transports to and from a covered destination (i.e., two 1-way trips) furnished to a recipient who is not an inpatient of a provider for the purpose of obtaining covered medical services are covered, if all other coverage requirements are met. In addition, coverage of ambulance transports to and from a destination under these circumstances is limited to those cases where the transportation of the recipient is less costly than bringing the service to the recipient. Refer to the non-emergent ground ambulance guidance in this manual for additional coverage criteria.

Transport to a Physician's Office

Ground ambulance transportation to a physician's office is covered only under the following circumstances:

- The ambulance transport is enroute to a covered destination; and
- During the transport, the ambulance stops at a physician's office because of the recipient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination.

In such cases, the recipient will be deemed to have been transported directly to a covered destination and payment may be made for a single transport and the entire mileage of the transport, including any additional mileage traveled because of the stop at the physician's office.

Emergent and Non-Emergent Services

South Dakota Medicaid covers both emergent and non-emergent ground ambulance services. Ground ambulances may bill for services using the appropriate base fee HCPCS code.

Emergent Ground Ambulance Services

Ground ambulance services are considered emergent when the recipient is suffering from an illness or injury and other means of transportation threaten the life or health of the recipient. Examples of medically necessary emergent ground ambulance services include:

- The recipient was transported in an emergency situation as a result of an accident, injury, or acute illness that threatened the life or health of the recipient;
- The recipient required oxygen as emergency treatment or the recipient required other emergency treatment during transport to the nearest facility;
- The recipient was unconscious or in shock;
- The recipient exhibited signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain;
- The recipient exhibited signs and symptoms that indicate the possibility of acute stroke;

- The recipient needed to remain immobile because of a fracture that had not been set or the possibility of a fracture; or
- The recipient experienced severe hemorrhage.

Non-Emergent Ground Ambulance Services

Non-emergent ambulance services are reimbursable to the allowable destinations referenced in this manual in the following situations:

- The recipient is confined to a bed and it is documented by a physician or other licensed practitioner that other means of transportation including secure medical transportation, such as stretcher van, are contraindicated; or
- The recipient's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

A recipient is considered confined to a bed when the following criteria are met:

- The recipient is unable to get up from bed without assistance;
- The recipient is unable to ambulate; and
- The recipient is unable to sit in a chair or wheelchair.

A recipient is limited to 12 one-way trips (6-round trips) in a state fiscal year.

For transports not meeting the above non-emergency ground ambulance criteria, ground ambulance providers may enroll as a secure medical transportation provider and may bill secure medical transportation services using the secure medical transportation codes on the Transportation fee schedule.

For non-emergent ground ambulance trips the ambulance provider must document in the medical record the reason secure medical transportation and other forms of transportation are contraindicated. Documentation must support medical necessity of the transport. A list of secure medical transportation providers is available on the Department's website.

Multiple Trips in a Single Day

If a recipient requires multiple trips via ground ambulance within a 24-hour period, the 59 modifier must be billed on the claim along with other appropriate ambulance modifiers.

Multiple Recipient Transport

If two recipients are transported to the same destination simultaneously, services for the additional recipient must be billed with the TK modifier. The TK modifier reduces the base fee reimbursement for the second recipient by 50 percent. Loaded mileage is only billable for one recipient and must not be billed for the second recipient.

Recipient Death

Generally, transport of a recipient must occur for ambulance services to be billable. Any payment by Medicaid depends on the time at which the recipient is pronounced dead by an individual authorized by the State to make such pronouncements.

Time of Death Pronouncement	Medicaid Reimbursement
Before dispatch.	None.
After dispatch, before recipient is loaded onboard ambulance (before or after arrival at the point-of pickup).	The BLS base rate is reimbursable if medically necessary services were provided at the point-of-pickup.
After pickup, prior to or upon arrival at the receiving facility.	Applicable medically necessary level of services furnished.

Non-Covered Services

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Ground Ambulance Non-Covered Services

Services not specifically listed in the covered services and limits section are considered non-covered.

Exceptions Process

Ground ambulance providers may request an exception for coverage of a non-covered service. Providers requesting an exception should complete sections one and two of the Transportation Exceptions Form and return it to South Dakota Medicaid for consideration. Exceptions must result in an overall cost savings for the department.

Documentation Requirements

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Ground Ambulance Documentation Requirements

Return trips or other non-emergency trips by ground ambulance must be justified by a physician or other licensed practitioner's order. Documentation of the order must exist in the provider's file but is not required to be submitted with the claim for payment. If a ground ambulance transports a recipient to a provider other than the closest provider, the provider must document that a physician or other licensed practitioner directed them to another provider.

Reimbursement and Claim Instructions

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the

month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
Reimbursement is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

Reimbursement is based on the level of medically necessary services furnished, not the vehicle used. Even if a local government requires an ALS response for all calls, payment is made only for the level of medically necessary service furnished.

Reimbursement is not allowed for transport of ambulance staff or other personnel when the recipient is not onboard the ambulance.

The following supplies/services are considered included in the base rate and are not separately reimbursed:

- A0384 - BLS Defibrillation Supplies
- A0392 - ALS Defibrillation Supplies
- A0394 - ALS IV Drug Therapy Supplies
- A0396 - ALS Esophageal Intubation Supplies
- A0422 - Ambulance Oxygen and Oxygen Supplies, Life Sustaining Situation
- A0424 - Extra Ambulance Attendant

If medically necessary services are provided at the pick-up point and the recipient is not transported, only the BLS base fee is reimbursable.

Claim Instructions
A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. A claim for ground ambulance service may contain only ground ambulance procedure codes found on the department's transportation fee schedule.

Transportation claims must list the address of the origin and destination. Providers should refer to the appropriate claim instructions for additional information.

A provider may not bill for loaded mileage during the time the recipient was not physically present in the ambulance. Mileage units must be rounded to the nearest whole mile.

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

Modifiers

If applicable, the following modifier codes must be included on a provider's claim:

- TK – Additional South Dakota Medicaid Recipient
- 59 – Distinct or separate services (multiple trips within a 24-hour period).
- Applicable descriptive modifiers are required to be included on the claim.

Modifier payment effects are described on the department's website.

Loaded Mileage

Allowable loaded mileage should be billed in whole numbers. Providers should not use decimals. Providers should round up or down to the nearest whole number using standard rounding conventions. Only one mileage allowance is billable for each trip regardless of the number of recipients transported. If there are multiple recipients transported, the provider should only bill the mileage on one recipient's claim. Mileage should not be billed if coverage requirements are not met.

DEFINITIONS

1. "Ambulance provider," a company, firm, or individual licensed by the Department of Health under the provisions of article 44:05 to provide ambulance services or, if based out of state, a company, firm, or individual which provides ambulance services and is a participating Medicaid provider in the state where it is located;

2. "Appropriate Facility," an institution generally equipped to provide the needed hospital or skilled nursing care for illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the recipient's condition;

3. "Ground ambulance," a motor vehicle licensed by the Department of Health under chapter 44:05:04 and used to respond to medical emergencies; and

4. "Loaded mileage," mileage driven while a recipient is being transported.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Does Medicaid pay for ambulance services when an ambulance is called and responds, but the recipient is not transported?**

   Yes, a provider can bill the base fee for medically necessary services provided at the pick-up point.

2. **Does Medicaid pay for a recipient to be transported to the hospital/health care facility of their choice?**

   No.

3. **May a Medicaid recipient be billed for mileage if the recipient requests transportation to a specific hospital other than the closest provider?**

   No, South Dakota Medicaid's rules state that providers may not bill a recipient once they have billed Medicaid for the service; Medicaid payment is considered payment in full. An ambulance provider could receive reimbursement to another hospital if the provider obtains specific documentation from the physician or other licensed practitioner regarding the medical necessity of a recipient travelling to a specific hospital in place of the closest hospital. The documentation should be retained in the recipient's medical record.

4. **May an ambulance provider bill for Secure Medical Transportation when the service does not meet the requirements for non-emergent ambulance transport?**

   Yes, an ambulance provider may enroll as a secure medical transportation provider and bill for services at the secure medical transportation provider rates.

5. **What documentation is required when an ambulance provider is diverted from the closest hospital to another hospital?**

   The provider should note the diversion in their trip report and obtain documentation from the hospital regarding the diversion. A fax or letter from the hospital stating the diversion and reason for the diversion for the specific trip should be retained in the recipient's medical record.