NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

July 1, 2023
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Changes Effective: July 1, 2024

NC Non-Emergency Medical Transportation Managed Care Policy

I. INTRODUCTION

Non-Emergency Medical Transportation (NEMT) is a critical service benefit to ensure that Medicaid members have access and availability to Medicaid covered services, including services carved out of Medicaid Managed Care as well as Value-Added and In Lieu of Services, to obtain medically necessary health care. Medicaid Managed Care Health Plans shall provide:

1. NEMT services to ensure that eligible and enrolled members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid enrolled providers.

2. NEMT services in an amount, duration and scope no less than the amount, duration and scope for the same services furnished to members under the Medicaid Direct (formally known as Medicaid Fee-For-Service) program.

3. Scheduling, payment and expense reimbursement for Non-Emergency Medical Transportation (NEMT) services.

4. NEMT services for all eligible and enrolled Health Plan members:

    a. When the member lacks both means and mode to arrange for their transportation.

    b. When the member has access to a suitable mode of transportation, but lacks the means to use it, the Health Plan must assist with the means through gas vouchers, mileage reimbursement, etc.

    c. Travel related expenses including food, parking fees/tolls, transportation vouchers (i.e., taxis, ride sharing services, public transit), and mileage.

    d. The obligation for the Health Plan to provide transportation is not without qualifications and prior authorization.

II. HEALTH PLAN CRITERIA FOR PROVISION OF NEMT SERVICES

A. The Health Plan shall develop, submit and maintain an NEMT Policy

The Health Plan is required to submit for approval their NEMT Policy to NC Medicaid (the State) ninety (90) days after Contract Award, thirty days (30) after any NEMT contract amendment and annually thereafter.

1. The Policy shall include, at a minimum, the following:

    a. Transportation options available to members;

    b. Methods and process by which to request transportation;

    c. Driver and vehicle requirements;

    d. Process for transportation assessment;

    e. Member rights and responsibilities; and

    f. Hours of operation

2. The Policy shall adhere to the following:

    a. Transportation shall be scheduled so that the member arrives on time for the appointment, but no sooner than one (1) hour before the appointment; nor must wait more than one (1) hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment;

    When provided as part of a multi-loaded*, long distance and/or coordinated trip, transportation shall be scheduled so that the member arrives on time for the appointment, but no sooner than two (2) hours before the appointment; nor must wait more than two (2) hours after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.

    *Multi-loaded is defined as more than 1 passenger in the vehicle. This does not apply to members of the same family.

    b. Members cannot be required to make transportation requests in person;

    c. Urgent transportation services, including hospital discharges, are exempt from any advance notice requirement;

    d. The Department's requirements for written materials; and

    e. All other requirements as indicated in this policy as well as the NC Medicaid Managed Care Health Plan Contracts.

B. The Health Plan only pays for transportation:

1. By the least expensive mode available and appropriate for the enrolled/eligible Medicaid member,

2. To a Medicaid covered service provided by a North Carolina Medicaid enrolled provider. Generally, this will be the nearest appropriate medical provider and can include a bordering state.

NEMT services must include transportation to and from Medicaid covered services under NC Medicaid Managed Care and Managed Care carved out services (e.g., Dental).

NEMT Services can include transportation to and from Value-Added and In Lieu of Services.

C. Individuals/Members Not Eligible to Receive NEMT Services from the Health Plan include:

1. NC Medicaid Direct Beneficiaries

2. Members in a Nursing Facility - The Nursing Facility is responsible for providing transportation to their patients and members transferring between facilities and/or hospitals.

3. Medicaid members receiving certain Innovation Waiver, TBI Waiver, and 1915(i) SPA services, transportation costs are included in the Medicaid provider's fee; therefore, members are not eligible for NEMT to these services listed below. Medicaid members receiving waiver and 1915(i) SPA services are eligible for NEMT services to and from Medicaid covered services, such doctor appointments, pharmacy trips, dialysis treatments, that do not include transportation as part of the Service Definition.

    i. Innovations Waiver, TBI Waiver, 1915(i) SPA covered services that have transportation included in the Medicaid provider's fee:

Innovation Services and TBI Services	**Service Code**
Community Living and Support	T2013TF(Individual) T2021TF HQ (Group
Day Supports	T2021 (Individual) T2021HQ (Group)
Respite	S5150 (Individual) S5150HQ (Group)
Supported Employment	H2025 (Individual) H2025HQ (Group)
Community Networking	H2015(Individual) H2015 UI (Group)
Cognitive Rehabilitation (TBI service)	97532

4. Mental Health (MH) or Substance Use Disorder (SUD) Services, listed below, are not eligible for NEMT services. The listed services below are provided to members in various community settings and travel for Behavioral Health Providers are included in the service rate models. Medicaid members receiving services below are eligible for NEMT services to and from other Medicaid covered services that do not include travel or transportation in the rate, such as doctor appointments, pharmacy trips, and dialysis treatments, etc.

i. Mental Health (MH) or Substance Use Disorder (SUD) services that have transportation included in the model rates:

MH and SUD Services	Service Code
Assertive Community Treatment Team (ACT)	H0040
Community Support Team	H2015HT
Intensive In-Home (IIH)	H2022
Mobile Crisis Management (MCM)	H2011
Multisystemic Therapy (MST)	H2033
Peer Support Services (PSS)	H0038
1915(i) Individual and Transitional Supports (ITS)	T1019 U4
1915(i) Individual Placement and Supports (IPS) for Mental Health and Substance Use Disorder	H2023 U4
1915(i) Respite	H0045 U4

Note: Medicaid members are eligible for NEMT services when receiving facility base services.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures within the scope of those categories listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] for Medicaid members under 21 years of age, if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician).

This means EPSDT covers medically necessary medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems if the service requested complies with the federal EPSDT requirements.

EPSDT Federal Requirements:

- Must be medical in nature
- Must be coverable under §1905(a) of the Social Security Act
- Must not be experimental or investigational
- Must be generally recognized as an accepted method of medical practice or treatment
- Must be safe
- Must be effective

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

a. The Health Plan must arrange and provide NEMT to children meeting EPSDT requirements for necessary service that might not be covered under the Medicaid state plan but are covered under EPSDT.

b. If the service, product, or procedure requires prior approval, the fact that the member is under 21 years of age does NOT eliminate the requirement for prior approval.

E. Hours of Operation

1. The Health Plan shall provide transportation after normal business hours when the medical service required by the member is available only during those hours.

2. The Health Plan shall have a phone system with an answering machine or other message recording device for taking transportation requests or cancellations 24 hours per day. The messages shall be retrieved during normal business hours. The instructions to clients on the answering machine or other recording device shall advise callers to dial 911 if they are having an emergency.

F. Designated Staffing

The Health Plan must have designated staffing that have responsibility for:

1. Facilitating members transition of care related to transportation services.

2. Informing members of the availability of Medicaid NEMT services (as defined in section II.B.2 or section IV in this policy guidance).

3. Informing members that there is no cost to the member.

4. Informing members of who may accompany a member without cost;

5. How to request, modify, reschedule, or cancel a transportation trip request (including any advance notification requirements).

6. Expected member conduct and procedures for no-show.

7. Receiving “problem” calls from members; and,

8. Completing necessary transportation documentation, equivalent forms or system interfaces that capture all required data fields to track each trip and/or reimbursement request - from intake through disposition.

G. NEMT Mode of Transportation Services Shall Include:

1. NEMT transportation providers include public transportation, taxis, vans, wheel-chair vans, mini-buses, mountain area transports, transportation network companies (TNCs) or other transportation systems and non-

emergency ambulance transportation.

2. Other transportation services including volunteers, family members and friends as well as non-emergency air travel.

H. Compliance with Transportation Policy (self-auditing)

Providing Medicaid transportation services to members who need those services and the proper utilization of NEMT services by members are important goals of Medicaid transportation policy. In order to attain these goals, the Health Plan is required to perform a self-audit of NEMT services.

1. The Health Plan must randomly sample 2% of the trips, or 200 trips whichever is less per calendar quarter.

2. Trips documented for self-auditing must capture all the data fields included in section VI.B. Utilization Documentation.

3. All modes of transportation must be included in the sample.

4. The Health Plan should maintain a control file with findings of the quarterly review and documentation of action taken.

The established self-audit process shall be outlined in the Health Plan's NEMT Policy and submitted to the Department for approval. The Health Plan's self-audit quarterly results shall be submitted to the Department annually for review.

I. Reporting Fraud, Waste and Abuse

Ensure all members receiving transportation services have been made aware of how to report suspected fraud, waste, and abuse (see Member Handbook). For additional requirements see policy guidance section X. Reporting Fraud, Waste and Abuse.

J. NEMT Provider Network Participation Requirements and Adequacy

1. NEMT Provider Networks and Adequacy

   The Health Plan is required to develop a network of NEMT providers to fulfill the requirements as outlined in this policy and in the NC Medicaid Managed Care Health Plan Contracts. This includes ensuring that its NEMT provider network can:

   a. Transport a member on time for their appointment, but no sooner than one (1) hour before their appointment; nor have to wait more than one (1) hour after the conclusion of the treatment; nor be picked up prior to the completion of treatment.

      When provided as part of a multi-loaded*, long distance and/or coordinated trip,

transportation shall be scheduled so that the member arrives on time for the appointment, but no sooner than two (2) hours before the appointment; nor must wait more than two (2) hours after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.
*Multi-loaded is defined as more than 1 passenger in the vehicle. This does not apply to members of the same family.

b. Accommodate timely, urgent transportation services (e.g., hospital discharges, trips to pharmacy and other ancillary service providers such as labs or radiology) without any advance notice requirement.

c. Transport a member in the mode most appropriate to meet the member's needs and circumstances.

d. Assure transportation is provided to members in a timely and cost-effective manner.

To ensure the NEMT provider network and adequacy requirements are met, PRV027-J for Standard Plans: NEMT Provider Contracting Report will be added to Attachment J of Contract #30-190029-DHB Prepaid Health Plan Services. To ensure the NEMT provider network and adequacy requirements are met for Tailored Plans, the PRV027-T: NEMT Provider Contracting Report will be added to Attachment J of Contract #30-2020-052 DHB Behavioral Health and Intellectual/Development Disability Tailored Plan. The reports will be required to be submitted to the State on the first and third Friday each month through the formal PCDU process with the same time-line as the PRV004-J: Network Data Details Extract until such time until Medicaid Managed Care launches. Following launch, DHB Health Plan Administration will determine new/or additional report requirements.

2. Development of a comprehensive NEMT provider network is necessary to:

a. Ensure that members have timely access and availability to obtain medically necessary routine and urgent medical care;

b. Through NEMT provider network contracting, support and promote the coordination of public and private/independent transportation services across geographies, jurisdictions, and program areas for the development of a seamless transportation network;

c. Support the provision of dependable transportation options to Medicaid members;

d. Demonstrate that the Health Plan has the capacity to transport on a non-emergent basis the expected enrollment statewide and/or in its region.

If administration of the Health Plans NEMT network is contracted out, the subcontractor is required to carry out all the responsibilities placed upon the

Health Plan by the NEMT Managed Care Policy Guidance as well as contractual requirements.

Summarily, development and maintenance of a robust NEMT provider network that maintains strong provider and community participation and demonstrates an understanding of the transportation needs of the North Carolina Medicaid Managed Care population to ensure access and availability to high quality care and services to all members is essential.

3. NEMT Network Participation

Notwithstanding any other provisions in the NC Medicaid Managed Care Health Plan Contracts related to provider network participation (e.g., contracting requirements, standard terms and conditions, any willing provider, good faith contracting and negotiation, etc.), Health Plans and/or their subcontracted transportation brokers shall not:

a. Include exclusivity or non-compete provisions in their contracts with transportation providers,

b. Require a transportation provider to participate in the governance of a Provider Led Entity (PLE) or,

c. Otherwise prohibit provider from providing services for or contracting with any other Health Plan.

4. Provider Credentialing and Enrollment Process

The Health Plan shall ensure that its NEMT providers as well as its subcontracted transportation broker, if applicable, must enroll as a Medicaid provider by completing a Provider Enrollment application online at www.nctracks.nc.gov. Providers of NEMT services may be from within the state of North Carolina and/or the approved bordering state areas as referenced in section IV.F. Health Plan transportation brokers can be within the state of North Carolina or Out-of-State.

a. Affordable Care Act fee and a North Carolina application fee are required.

b. NEMT providers should be enrolled with the following taxonomy codes:

   i. NEMT Transportation Brokers should enroll through NCTracks using Taxonomy Code 347E00000X.

   ii. All other NEMT Transportation providers should enroll through NC Tracks using one of the following taxonomy codes:

NEMT TAXONOMY CODES		
Taxonomy Code	**Description**	**Washington Publishing Company Definition**
343900000X	Transportation Services /Non-Emergency Medical Transport (Van)	A land vehicle with a capacity to meet special high, clearance, access, and seating, for the conveyance of persons in non-emergency situations. The vehicle may or may not be required to meet local county or state regulations.
344600000X	Transportation Services /Taxi	The land commercial vehicle used for transporting of persons in non-emergency situations. The vehicle meets local, county, or state regulations set forth by the jurisdiction where it is located.
347B00000X	Transportation Services /Bus	A public or private organization or business licensed to provide bus services
347C00000X	Transportation Services /Private Vehicle (Gas Reimbursement)	An individual paid to provide non-emergency transportation using their privately owned/leased vehicle.
347D00000X	Transportation Services /Train	An organization or business licensed to provide passenger train service, including light rail, subway, and traditional services.
342000000X	Transportation Services/Transportation Network Company (TNC)	An entity that uses a digital network to connect with TNC drivers using their privately owned/leased vehicle for the purpose of providing prearranged rides.

iii. For Health Plans that are providing ALS and BLS services, the transportation providers should enroll through NC Tracks using one of the following taxonomy codes:

ALS/BLS TRANSPORTATION TAXONOMY CODES		
Taxonomy Code	**Description**	**Washington Publishing Company Definition**
341600000X	Transportation Services Ambulance	An emergency vehicle used for transporting patients to a health care facility after injury or illness. Types of ambulances used in the United

		States include ground (surface) ambulance, rotor-wing (helicopter), and fixed-wing aircraft (airplane)
3416A0800X	Emergency Air Ambulance	Definition to come...
3416L0300X	Land Ambulance Transport	Definition to come...
3416S0300X	Transportation Services Ambulance	Definition to come...
343800000X	Transportation Services /Secured Medical Transport (Van)	A public or privately-owned transportation service with vehicles, specially equipped to provide enhanced safety, security and passenger restraint, and staffed by one or more individuals trained to work with patients in crisis situations resulting from mental or emotional illness and/or substance abuse.

c. NEMT providers can enroll with a National Provider Identifier (NPI) or enroll as Atypical providers. Obtaining an NPI is not required.

d. Online training is required.

   i. For training, please refer your contracted providers to the NCTracks website www.nctracks.nc.gov or their call center, 1-800-688-6696.

e. No certification, accreditation or license is required.

f. On-Site Visit is required

   i. All accepted provider types that provide NEMT services (see above NEMT taxonomy codes) will receive a State compliance monitoring visit.
      1. Providers are screened based on the categorical risk level of the taxonomy code selected. For NEMT services, this includes moderate to high risk.

      2. Compliant and approved NEMT providers will be displayed on the daily Provider Directory file.

III. MEMBER RIGHTS AND RESPONSIBILITIES

The local agency/DSS must give or mail the DMA-5046, The Medicaid Transportation Assistance – Notice of Rights/Responsibilities, to the Beneficiary/Member at each Medicaid application and recertification. This includes all types of eligibility except Medicare Qualified Beneficiaries (MQB) and those Beneficiaries who reside in long term care facilities.

A. Rights of the Member

1. To be informed of the availability of Medicaid transportation
2. To have the transportation policy explained including how to request a trip or cancel a trip, limitations on transportation, personal conduct and no-shows
3. To be transported to medical appointments if unable to arrange or pay for transportation
    a. By means appropriate to circumstances
    b. To arrive at medical provider in time for their scheduled appointment
4. To request a hearing if the request for transportation assistance is denied

B. Responsibilities of the Member

1. To use those transportation resources which are available and appropriate to their needs in the most efficient and effective manner.
2. To utilize transportation services, such as gas vouchers, appropriately.
3. To travel to the requested location and receive a Medicaid covered service.
4. To make timely requests for transportation assistance.
5. To be ready and at the designated place for transportation pick-up or cancel the transportation request timely.
6. To follow the instructions of the driver.
7. To respect and not violate the rights of other passengers and the driver, such as not creating a disturbance or engaging in threatening language or behavior.

IV. DESCRIPTION OF MEDICAID MANAGED CARE NEMT COVERED SERVICE

A. NEMT Covered Service

Non-Emergent transportation to Medicaid services, including carved out services, and value-added and in lieu of services, is required to assure access to medical care and treatment provided by a qualified Medicaid provider (enrolled in NC Medicaid).

Key NEMT services are listed in the NC Medicaid Managed Care Health Plan Contracts and OBJ:

1. 42 C.F.R. §431.53

2. 42 C.F.R. §440.170

3. North Carolina Medicaid State Plan, Att. 3.1-D page 1-4

4. NC Medicaid Managed Care Policy Guidance – NEMT

B. NEMT Transportation to NC Enrolled Provider

The Health Plan must provide NEMT services to a Medicaid covered service provided by a North Carolina Medicaid enrolled provider. Generally, this will be the nearest appropriate medical provider and can include a bordering state.

C. NEMT for Transition of Care Services

For newly enrolled members transitioning to a Health Plan from Medicaid Direct or another Health Plan, the Health Plan is required to follow the Department's Transition of Care Policy. Health Plans must ensure that transportation services are coordinated and that prescheduled transportation appointments are successfully managed with minimal disruption to the members established provider relationships and care treatment plans. Health Plans are required to have NEMT and Transition of Care Policies that address how coordination of transportation will be managed.

D. Ambulance Transportation

Note: Guidance provided in this section of policy is not intended to replace NC Medicaid Ambulance Service Clinical Coverage Policy No.15, but to provide guidance for the use of an ambulance in a non-emergency situation.

1. Medically Necessary means: the member's condition requires ambulance transportation, and any other means of transportation would endanger the member's health or life.

2. The ambulance provider must submit claims to the Health Plan or Broker for reimbursement. Refer to the Process Flow Chart in Section E.

3. The ambulance provider must be licensed by the State of North Carolina.

4. Medically Necessary Ambulance Transportation may be emergency or non-emergency ambulance, and the Medicaid member may be transported via ground or air medical ambulance.

   a. Emergency:

   Emergency ambulance transportation is medically necessary transport for a Medicaid member with an emergency medical condition and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

   Example: Individual seriously injured in a car accident and emergency ambulance required. Coverage under the plan for emergency services shall be provided to the extent necessary to

screen and stabilize the member. The plan shall not require prior authorization of services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the member.
Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possessed an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

1) Placing the health of the individual (or, in the case of a pregnant woman, the health of a woman or her unborn child) in serious jeopardy.

2) Serious impairment to bodily function, or

3) Serious dysfunction of any bodily organ or part

For emergency air ambulance transportation:

1) Air ambulance is not arranged by the Health Plans

2) Air ambulance by helicopter and fixed wing aircraft is a Medicaid covered service when the member's medical condition requires immediate and rapid transportation that cannot be provided by ground ambulance.

3) Transportation must be to the nearest hospital with appropriate facilities

4) The air ambulance provider must submit claims to the Health Plan for reimbursement.

Examples of medical conditions which may require emergency air ambulance transport includes:

1) Intracranial bleeding requiring neurological intervention

2) Cardiogenic shock

3) Burns requiring treatment at a burn center

4) Multiple severe life-threatening injuries

5) Life threatening trauma

There are two types of emergencies, medically necessary ambulance transportation: Basic Life Support and Advance Life Support.

1) Basic Life Support (BLS)
Basic Life Support ambulance includes the necessary equipment and staff to treat basic service when transport requires a stretcher.

2) Advance Life Support (ALS)
An Advance Life Support ambulance is a vehicle with complex specialized life sustaining equipment and is ordinarily equipped for radio-telephone contact with a physician or hospital. It is staffed by trained personnel authorized to administer ALS services

b. Non-Emergency:

1) Non-Emergency ambulance transport is a medically necessary transport for a Medicaid Member to obtain medical services that cannot be provided at the member's place of residence, and it is medically necessary that the member be transported by ambulance due to a medical/physical condition.

2) The member must be bed-confined and have a debilitating physical condition(s) that requires travel by stretcher only and ground transportation to receive medical services.

3) Non-Emergency medically necessary ambulance transport is appropriate in either of the following situations:

a. The member is bed-confined, and it is documented that the member's medical condition is such that a stretcher is the only safe mode of transportation; or

b. The member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

c. A member is bed-confined when all of the following criteria are met. The member is:

i. Unable to get up from bed without assistance

ii. Unable to ambulate; and
iii. Unable to sit in a chair or wheelchair

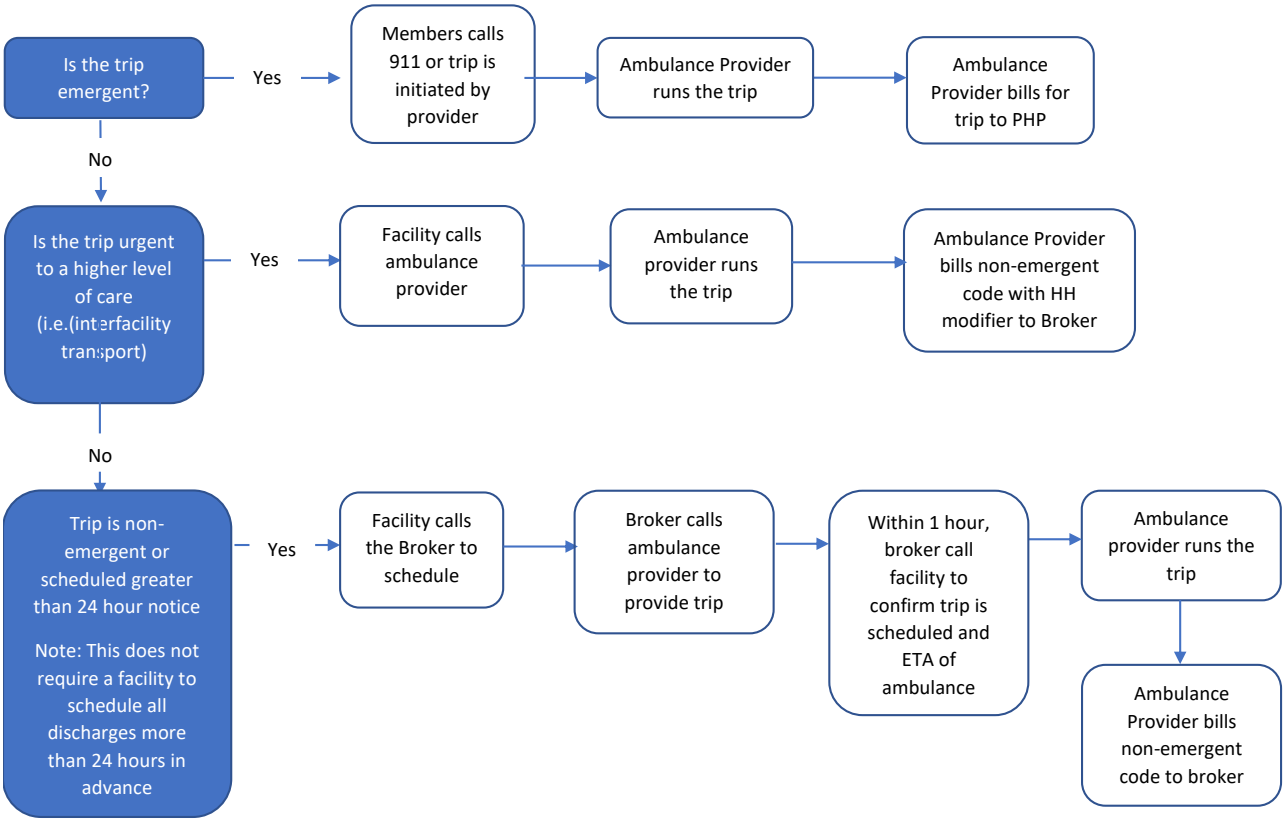
Example: Individual is morbidly obese to the point of not being able to walk or climb stairs.

Non-Emergency Ambulance Transportation must be arranged through the Health Plans.

To accommodate these members, the Health Plan must contract with an ambulance company or negotiate a trip cost with the ambulance company to transport these members to their designated location.

E. Ambulance Provider Emergent, Urgent, and Non-Emergent Trip Process Flow

Chart below provides guidance of how providers should remit payment for emergency, urgent, and non-emergency ambulance services rendered.



F. Transportation Providers and Border/Out-of-State Trips

The Health Plan can contract with in-state and border (i.e., providers that reside within forty (40) miles of the NC state line) network providers for NEMT Services.

Appropriate NEMT services must accommodate medically necessary trips to and from boarding and out-of-state network medical providers. Refer to Section VII. for advance notice for out-of-state and bordering state trip requests. For a list of NC border zip codes: https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information/zip-codes.html.

V. ASSESSMENT AND PRIOR AUTHORIZATION FOR TRANSPORTATION SERVICES

For the purpose of NEMT, the assessment process is defined as review of the member's most current circumstances to determine the means and mode of NEMT services appropriate to fit the needs of the member.

A. Assessment Purpose

When a request for transportation is made, an assessment of the request must be completed. The purpose of the assessment is to:

1. Determine the member's eligibility for transportation services,
2. Determine any special needs requirements,
3. Determine mode of transportation, and
4. Assess other sources that may be available to the member

B. Assessment Process

1. An assessment must be completed in its entirety:
    a. At the initial request for transportation assistance
    b. At least once a year after initial request
    c. When there is a change in situation which may impact the need for transportation assistance
    d. To coincide with each Medicaid recertification, if the member is still in need of services
2. The assessment process should assess the amount, duration, and scope that the member has previously had or to establish current need for transportation services. Considerations should be given to the following areas listed below:
    a. Assess how medical transportation has previously been provided and why it is not available now.
        i. Does the enrolled/eligible member have access to a vehicle that can be used to get to and from medical appointments?
        ii. Ask the enrolled/eligible member and/or authorized representative if she/he has a working vehicle.
        iii. Ask the enrolled/eligible member and/or parent, guardian, legally authorized representative, advocate if he/she has friends, relatives or neighbors who would be willing to transport him/her to medical appointments.

b. Ask the enrolled/eligible member and/or parent, guardian, legally authorized representative, advocate how he/she has been getting to medically necessary appointments.

   i. Drives self

   ii. Friend/relative/neighbor provides transportation

   iii. Takes a bus

   iv. Takes a cab

   v. Other. Document who (e.g. organization name, DSS Agency, non-profit)

c. Ask if there is a reason the member can no longer use the source, he/she had been using for transportation to get to medical appointments.

   i. If the member has access to a vehicle, find out why that vehicle cannot currently be used to transport him to medical appointments. If member states that he cannot afford to pay for gas, explain that gas reimbursement is available.

   ii. If the member states that he cannot afford to pay (for gas, bus fare, car repairs, insurance, vehicle registration, cab fare, etc.) accept their statement.

d. If it is determined that the member can provide their own transportation, the request should be denied.

C. Assessment by Other Entities

The Health Plan may subcontract with other entities to have transportation assessments completed. However, before they begin the process, the Health Plan is responsible for assuring that:

1. The subcontractor follows the defined assessment process, outlined in this policy guidance; and

2. Documentation of the NEMT assessment, service determinations (any increase or decrease in amount, duration, scope or frequency), prior authorization decisions, copies of notices, approval, and denials are reviewed and audited by the Health Plan and comply with guidelines.

D. Special Member Considerations for NEMT Services

1. Ask the member about special needs or impediments to using certain forms of transportation. Does the member use/require?

   a. An attendant (required for children under age 18 unless they are

emancipated), who may or may not be a parent. Other members may need an attendant due to special medical, physical or mental impediments;

b. Mobility Device – ask what type of mobility device is used (wheelchair, scooter, etc.).

c. Cane/crutches/walker;

d. Portable oxygen tank;

e. Service animal, or

f. Have a condition, such as blindness, deafness or disorientation which can impact transportation options;

2. Ask the member if he/she has other special needs.

a. Member is a minor child that needs to be accompanied by an adult

b. Accompanying translator

c. Other member considerations

3. If any criteria in V.D.1 or V.D.2 are met the special needs indicator on the encounters information should be yes (Y).

E. Prior Authorization Process

For transportation services for which the Health Plan requires prior authorization, meaning a medical necessity review, the Health Plan must follow the prior authorization standards outlined in the NC Medicaid Managed Care Health Plan Contracts. The Health Plan may subcontract with other entities to have transportation prior authorization completed. However, before they begin the process, the Health Plan is responsible for assuring that:

1. The subcontractor follows the defined prior authorization process, outlined in NC Medicaid Managed Care Health Plan Contracts; and

2. Documentation of the prior authorization decisions, copies of notices, authorizations, approval, and denials are received by the Health Plan and comply with guidelines.

F. Documenting NEMT Trip Requests

All NEMT requests and prior authorizations should be documented appropriately.

All trip requests and the prior authorization outcomes must be logged, including approval date or denial date, reason for denial, and, when applicable, the date the Notice of Adverse Benefit Determination (NABD) was sent to the member.

If the NEMT prior authorization request is approved, the member must be notified of the means and mode granted.

If the NEMT prior authorization request is denied, the Member must be notified via a Notice of Adverse Benefit Determination (NABD) which indicates why the request was denied and the process for the member to appeal the determination.

VI. SCHEDULING NON-EMERGENCY MEDICAL TRANSPORTATION

A. Transportation Requests

1. Health Plans shall not require members to make transportation requests more than two (2) business days in advance.

2. The member should be able to contact the Member Services Department or transportation coordinator at Health Plan to request assistance for all medical service trips during their Health Plan enrollment period. The request may include multiple trips (reference VI.C. Types of Approvals).

3. Health Plans shall offer the trip request to in-network NEMT providers first. If the in-network NEMT providers are not able to fulfill the request, Health Plans may schedule the trip request through TNC providers. TNC providers may be used as first choice for members assigned to a Standard Plan, when the trip is requested less than 2 days in advance. Tailored Plans will continue utilizing TNC providers for recovery trips only.

4. All requests for medical transportation by the members must be documented and treated as trip requests even if it appears obvious that the individual will not be entitled to NEMT for the trip requested.

5. Health Plans shall ensure that an attendant (e.g., parent, guardian, neighbor, friend, other relative) is present with:

    a. Members under the age of eighteen (18), unless emancipated, at no additional cost to the member or attendant. The attendant may or may not be the parent.

    b. Members with special medical, physical or mental impediments, at no additional cost to the member or attendant. The attendant may or may not be the parent.

B. Utilization Documentation

Utilization Documentation should be captured via BCM011-J, for Standard Plans and BCM011-T for Tailored Plans: Non-Emergency Medical Transportation (NEMT) Report. The Health Plan/and or the subcontractor should capture the

following for each scheduled trip at a minimum, including no-shows:

1. Date of request
2. Date of trip,
3. Medicaid Identification Number of the individual obtaining a Medicaid covered service (do not provide the MID of anyone traveling with this individual)
4. NEMT Source Type (Member, Provider, Case Manager, Other)
5. Destination (name of medical provider/business and address)
6. Whether the trip is approved and, if not, the date notice was sent
7. Date denial notice sent (if applicable)
8. Mode of transport
9. Number of additional riders
10. No-shows (member was a no-show, provider was a no-show,)
11. Special needs and considerations
12. Trip Location (must identify out-of-state or bordering state trips)
13. Appeal Date of each NEMT member appeal
14. Appeal Decision of each NEMT member appeal
15. Appeal Decision Date of each NEMT member appeal

The Health Plan and/or subcontractor should maintain the following transportation utilization information for each member's trip request:

1. Prior Authorization Documentation (e.g. date or date span, method and mode)
2. NEMT Utilization Documentation (Section VI.B)
3. Documentations of Approval and Denial notices
4. Dates or documentation of no-show and conduct policy was reviewed with the member

C. Types of Approvals

The Health Plan must provide NEMT services and may approve transportation in one of the following manners based on the member's situation and needs:

1. Individual Medical Trips

    a. Approve trips to medical services as needed for members that meet requirements for transportation assistance.

    b. To avoid providing services to ineligible members, Medicaid eligibility must be verified for each month in which NEMT is requested before approving a transportation request.

2. Series of Appointments

    Transportation can be approved for a series of appointments with a medical provider if the provider is Medicaid enrolled and the service(s) is covered. The transportation coordinator must verify the series of appointments with the provider.

    a. The member must contact the transportation coordinator to request assistance for all medical visits during the designated period.

    b. The transportation coordinator must verify Medicaid eligibility prior to scheduling each trip in the series of appointments, as well as document that the trip is for a Medicaid enrolled provider/Medicaid covered service.

    c. Example: Ms. Sky Blue states that she must visit her heart specialist every two months for a checkup and blood work. Approve bi-monthly visits to this provider for the length of her Medicaid certification period.
    Eligibility for each month must be verified prior to scheduling each trip.
    If Ms. Blue has other transportation needs, she must contact the transportation coordinator and request assistance for those trips separately.

D. Notification Requirements for Trip Requests and Prior Authorization

Members shall have access to a formal appeals and grievance process regarding all NEMT determinations. The Member has the right to request an appeal if they disagree with a decision made on their NEMT trip request (including trip requests that require prior authorization). Written notification must be sent to members when a trip request requiring prior authorization is approved and for all trip denials (including changes in the amount, duration, frequency and scope of the request). The Health Plan must include and maintain this information in their utilization documentation as specified in the policy guidance.

1. Approvals

   The member must receive written notification of approval when prior authorization was required to approve the trip or series of trips. The member may be notified verbally of trip approvals when NEMT requests are initiated by phone if known at the time of the call.

2. Denials

   The Health Plan must follow the formal appeals process for all NEMT trip request denials (including trip requests that require prior authorization) and ensure the following:

   a. An NABD, documenting the reasons for the decision, is sent for each request that is denied (including changes in the amount, duration, frequency and scope of the request). If a series of appointments are requested, only one NABD is needed to deny one, all, or any of the trips included in the request.

   b. If multiple Members in a household are denied NEMT services, then all Members receive a separate NABD.

   c. Copies of the NABD notices are retained in the utilization documentation transportation file.

   d. That trip requests are not denied when the Member fails to comply with the advance notice policy, if services are provided on a different date or a gas voucher is issued.

   e. That trip requests are not denied due to the Health Plan's lack of resources. The Health Plan must develop an adequate network to meet the needs of the members (reference section II.I).

3. Reporting

   The Health Plans must comply with the Member Appeals and Grievance reporting requirements outlined in their contracts with the Department.

VII. ADVANCE NOTICE, NO-SHOW AND CONDUCT POLICIES

A. Advance Notice Policy

1. The Health Plan cannot require the member to make transportation requests in person.

2. While members should be encouraged to make transportation requests as far in advance as possible, they cannot be required to make such requests more than two (2) business days before their scheduled medical appointment and five

days for trips at a greater distance.

3. Urgent transportation services are exempt from any advance notice requirement. The Health Plan must try to satisfy any urgent request for transportation.

   Example: the doctor refers the member for a test that must be completed same day or within days.

4. Hospital discharges should be considered urgent transportation services. Members being discharged from hospitals or emergency departments shall be picked up within three (3) hours of receipt of the request from the member, member's representative or hospital staff.

   If a facility schedules a hospital discharge 24 hours in advance, transport shall be available at the time of discharge.

5. The member must be informed in writing of the advance notice policy (i.e., Member Handbook).

B. No-Show Policy

A No-Show is when a member does not go to the medical appointment. This includes members issued gas vouchers and mileage reimbursement. The purpose of a no-show policy is to establish consistent rules and procedures to follow when a member misses a scheduled trip without good cause.

1. The Health Plan can develop their own no-show policy so long as it is no less restrictive than the no-show policy outlined in MA-3550/2910. The Health Plan is required to explain their no-show policy and provide a written copy of it to the member.

2. For reference, the MA-3550/2910 No-Show Policy is below:
   a. The member must be ready and at the designated place for pick up at the time required by the transportation vendor.

   b. The member must complete their trip and show evidence in order to be issued a gas voucher for mileage.

   c. The member must call the number provided for trip requests to cancel scheduled transportation at least 24 hours in advance. Cancellations made less than 24 hours in advance may count as one "no-show," unless there was good cause for the cancellation.

   d. A first missed trip without good cause will result in counseling by phone, (by letter if the member cannot be reached by phone) that further missed trips may result in a suspension of transportation services for a period of thirty days.

Document the phone conversation in the member's NEMT utilization documentation.

e. A second missed trip within three months of the first missed trip will result in a telephone call (or letter if the member cannot be reached by phone) warning that the next missed trip will result in a suspension of transportation services for a period of thirty days. Document the phone conversation or file the letter in the member's NEMT utilization documentation.

f. A third missed trip within three months of the first missed trip will result in a 30-day suspension of the member's transportation services. The member should be notified of their transportation suspension through the formal appeals and grievance process (NABD) informing the member of their transportation impact, the suspension dates, and their previous no-show information.

g. Continue to follow the no-show policy above after the suspension has ended.

Example: Raven Nevermore is a no show for scheduled NEMT appointments on March 16, April 22 and May 2. After counseling and warnings have occurred, Raven is suspended from transportation assistance from May 16 through June 14. Raven requests transportation services for an appointment on June 18. Raven is a no-show for this trip as well. Raven can be suspended for another 30 days because she has missed three appointments in a three-month span.

3. Good Cause

Good cause consists of illness of the member or illness/death of the member's spouse, child or parent.

4. Exception to suspension for critical needs Members.

Critical needs members, such as those receiving dialysis or chemotherapy, cannot be denied transportation to critical services, no matter how many transportation appointments they miss. However, these individuals can be suspended from receiving NEMT to their non-critical appointments.

C. Conduct Policy

1. The Health Plan can develop their own conduct policy so long as it is no less restrictive than the conduct policy outlined in MA-3550/2910. The Health Plan is required to explain their conduct policy and provide a written copy of it to the member.

2. For reference, the MA-3550/2910 Conduct Policy is below:

a. Any conduct which jeopardizes the safety of other passengers and/or the driver will result in suspension of transportation services by the Health Plan for 30 days.

b. Public transit systems, TNC providers, and other NEMT providers shall have conduct policies. NEMT riders are subject to the conduct policies of the transportation providers. Violation of such conduct policies may result in suspension of transportation services in accordance with the vendor's policy. A vendor's suspension from their services may exceed 30 days.

c. Any member who has been suspended from transportation services due to violation of the conduct policy shall be provided a gas voucher or mileage reimbursement in advance, if unable to pay, for trips to Medicaid covered services as long as he remains otherwise eligible for transportation assistance.

d. Any member who has a time limited suspension from transportation services due to violation of the conduct policy should receive an NABD with the reason and timespan of their transportation service suspension.

VIII. NEMT ENCOUNTERS

All NEMT trip requests are to be submitted through the EPS process. Please reference the Encounter Data Submission Guide and the EPS 837-P Companion Guide for more detailed information regarding NEMT Encounters. In summary, NEMT encounters should capture each leg of the trip request as a separate encounter that includes the following information:

1. **Billing Provider**: NEMT Broker or subcontractor.

2. **Rendering Provider**: NEMT provider who provided the service.

   - For claims related to mileage reimbursement, meals, lodging, and commercial air, submit the same rendering provider as the billing provider.

   - Meals, Lodging, and Commercial Air: Submit [Name] and [NPI/Atypical]

     i. Name: meal, lodging, or Commercial Air

     ii. NPI/Atypical: Billing Provider

   - Mileage reimbursement: Submit [Name] and [NPI/Atypical]

     i. Name: Name of the member or volunteer that will receive the reimbursement

     ii. NPI/Atypical: Billing Provider

3. **Trip Number:** 9 characters long (must add leading zeros) and must be unique for each encounter.

4. **Special Needs Indicator**: Determined during the initial assessment and NEMT prior authorization process.

5. **Type of Attendant**: Medical Professional, Non-Medical Professional or Parent, No Attendant. Reference X.F for more information regarding attendant information

6. **Number of Individuals Accompanying the Member**: This will be the number of individuals who are accompanying the member on the trip excluding the attendant.

7. **Member Picked Up Indicator:** This will help determine no-shows for members and providers.

8. **Date the Trip was Requested**: Must be in the yyyy/mm/dd format and on or before the date of the trip.

9. **Transportation HCPCS:** Reference section X.C.2 for the list of approved transportation procedure codes.

10. **Unit Measurement Code:**

    a. MJ: Transportation waiting time in ½ hour increments for minutes for procedure code T2007

    b. UN: Unites for all other procedure codes

11. **Actual Miles of the Trip:** The actual miles of the trip associated to the transportation mileage procedure codes, or the number of minutes spent waiting for the Member.

12. **Place of Service:**

    a. 99 for taxi, bus, mini-bus, van, car, TNC

    b. 41 for ambulance – land

    c. 42 for ambulance

13. **Trip Type:** This will distinguish different legs of the trip

    a. **Initial**: First leg of the trip

    b. **Return**: Last leg of the trip

    c. **Transfer**: All the legs in-between the initial and return trip to be marked with the corresponding trip leg number

14. **Trip Leg:** The number (1-9) of the trip leg in order to sequence the legs of the trip. A trip leg is defined as an instance of pickup/origination and drop off/destination of the Member for their requested trip.

15. **Transportation Type**: Reference II.F for the different types of NEMT transportation types and below is the code and description allocated for NEMT encounters.

Code	Description
PT	Public Transportation
WV	Wheelchair Van
MV	Multi-person Van
TX	Taxi
AM	Ambulance
VN	Van
MB	Mini-Bus
MT	Mountain Area Transports
PV	Private/Personal Vehicle
TNC	Transportation Network Company
OT	Other

16. **Appointment Time**: The appointment time should be either the time of the appointment specified by the member or the time the member specified to arrive for their appointment. If the member is being taken to an appointment, the appointment time should be supplied in military time format. If the member is being taken somewhere but there is no appointment time, the time should be entered as 0000.

17. **Scheduled Pickup Time:** The time the member has indicated that they should be picked up, this should be in military time format.

18. **Pickup Location:** Allowed pickup locations are indicated below.

Code	Description
AD	Adult Day Care
AL	Intensive Assisted Living
CL	Clinic
DI	Dialysis
DN	Dental
DO	Doctor’s Office
DR	Drug Rehabilitation
DS	Day Support
HM	Home
HO	Hospital
LX	Lab and X-Ray
MH	Mental Health
NH	Nursing Home
OS	Out of State Transportation
PR	Physical Rehabilitation
PT	Psych Transport

Code	Description
PV	Patient Visitation
RC	Respite Care
RE	Residence
RX	Pharmacy
SC	School
SE	Supported Employment
SG	Surgical Center
SP	Specialist
UN	Unknown
OT	Other

Use the out-of-state transportation code (Code OS) when the pickup or drop-off state is outside the State of North Carolina.

19. **Arrival Time:** The time the driver arrives at the pickup (origin) location.

20. **Departure Time:** The time the driver leaves the pick-up (origin) location.

21. **Drop-off Location:** See valid values from section VIII. Pickup Locations.

22. **Drop-off Time**: The time the driver arrives at the drop-off (destination) location.

23. **Pick Up Location:** Pick-up Address, including street, city, state, and zip code.

24. **Drop Off Location:** Drop-off Address, including street, city, state, and zip code.

A. NEMT Encounters Special Considerations

1. Cancelled trips should be reported as denied trips through the encounters process.

2. Duplicate encounters will be validated against same claim number, or the same billing and rendering provider, member, date of service, procedure codes/modifier, and trip leg.

3. An ICD-10-CM diagnosis code is required on all NEMT encounters. Diagnosis code Z76.89 is recommended.

Note: transportation benefits that are defined as value-added services should be reported using the submission rules for value-added services encounters and not under NEMT.

Please reference the EPS Business Rules Spreadsheet for the list of NEMT encounters business rules and the Encounter Data Submission Guide and the EPS 837-P Companion Guide for additional clarification on NEMT encounter file layout.

IX. COMPLIANCE AND RISK MANAGEMENT

The Health Plan is responsible to ensure that their contracted NEMT participating providers are in compliance with all the risk management procedures outlined below. **These requirements do not apply to members and financially responsible persons who seek reimbursement for mileage.**

A. Safety and Risk Management Monitoring

From a risk and compliance monitoring perspective, the Health Plan and/or designated entity shall:

1. Ensure contracts with NEMT providers include all provisions specified in this policy.

2. Ensure all appropriate contract NEMT providers are enrolled with the State Medicaid program.

3. Ensure contracts include a certification and/or assurance of compliance with contractual safety and risk obligations.

4. Conduct an annual review of contractors to ensure all contract requirements are met.

5. Ensure contracted NEMT Providers maintain a file for their staff, approved volunteers, and member relatives and friends who are reimbursed directly for NEMT services.

    a. The Health Plan is required to review these files to assure that all information is current within timeframes specified in the Health Plan's fraud, waste, and abuse monitoring plan.

6. Ensure all contracted NEMT providers maintain the following for their staff and approved volunteers:

    a. Driver's License;

    b. Current vehicle registration/inspection;

    c. Current driving record;

    d. Liability insurance;

    e. An agreement stating that the staff/agency volunteers will report all changes

7. Ensure that member relatives and friends providing NEMT services via

reimbursement possess the following:

a. Driver's License;

b. Current vehicle registration/inspection;

c. Liability insurance;

d. An agreement stating that the staff/volunteers/ member relatives and friends will report all changes;

These files are required to be reviewed at time of initial member request for a relative/friend to provide transportation when member changes the relative/friend providing transport and annually thereafter to assure that all information is current.

8. Ensure liability Insurance is met for the following:

Sufficient insurance coverage is necessary to adequately protect the contracted NEMT provider and the members transported. A guide for minimum coverage shall be the amount required for common carrier passenger vehicles by the North Carolina Utilities Commission (see http://www.ncuc.net/ncrules/chapter02.pdf, Rule 02-36).

a. Commercial Vehicles

i. The Health Plan should require contracted transportation providers to carry liability at the minimum statutory requirements.

ii. When commercial vehicles (16 passengers or more) are used to provide member transportation services, the Health Plan should obtain a copy of the private contractor's Certificate of Insurance documenting that the Health Plan transportation coordinator or designee is an "additional insured." The party identified as an "additional insured" will be notified 30 days in advance of a contractor dropping any coverage.

b. "For Hire" Vehicles

i. "For Hire" passenger vehicles are defined as vehicles used for compensation to transport the general public as well as human service members and are, therefore, subject to the regulations of the N.C. Public Utilities Commission. Taxi cabs and public transportation systems do not fall into this category.

ii. Transportation providers licensed as "For Hire" public conveyance operators must meet statutory requirements for their classification and operator responsibilities. Currently, $1.5 million liability insurance coverage is required on vehicles with a seating capacity of 15 passengers or less, including the driver, and $5 million coverage for vehicles designed to transport more than 15 passengers, including the driver.

c. Taxi Cabs

Liability insurance requirements are set by local ordinances and can vary widely from county to county. Any taxi service used for NEMT must carry at least the minimum liability insurance coverage for their vehicle's classification for their local ordinance (for minimum liability requirements for passenger vehicles, see https://www.ncdot.gov/dmv/title-registration/insurance-requirements/Pages/default.aspx).

9. Ensure the validity of licensed operators

a. The Health Plan and/or designated entity is required to attest that contracted NEMT providers are meeting all contractual requirements by periodically reviewing driver licenses and verifying all drivers are at least 18 years of age and properly licensed to operate a vehicle and driving records are reviewed every 12 months. If the review is performed by a designated entity, the designated entity is required to periodically (at the discretion of the Health Plan) provide to the Health Plan a sample of their reviews.

b. The Health Plan is required to ensure that all drivers are at least 18 years of age and properly licensed to operate the specific vehicle used to transport Members. This also applies to family members, friends, etc., reimbursed to transport the member, but not to members and financially responsible persons.

10. Ensure that vehicle state inspections are valid

The Health Plan and/or designated entity is required to ensure that all vehicles used to transport members have valid State registration and State inspection. This also applies to family members, friends, etc., reimbursed by the agency to transport the member, but not to member and financially responsible persons.

11. Alcohol and Drug Testing

The Health Plan and/or designated entity shall ensure both private and public contract transportation providers to participate in a random alcohol and drug testing program which meets the requirements of the Federal Transit Authority (FTA) (see https://www.transit.dot.gov/drug-alcohol-program). The providers shall be contractually obligated to pay for the alcohol and drug testing program.

TNC drivers are not required to participate in random alcohol and drug testing. TNCs utilize their own comprehensive and effective background screening processes to qualify drivers for operation in their transportation network platform. Drivers operating on a TNC platform cannot have disqualifying drug/alcohol offenses in their background and screening results based on NC State TNC requirements.

12. Background Checks

The Health Plan and/or designated entity shall ensure a criminal background check is performed on all employed or agency volunteer drivers through the North Carolina Law Enforcement Division or, if not a resident of North Carolina for at least 5 consecutive years, the National Crime Information Center (NCIC) prior to employment or volunteer enlistment and every three years thereafter. Conviction, guilty plea or plea of no contest to any of the following is grounds for disqualification from employment/volunteer service if committed within the 10-year period preceding the date of the background check.

a. Murder,

b. Rape or aggravated sexual abuse,

c. Kidnapping or hostage taking,

d. Assault inflicting serious bodily injury,

e. A federal crime of terrorism,

f. Unlawful possession, use, sale, distribution, or manufacture of an explosive device,

g. Unlawful possession, use, sale, distribution, or manufacture of a weapon,
h. Elder abuse/exploitation,

i. Child abuse/neglect,

j. Illegal sale or possession of a Schedule I or II controlled substance,

k. Conspiracy to commit any of the above.

l. TNCs shall align background check screening standard and offenses for TNC drivers to the State TNC standards cited in NC Department of Transportation statue N.C.G.S. § 20-280.6. which states: Prior to permitting an individual to act as TNC driver, the TNC must do all of the following:

(1) Require the individual to submit an application to the Transportation Network Company, including, at a minimum, the following:

a) Address
b) Age
c) Driver’s license number
d) Driving history
e) Motor vehicle registration
f) Automobile liability insurance information

(2) Conduct, or have a third-party conduct, a local and national criminal background check for each applicant, including, at a minimum, the following:

a) Multi-State/Multi-Jurisdiction Criminal Record Locator or other similar commercial nationwide database with validation (primary source search)
b) National Sex Offender Registry

13. Driving Record

a. The Health Plan and/or designated entity is required to ensure the NEMT providers have a driver screening policy for employees, and volunteers who transport members.

b. The driving records of all drivers shall be reviewed every 12 months.

c. Drivers must have no more than two chargeable accidents or moving violations in the past three years and must not have a driver's license suspension or revocation within the past five years. Effective December 27, 2021, drivers with three or more chargeable accidents or moving violations during the last three years or who have had one or more driver's license suspensions or revocations within the past five years cannot transport Medicaid beneficiaries per the July 12, 2021, Center for Medicaid and CHIP Services (CMCS) Information Bulletin regarding Medicaid Coverage of Certain Medical Transportation under the Consolidated Appropriations Act, 2021 (Public Law 116-260).

d. Applicants for driver positions shall be required to submit a copy of their driving record for the last three years prior to the date of application.

e. Driving records may be obtained from the Department of Motor Vehicles (DMV). Accept the DMV information provided by the applicant unless questionable.
f. The driver screening policy does not apply to members, financially responsible persons, or family and friends of the member.

14. For public transit providers, the PHP and/or designated entity shall rely on NC Tracks (and any successor NC DHHS provider enrollment system) and NC DOT credentialing requirements and NC DOT requirements outlined in the NC DOT Business Guide as evidence of compliance with the safety and risk management standards found in this Subsection X.A and in credentialing a provider for participation in the PHP and/or designated entity's network. The Health Plan and/or designated entity shall verify the Provider's enrollment with the State of North Carolina and the Provider's continued status as an active enrolled Medicaid provider as proof of compliance.

15. For taxi cab providers, the PHP and/or designated entity shall rely on NC Tracks (and any successor NC DHHS provider enrollment system) and credentialing requirements and taxi standards outlined by the NC Taxi Regulatory authorities (whether city/town/county/municipality) as evidence of compliance with the safety and risk management

standards found in this Subsection X.A and in credentialing a provider for participation in the PHP and/or designated entity's network. The Health Plan and/or designated entity shall verify the Provider's enrollment with the State of North Carolina and the Provider's continued status as an active enrolled Medicaid provider as proof of compliance.

16. For TNC providers, the PHP and/or designated entity shall rely on NC Tracks (and any successor NC DHHS provider enrollment system), TNC credentialing requirements, and NC Department of Transportation statue N.C.G.S. § 20-280.6 which states:
    1) Review, or have a third-party review, a driving history research report for such individual.
    2) The transportation network company must confirm that every TNC driver continues to meet all the requirements of section N.C.G.S. § 20-280.6 every five years starting from the date the TNC driver met all the requirements of section N.C.G.S. § 20-280.6.
    3) The transportation network company must not permit an individual to act as a TNC driver if any of the following apply:
        a. Has had more than three moving violations in the prior three-year period or one major violation in the prior three-year period, including attempting to evade the police, reckless driving, or driving on a suspended or revoked license.
        b. Has been convicted within the past seven years of driving under the influence of drugs or alcohol, fraud, sexual offenses, use of a motor vehicle to commit a felony, or a crime involving property damage, theft, acts of violence, or acts of terror.
        c. Is a match in the National Sex Offender Registry.
        d. Does not possess a valid driver's license.
        e. Does not possess proof of registration for the motor vehicle to be used to provide TNC services.
        f. Does not possess proof of automobile liability insurance for the motor vehicle to be used to provide TNC services.
        g. Is not at least 19 years of age.

17. For TNC providers, the PHP and/or designated entity shall rely on NC Tracks (and any successor NC DHHS provider enrollment system), TNC credentialing requirements, and the standard outlined in NC Department of Transportation statue N.C.G.S. § 20-280.6 as evidence of compliance with the safety and risk management standards found in this Subsection X.A and in credentialing a provider for participation in the PHP and/or designated entity's network. The Health Plan and/or designated entity shall verify the Provider's enrollment with the State of North Carolina and the Provider's continued status as an active enrolled Medicaid provider as proof of compliance.

18. The Health Plan is required to report the results of the plan's annual review of NEMT providers/contractors' compliance with contract requirements. The Health Plan shall submit the results of the plan's annual review to the Department in a format specified by the Department. The Health Plan shall provide the results of its annual review to the Department on an annual basis and at the request of the Department.

B. Provider Transportation Contract

A written contract, signed by the vendor, must be obtained by the Health Plan or its transportation broker when purchasing private transportation. The document must authorize services and include the following contract requirements:

1. A guarantee the contractor will meet all safety and liability requirements for its vehicles and employees as specified above;

2. An obligation to maintain records documenting compliance with all vehicle and employee requirements as specified above;

3. An obligation that no more than one quarter of one percent of all trips be missed by the vendor (vendor no-show) during the contract year;

4. An obligation to meet on-time performance standards such that no more than five percent (5%) of trips should be late for Member drop off to their appointment per month (past the member's appointment time);

5. An obligation to report any changes such as insurance provider, business ownership, provider enrollment status;

   Public transit providers meet this requirement through NC DOT credentialing and reporting.

   Taxicab providers meet this requirement through the NC Taxi Regulatory authorities (whether city/town/county/municipality) credentialing and reporting.

6. An obligation to allow monitoring of records to ensure all contract requirements are met;

7. An obligation to report all no-shows daily and cancellations monthly.

8. If the Health Plan agrees to pay for no-shows or driver wait time, an obligation that all charges for no-shows or driver wait time are separately invoiced from Medicaid transportation reimbursable costs.

9. An obligation to record all member complaints which deal with matters in the vendor's control, including the date that the complaint was made, the nature of the complaint and what steps were taken to resolve the complaint.

   Example 1: A member complains about the speed of the vehicle in which he was transported. This complaint must be logged.

   Example 2: A member complains that the driver was late. This complaint must be logged.

Example 3: A member complains that one of the other passengers was talking on a cell phone for the entire trip. There is no need to log this complaint.

10. An obligation to have written policies and procedures regarding how drivers handle and report incidents, including client emergencies, vehicle breakdowns, accidents and other service delays.

    Public transit providers meet this requirement through NC DOT credentialing and reporting.
    Taxicab providers meet this requirement through the NC Taxi Regulatory authorities (whether city/town/county/municipality) credentialing and reporting.

11. An obligation to use the provided transportation billing codes on invoices to the Health Plan for reimbursements or filing claims.

12. An obligation to meet all Provider Enrollment requirements.

C. Direct Services to Members by Contract Transportation Providers

1. Contract transportation providers include public transportation, taxis, vans, and non-medically necessary ambulance transportation.

2. Billing Codes

   For non-emergency transportation costs, use the following billing codes for encounter data reporting:

HCPCS	HCPCS Code Description
A0021	Ambulance service, outside state per mile (Medicaid only)
A0080	Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization) with no vested interest
A0090	Non-emergency transportation, per mile – vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Non-emergency transportation, taxi, TNC
A0110	Non-emergency transportation and bus, intra or interstate carrier
A0120	Non-emergency transportation; mini-bus, mountain area transports or other transportation systems
A0130	Non-emergency transportation: wheel-chair van
A0140	Non-emergency transportation and air travel (private or commercial) intra or interstate
A0160	Non-emergency transportation: per mile – case worker or social worker
A0170	Transportation ancillary – parking fees, tolls, other
A0180	Non-emergency transportation – ancillary – lodging - recipient

HCPCS	HCPCS Code Description
A0190	Non-emergency transportation – ancillary – meals- recipient
A0200	Non-emergency transportation – ancillary – lodging- escort
A0210	Non-emergency transportation – ancillary – meals - escort
A0380	BLS mileage (per mile)
A0390	ALS mileage (per mile)
A0394	ALS specialized service disposable supplies – IV drug therapy
A0420	Ambulance waiting time (ALS or BLS) one half (1/2) hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0999	Unlisted ambulance service
S0215	Non-emergency transportation; 2, per mile
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
S9975	Transplant related lodging, meals and transportation, per diem
S9976	Lodging, per diem, not otherwise classified
S9977	Meals, per diem, not otherwise specified
S9992	Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion
T2001	Non-emergency transportation; patient attendant/escort
T2002	Non-emergency transportation; per diem
T2003	Non-emergency transportation; encounter/trip
T2004	Non-emergency transport; commercial carrier, multi-pass
T2005	Non-emergency transportation; stretcher van
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments
T2049	Non-emergency transportation; stretcher van, 2; per mile

D. Other Transportation Services Provided by the Health Plan

1. Volunteers using their own vehicles,

2. Direct payments such as gas vouchers and mileage reimbursement to members, family members and friends (see E., Gas Vouchers and Reimbursement below for more information on gas vouchers and mileage reimbursement),

3. Attendant expenses,

4. Travel-Related expenses (see below for more information on travel-related expenses), and

5. Ancillary Costs and Attendant Pay,

6. Non-Emergency Air Travel

E. Gas Vouchers and Mileage Reimbursement

1. Gas vouchers are issued to eligible members who can use their own car or a friend/relative's car for transportation to a Medicaid covered service.

2. Gas vouchers can be redeemed at local gas stations and may not exceed the current IRS rate or half the IRS rate unless the gas provider requires a minimum rate.

3. Mileage reimbursement may not exceed the current IRS rate or half the IRS rate.

4. Both mileage reimbursement and gas vouchers must be provided in an amount sufficient to cover the cost of gas.

5. Because members are unlikely to have fuel efficient vehicles, the amount of fuel required to complete the trip must be calculated using a conservative miles-per-gallon figure.

6. Mileage reimbursement issued should be the exact amount and not rounded to the nearest dollar.

F. Attendants

1. All attendants, including family members, are entitled to reimbursement of expenses incurred during transportation at the least expensive rate that is appropriate to the member's circumstances, including reimbursement for return trips with or without the member;

a. Attendants, other than family members, may charge for their time.

b. Non-medical professionals

The Health Plan, at its discretion, may use the state or, if greater, the county per diem, but must not exceed the state minimum hourly wage (Minimum Wage in N.C.). The attendant may also be the driver if it's the least expensive means.

c. Medical professionals serving as attendants

If the medical professional administers medical services during the trip, he can bill Medicaid for that service. Do not pay the attendant when he can bill Medicaid directly.

d. If the medical professional does not perform a medical service during the trip, maximum reimbursement for the attendant cannot exceed the hourly minimum wage.

2. Reimbursement for travel for parents/guardians to care for, or be taught how to care for, an in-patient child (necessity verified through NEMT prior authorization).

3. If both parents are accompanying the child, reimbursement for the other parent must be necessity verified.

G. Travel-Related Expenses

1. Reimbursement for travel related expenses may not exceed the state mileage sustenance and lodging reimbursement rates. The rates can be found in section 5.1, travel policies for State Employees, of the budget manual: https://www.osbm.nc.gov/budget/budget-manual. Additionally, please stay current with budget memos.

2. The Health Plan has the option of providing money for travel related expenses to the member in advance or after the trip is completed.

3. If the worker feels that verification of the appointment is necessary, he should request the appointment card or contact the provider.

4. Breakfast

Under State policy, reimbursement for breakfast may be claimed if the member must leave before 6:00 a.m.

5. Lunch

Reimbursement for lunch is only allowable on overnight stays. If a day trip will

last from morning through afternoon the Health Plan should counsel the member to make arrangements for lunch. At the Health Plan's discretion, lunch may be provided for the member and attendant.

6. Dinner

   Reimbursement for dinner is allowable if the member does not return until after 8:00 p.m.

7. Parking Fees, Tolls

   Reimbursement for parking fees and tolls is allowable if reimbursement is based only on mileage. If transportation is reimbursed on a per-trip basis, parking fees and tolls are already included in the payment for the trip.

8. Overnight Lodging

   a. When the medical service is available only in another county, city, or state, medical condition, travel time and distance may warrant staying overnight.

   b. Allowable expenses include overnight lodging and meals for eligible members while in transit to and from the medical resource.

   c. Lodging and transportation to and from the lodging must be determined to be less expensive than daily travel from home (unless deemed medically necessary).

   d. Overnight lodging, not to exceed the state rate or, at the Health Plan's discretion, the county reimbursement rate if higher, can be reimbursed. If the county per diem is higher than the state per diem, the Health Plan may choose but is not required to use the higher reimbursement rate.

9. Long-Term Lodging

   a. When the medical service is only available in another county, city, or state and beneficiary and/or Member's attendants(s) must remain in the county, city, or state of the medical service for the duration of the treatment.

   b. A member and/or a member's attendant(s) long-term lodging shall be covered when necessitated on the basis of medical advice. Long-term lodging is defined as an overnight stay that is expected to last or has lasted for 5 days or more.

   c. If a member and/or a member's attendant(s) require long-term lodging, the Health Plans shall follow the prior authorization process outlined in this policy. The Health Plan is responsible for ensuring that long-term

lodging prior authorizations are approved or denied within 5 business days.

i. A Health Plan may designate a subcontractor to approve or deny prior authorizations for long-term lodging. The Health Plan is responsible for ensuring that responses to long-term lodging prior authorization are approved or denied in a timely manner and prior to the authorization of the stay. The subcontractor must follow prior authorization processes as outlined in Policy.

ii. If a member and/or a member's attendant(s) require lodging beyond the length of the stay originally approved in the prior authorization process on the basis of medical advice, these requests for lodging extensions shall be assessed within 48 hours by the Health Plan or designated subcontractor.

d. Reimbursements for breakfast, lunch, and dinner during long term lodging may be claimed by the member if these meals are not provided by the long-term lodging entity.

H. Non-Reimbursable costs

1. Expenses of an attendant to sit and wait following member admission to a medical facility.

2. Transportation provided when free or lower cost suitable transportation was available.

3. Purchase price of a vehicle for transportation. The purchase of a vehicle may be recovered over the life of the vehicle through trip reimbursement.

4. Trip costs higher than appropriate when less expensive means of transportation is available.

5. Routine transportation to school on a school day even though health services may be provided in the school during normal school hours.

6. Travel to visit a hospitalized patient (except to provide or learn to provide care for an in-patient child).

7. Empty miles.

   a. Miles to or from a transportation vendor's office/home/garage to or from the Medicaid member's residence are not compensated by Medicaid.

   b. Medicaid only pays from point of member pickup to the point of drop off.

c. The cost of empty miles should be factored in the total cost in setting mileage rates.

d. Exceptions for Empty Miles

iii. For Public Transportation systems, a “share ride” system can be implemented to ensure a cost-effective utilization of public transportation systems.

iv. Share rides refers to a cost based on the total vehicle’s miles divided by the total # of passengers instead of a cost based on the point of pick-up and drop-off of each passenger.

8. Ambulance transportation of a deceased person.

9. Transportation costs incurred by a vendor not contracted with the Health Plan.

10. Trips when the member is not seen by the provider due to the fault of the member (e.g. member did not bring proper documentation, x-rays, etc.)

11. No-Shows (refer to section VII. Advance, No-Show, and Conduct Policies)

X. Transportation for Adult Care Home Residents

The Health Plan is responsible for arranging and/or providing non-ambulance transportation for Adult Care Home (ACH) members with no appropriate means of transportation.

1. Facilities may contact the Heath Plan to request transportation services on behalf of the Medicaid member residing in an adult care home.

2. Facilities may provide transportation directly to their residents

   a. If the facility possesses an appropriate mode of transportation, they must enter into a contract with the Health Plan and add Non-Emergency Medical Transportation to their provider profile before they can be utilized as a NEMT vendor.

   b. Facility would need to submit claims to the Broker

   c. Facilities are not reimbursed unless they are contracted with the Health Plan as a NEMT provider and providing transportation.

3. Ambulance transportation for adult care homes residents is permitted only for medical necessity. If an adult care home schedules non-emergency ambulance transportation for a Medicaid member and the claims is denied due to lack of justification for medical necessity (the member’s medical/physical condition did not warrant stretcher transport), the adult care home facility is responsible for payment. The facility cannot bill the patient or his family for non-covered services.

4. Attendants employed by the facility cannot be reimbursed by Medicaid for attendant cost.

XI. REPORTING FRAUD, WASTE AND ABUSE

The Office of Compliance and Program Integrity mission is to protect the resources of the Division of Health Benefits by reducing or eliminating fraud, waste, and abuse (FWA) of providers and members in the NC Medicaid Program. The Health Plan's NEMT Policy is required to include information on the following:

A. Definition of Fraud, Waste and Abuse

1. **FRAUD**: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefits to himself or some other person.

2. **WASTE**: Costs that could have been avoided without a negative impact on quality.

3. **ABUSE:** Occurs when provider practices are inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health.

B. Procedures

1. Any matters involving potential or suspected Medicaid fraud, waste, and abuse shall be investigated by the Health Plan's Special Investigations Unit.

2. As required by contract, the Health Plan shall refer credible allegations of fraud, waste and abuse to the Department. The Health Plan staff shall work collaboratively to ensure that all fraud, waste and abuse referrals get routed to the appropriate contacts.

3. The Health Plan shall ensure all its members have been made aware of how to report suspected fraud, waste, or abuse.

4. Individuals may remain anonymous; however, sometimes to conduct an effective investigation, staff may need to contact individuals. Individual name will not be shared with anyone investigated. In rare cases involving legal proceedings, an individual name may need to be revealed.

C. Examples of Medicaid Member fraud, waste and abuse:

1. A member does not report all income when applying for Medicaid

2. A member does not report other insurance when applying for Medicaid

3. A non-member uses a member's card with or without the member's knowledge

D. Examples of Medicaid Provider fraud, waste and abuse:

1. A provider's credentials are not accurate
2. A provider bills for services that were not rendered
3. A provider performs and bills for services not medically necessary

E. Fraud, Waste and Abuse Reporting

Report complaints by accessing one of the following methods:

1. State Medicaid Fraud, Waste and Program Abuse Tip-Line Phone: (919) 814-0181.
2. Health Plan Fraud, Waste and Program Abuse Tip-Line Phone
3. Health Plan Online Confidential Complaint Form
4. State Online Confidential Complaint Form: https://medicaid.ncdhhs.gov/reportfraud

XII. DEFINITIONS

a. **Attendant –** A person whose presence is needed to assist the member during transport.

b. **Certification Period –** The period of time for which assistance is requested and in which all eligibility factors except need and reserve (when applicable) must be met. Generally, certification periods last 6 or 12 months.

c. **Family Members & Friends** – Family members other than spouses and parents of minor children, as well as other non-related individuals, who comprise a Medicaid member's potential support for transportation needs.

d. **Gas Voucher –** A voucher that is issued to the member or other drivers with which he/she may purchase gasoline at a contracted station.

e. **In Lieu of Services (ILOS)** – Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

f. **Least Expensive Means –** Most cost-effective mode of transportation.

g. **Local Agency-**County Department of Social Services.

h. **Mileage Reimbursement –** Reimbursement to a Medicaid member and/or other driver based on a specific rate per mile driven to allow a Medicaid member to receive covered services.

i. **Mountain Area Transport –** Allows for alternate transportation sources due to mountainous regions including buses and vans.

j. **Mobility Device –** Wheelchair, scooter or other device used to aid personal mobility.

k. **NCTracks-** Medicaid Management Information System (MMIS). North Carolina's Medicaid billing system.

l. **Non-Emergency Medical Transportation (NEMT) –** Transportation to and from medical services on a non-emergent basis. Emergency transportation needs are provided by emergency service vehicles and are billed directly to Medicaid by the provider. NEMT needs for Medicaid members are addressed by the Health Plan's Member Services Department and/or transportation coordinator when requested.

m. **NEMT Provider No-Show:** any instance where the transportation provider does not arrive for pick-up of member to scheduled trip.

n. **Prior Authorization-**An approval process for members to be determined eligible on a trip-by-trip basis to receive NEMT services.

o. **Plan of Care (POC) –** A document which summarizes the CAP evaluation and assessment information into a statement of how the member's needs are to be met; outlines goals and objectives; and indicates the specific services needed, both formal and informal.

p. **Provider –** An individual or entity that provides a medical service, such as a doctor, hospital, pharmacy or transportation.

q. **Provider Enrollment-**The application process to become a NC Medicaid provider for the purpose of rendering services.

r. **Public Transportation –** or public transit is shared transportation available for use by the general public. Public transportation includes buses, trolleys, trains, and ferries, share taxi in areas of low-demand, and paratransit for people who need a door-to-door service.

s. **Series of Appointments –** A group of transportation dates for medical services with the same medical provider which are requested and approved at the same time, rather than as they occur.

t. **Suitable Transportation –** The mode of transportation that is appropriate to the Medicaid Member's medical and other identified needs.

u. **Transportation Coordinator** – The person designated by the Health Plan to coordinate Medicaid transportation trips. This person may be employed by the Health Plan or by a transportation broker under contract with the Health Plan to arrange transportation.

v. **Transportation Providers** consist of businesses with which the Health Plan contracts to provide Non-Emergency Medical Transportation. Providers may be public, such as local transit systems, or private, such as private van services or TNCs. They are also referred to as providers.

w. **Trip –** A NEMT "trip" consists of the length between one pick-up and drop-off. For example, picking up a member at his home and driving him to a doctor's office is one trip. If the same member is picked-up at the doctor's office and driven back to his home that is a second trip. If before being driven home, the same member is driven to a drug store that would constitute a third trip.

x. **Urgent Transportation Need–** A need for transportation to a medical service which does not warrant ambulance transport but cannot be postponed to another time. Examples include hospital discharge, acute illnesses, trip modification/transfer request, and non-emergent injuries, as well as necessary medical care that cannot be rescheduled to another time.

y. **Value-Added Services** – Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the Health Plan's discretion and are not included in capitation rate calculations. Value added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

Version

DATE	SECTION UPDATED	CHANGE
2/18/2020	Original Document	N/A
6/1/2020	VI.B Utilization Documentation	Updated list of report fields to match the BCM011 report template.
2/1/2021	II.A.2.a II.I.1.a VII.A.2 X.A.14 X.B.5 X.B.10	Add provisions specific to Public Transit providers, multi-load vehicles, and clarified requirements for scheduling trips in advance.
12/9/2021	X.A.13.c X.A.15	Added requirements for drivers and reporting
1/7/2022	X.A.15 X.B.5 X.B.10	Added provisions specific to taxi cab providers.
2/15/2022	II.A.2.c II.I.1.b VII.A.4 XII.X	Added requirements for hospital discharges.
8/29/22	II.C.3	Clarification regarding Individuals/Members who are not eligible to receive NEMT services from Health Plans to better define Members in a Nursing Home.
10/3/22	II.C.3 X.G.9	Capitalize Nursing Home Addition of language around Long-Term Lodging
11/11/22	I.1 II,C.2 III IV.A IV.D VI.B.5	Removed NC Health Choice as members will be moving to Medicaid
7/1/2023	IV.D IV.E	Update Ambulance Section Add Ambulance Provider Emergent, Urgent, and Non-Emergent Trip Process Flow
2/1/2024	II.F.1 II.I.4.b.ii VI.A.3 VII.C.2 IX.15 X.C.2	Add Transportation Network Company (TNC)
2/1/2024	X.C.2	Remove billing codes: A0382, A0384, A0392, A0394, A0396, A0398
7/1/2024	II.C.3 II.D X.C.2 IV.A.3 X.	Added Innovation Waiver Added EPSDT Section Removed billing codes: A0424, A0432, A0433 Increased use of TNC providers Added Transportation for Adult Care Home Residents Section