North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501 • Tel 919-855-4100 • Fax 919-733-6608

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Craigan L. Gray, MD, MBA, JD, Director

January 13, 2012

Re: Non Emergency Medical Transportation Vendor Requirements

Dear County Director of Social Services:

The Division of Medical Assistance has issued revised policy for the Non Emergency Medical Transportation (NEMT) program, which will be effective January 1, 2012. Several changes within the policy will have an impact on the NEMT vendors. Counties shall share this information with their current NEMT vendors in advance of the effective date of the change.

Changes to the NEMT policy will require:

- All NEMT vendors and counties shall utilize the Transportation Billing Codes when submitting invoices for re-imbursement. A copy of the DMA-2055, Reimbursement Request Form, which includes the Billing Codes and their descriptions, has been attached. All billing with inappropriate documentation or missing codes shall be denied for payment.

- Counties shall complete inquiries into Federal and State databases to determine if any vendor, owner, or manager, (with the exception of any county transportation systems) has been excluded from participation in Medicare or North Carolina Medicaid. If either database inquiry results in an exclusion match, the vendor shall not be a NEMT vendor. All current and prospective NEMT vendors must provide information required to complete the exclusion matches. A copy of the DMA-5124, Medicaid Transportation Provider Documentation is attached which contains the required information. This review must occur on a monthly basis. Initially, counties shall gather this information from current vendors by February 1, 2012, and complete the inquiries by February 15, 2012.

- Vendors shall report information to the county for each recipient who fails to be available for a scheduled transportation pick up, on a daily basis, and information about cancellations on a monthly basis.

- Vendors shall agree to an obligation that no more than one quarter of one percent of all trips be missed by the vendor during the course of the contract year.

- Vendors shall agree to an obligation to meet on-time performance standards such that no more than five percent of trips should be late for recipient drop off to their appointment per month.

- Vendors shall agree to report any changes such as insurance provider, business ownership or management or exclusion from participation in Medicare or North Carolina Medicaid.

- Vendors shall agree to allow monitoring of records to ensure all contract requirements are being met.

- Vendors shall agree to bill the county separately for any agreed upon costs for no-shows or driver wait time.

- Vendors shall agree to an obligation to record and provide to the county all recipient complaints which deal with matters under the vendor's control, including the recipient's name, recipient's Medicaid Identification Number, date the complaint was made, the nature of the complaint and what steps were taken to resolve the complaint.

- All contracts with NEMT vendors shall include the above requirements. Current contracts with NEMT vendors shall require an addendum to include these requirements. Counties shall review all current contracts by January 31, 2012, and complete the contract addendums, if at all possible, by February 29, 2012.

If you have any questions regarding this information, please contact your Medicaid Program Representative.

Sincerely,

Craigan L. Gray, MD, MBA, JD, Director

CLG/lkf
Attachment: 2

REIMBURSEMENT REQUEST FORM
MEDICAID TRANSPORTATION

COUNTY DSS: _____ COUNTY #: _____

MONTH: _____ YEAR: _____

(Include only one month of transportation per DMA 2055.
The month should be the month in which the transportation occurred.)

Transportation Expense Code	Number of Unduplicated Medicaid Recipients	Number of One Way Trips	Amount Requested for Reimbursement
A0080			
A0090			
A0100			
A0110			
A0120			
A0130			
A0160			
A0170			
A0180			
A0190			
A0200			
A0210			
A0999			
TOTAL			

Attestation: I certify that 1) all individuals who received transportation services for which reimbursement is being requested were authorized Medicaid eligible, 2) transportation was provided in accordance with the policies and guidelines published by the Division of Medical Assistance, 3) full documentation exists for all services for which reimbursement is being requested, 4) the information provided in the chart above is accurate for reimbursement being requested for this period.

_____ _____
Prepared by DSS Director or Designee

_____ _____
Phone Date

_____
Email address

FAX to DMA Budget Management, **919-715-0896** by the 15th of the month following the month of transport. DMA contact phone number: 919-855-4140.

Note: Administrative costs are reported on the DSS-1571.

Requests for reimbursement received after the 15th of the month (or next business day if the 15th falls on the weekend), will be delayed for reimbursement until the next month.

INSTRUCTIONS FOR COMPLETING DMA-2055

I. Definitions

One Way Trip is transportation of a recipient either to a medical service **or** from a medical service. A one-way passenger trip consists of one passenger pick-up and drop-off.

Unduplicated Medicaid Recipients means the number of recipients transported during the reporting period under a particular billing code, not the number of trips. An individual who has been transported on more than one occasion under a single billing code during the reporting period counts as one Medicaid recipient transported for that month. An individual who has been transported under more than one billing code during the reporting period is a distinct "unduplicated Medicaid recipient" for each applicable billing code.

II. Instructions for Completing DMA-2055

1. The DMA-2055 must be completed in its entirety or it will be returned without being processed for payment. Do not leave any field blank. Enter a zero, if it does not apply.
2. Include only one month of transportation data per DMA-2055. The data reported should be for the month in which the transportation occurred.
3. Enter the number of unduplicated Medicaid recipients transported.
4. Enter the number of one way trips for each code.
5. Enter the amount requested for reimbursement for each code.
6. Enter the total amount of reimbursement requested.
7. Sign and have the Director (or designee) sign and date.
8. Fax to DMA Budget Management at number shown on form.

III. Codes

A0080	Mileage paid to volunteer/volunteer provided vehicle
A0090	Mileage paid when vehicle is provided by individual, family, neighbor, etc.
A0100	Taxi
A0110	Bus, Interstate or Intrastate Carrier
A0120	Van service, public and private transportation, except wheel chair vans.
A0130	Wheel-chair Van
A0160	Mileage paid to caseworker or social worker
A0170	Ancillary costs – parking fees, tolls, other
A0180	Recipient Lodging
A0190	Recipient Meals
A0200	Attendant Lodging
A0210	Attendant Meals
A0999	Ambulance Service, (Stretcher transport, no life support)

Medicaid Transportation Provider Documentation

North Carolina _____County Department of Social Services

Organization Information

Organization Name as shown on income tax return_____EIN_____

Doing Business As (DBA) information

DBA Name_____EIN_____ Former DBA Name(s)_____EIN_____

Former DBA Name(s)_____EIN_____

Years Doing Business under Current Name_____Years Doing Business under Previous Name(s)_____

Ownership Information

How would you describe the ownership? (circle one)

Sole Proprietor Partnership Single –Owner LLC Corporation City/Municipality Non-Profit

For Corporation, Partnership, or Non-Profit: P lease provide ownership information for each owner who has direct or indirect ownership or control interest of 5% or more in the organization or entity.

Owner 1

Full Name (Last, first, Middle)_____ SSN or EIN_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Owner 2

Full Name (Last, first, Middle)_____ SSN or EIN _____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Owner 3

Full Name (Last, first, Middle)_____ SSN or EIN_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Owner 4

Full Name (Last, first, Middle)_____SSN or EIN _____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Managing Relationships

As required by 42 CFR 1002.3, Non Emergency Medical Providers must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator) and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

Relationship 1

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Relationship 2

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Relationship 3

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

Relationship 4

Full Name (Last, first, Middle)_____ Social Security Number_____

Date of Birth (MM/DD/CCYY)_____Business Relationship to NEMT Provider_____

Familial Relationship to NEMT Provider (Mother, Father, Sister, Brother, None, etc.)_____

By my signature, I attest that no one affiliated or employed with _____ has ever been convicted of:

- Medicare/Medicaid or any other healthcare program fraud;
- Neglect or abuse of a client;
- Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- Interference or obstruction of an investigation into any of the above criminal offenses.

Name_____Signature_____

Date_____

http://oig.hhs.gov/exclusions/index.asp

Results of OIG Federal Inquiry:

Circle One: No Match Found Organization or Business Owner Manager

Name of individual/entity which resulted in an exclusion match_____

Exclusion Code_____

Transportation Coordinator/Designee Signature_____

Date_____

https://providertracking.dhhs.state.nc.us/default.aspx

Results of NC DHHS Provider Penalty Tracking Database

Circle One: No Match Found SSN Owner

Name of owner and/or SSN of owner which resulted in an exclusion match_____

Exclusion Reason (Action Issued)_____

Transportation Coordinator/Designee Signature_____

Date_____