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**NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)**

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**I. INTRODUCTION**

Transportation to and from providers is a critical component for Medicaid beneficiaries to obtain necessary health care.

- A. Non-Emergency Medical Transportation (NEMT) services consist of arranging and/or paying for transportation.
- B. When the beneficiary lacks both means and mode, the local agency is responsible for arranging transportation at a cost within allowable Medicaid regulations.
- C. When the beneficiary has access to a suitable mode of transportation, but lacks the means to use it, the local agency must assist with the means through gas vouchers, mileage reimbursement, etc.
- D. The obligation to provide transportation is not without qualifications.

**II. CRITERIA**

**A. Medicaid only pays for transportation:**

- 1. By the least expensive mode available and appropriate for the beneficiary,
- 2. To the nearest appropriate medical provider,
- 3. To a Medicaid-covered service provided by a NC enrolled Medicaid provider (with exceptions outlined in this policy). A Medicaid covered service is a service that is covered under the NC Medicaid program. Refer to Division of Health Benefits (DHB) [clinical coverage policy](#).

The following individuals/services are not Eligible for NEMT:

- 4. MQB-Q, B, or E only beneficiaries
- 5. Beneficiaries in deductible status-An applicant/ beneficiary is not eligible for Medicaid transportation assistance until their deductible is met.
- 6. North Carolina Health Choice (NCHC) beneficiaries
- 7. Nursing home beneficiaries-The facility is responsible for providing transportation to their patients.
- 8. Individuals receiving certain mental health services: Transportation costs are included in

the Medicaid provider’s fee; therefore, beneficiaries are not eligible for NEMT to these services. See below.

Innovations Waiver covered services that have transportation included in the Medicaid provider’s fee:

Innovation Services	CODE
Day Supports – Individual	T2021
Day Supports – Group	T2021HQ
Supported Employment – Individual	H2025
Supported Employment – Group	H2025HQ

**III. COMMUNITY TRANSPORTATION SERVICES PLAN**

**A. The local Agency Participation in Community Transportation Services Plan**

Every local agency has an approved Community Transportation Services Plan (CTSP) which must be updated periodically. The local agency is encouraged to participate in CTSP development of the planning, design, and delivery of local Medicaid transportation services to assure that transportation is provided to Medicaid beneficiaries in a timely and cost-effective manner.

The purpose of a CTSP is to:

1. Develop and promote the full integration of the community transportation system’s programs with other federal and state programs supporting public and human service transportation.
2. Support and promote the coordination of public transportation services across geographies, jurisdictions, and program areas for the development of a seamless transportation network.
3. Support the provision of dependable transportation options to the general public, low-income individuals, elderly persons, and/or persons with disabilities within the guidelines and funding levels provided by NCDOT and FTA.

**B. Participation**

To assure that transportation is provided to Medicaid beneficiaries in a timely and cost-effective manner, the local agency is encouraged to participate in CTSP development of the planning, design, and delivery of local Medicaid transportation services

**IV. MEDICAID COVERED SERVICES**

**A. Medicaid Covered Services**

Non-Emergency Medical transportation is only provided for Medicaid covered services and when the primary reason for the trip is medical care. Consult the

Medicaid Clinical Coverage Manual for information on the service in question ([DHB Clinical Coverage Policy](#)).

**Example 1:** Beneficiary participates in a sheltered workshop program at a facility that provides medical services. Because the primary reason for the trip is to participate in the sheltered workshop program, transportation would not be covered even though a medical service is received during the course of the day.

**Example 2:** Beneficiary is a child who receives medical services while at school. Transportation would not be provided to the school because a medical service is not the primary reason for the trip.

## **B. Classes for Organ Transplants and Gastric Bypass surgery**

Medicaid covered service may include classes that are a medical requirement that the patient attend prior to the surgery. The classes are free and therefore are not Medicaid covered services. However, because the classes are a mandatory prerequisite to obtaining the Medicaid covered service, transportation shall be provided to these classes.

## **C. Specific Medicaid Covered Services (not all-inclusive)**

### **1. Pharmacy**

Medicaid covered service also includes trips to the pharmacy to pick up medication, including dual eligibles (Medicare/Medicaid).

### **2. Community Alternative Program (CAP)**

A beneficiary of CAP is entitled to transportation to any service included in the Medicaid column of their plan of care cost summary. This may include services that are not usually Medicaid covered services. The CAP plan of care shall be obtained from the CAP case manager.

### **3. Annual Visits limits, Physical Therapy, or other limited covered services**

The local agency is not responsible for verifying whether the beneficiary has exceeded their annual visit limit or other covered service limitations prior to the provision of transportation services.

### **4. 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 for Medicaid beneficiaries 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).

- a. The local agency 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. When EPSDT beneficiaries request transportation for a non-covered service, verify with the provider that prior approval was obtained.
- c. If unable to obtain a copy of the approval letter from the provider, call the DHB Clinical Policy section to verify prior approval. DHB Clinical Policy can be reached at 919-855-4260.
- d. File the EPSDT approval or document in the transportation file.

#### **D. Verification Requirements for Medicaid Covered Services**

1. The local agency is responsible for ensuring transportation is provided only to a Medicaid covered service. To meet this responsibility, a minimum of 10% of trips must be pre-verified (prior to the trip) and a minimum of 10% of trips must be post-verified (after the trip has occurred). The type of trip should vary in the sample (e.g., van, gas vouchers, public transportation). Verification can be accomplished by:
  - a. Phone call to the providers. Document the date of the call, the person to whom you spoke and what was verified.
  - b. Utilizing the [DHB-5118A](#), Verification of Receipt of Medicaid Covered Service, form (use [DHB-5118B](#) only if provider requires a signed release). The responsibility for getting the DHB-5118 signed and returned to the local agency can be placed upon the beneficiary or the transportation vendor.
  - c. Any other method sufficient to elicit the information. Document the method and result in the file.
  - d. A DHB-5118 is not required if verification was accomplished by a phone call to the provider or by other documentation.
2. The local agency cannot authorize a claim or request reimbursement for a trip that is not to a Medicaid covered service.
3. Calculate the 10% by using the average number of monthly trips completed in the July through September quarter from the previous year. For example: The following number of trips occurred in 2017: July 2017-260 trips, August 2017-300 trips, September- 100 trips. The average for the quarter is 220. The local agency would pre-verify 22 trips per month and post-verify 22 trips per month in 2018.

#### **V. NEAREST NC ENROLLED PROVIDER**

##### **A. Nearest NC Enrolled Provider**

1. The local agency is required to arrange transportation to medical services

which are closest to the beneficiary's pick-up location. This can include a bordering state.

2. Transportation is not provided to a provider at a significantly greater distance **when the needed services can be obtained in the community**. For Medicaid purposes, "significantly greater distance" is defined as a one-way trip that is over 30 miles from:
  - a. The beneficiary's pick-up location, or
  - b. The nearest provider, if not available within the community
  - c. Transportation requests that are significantly greater than 30 miles must have prior approval but can be approved under special circumstances and exceptions.

Refer to V.A.3. and 4. below regarding the circumstances and exceptions for approving beneficiary transportation requests that are significantly greater than 30 miles.

3. Medicaid may not pay for transportation if a beneficiary chooses a provider at a significantly greater distance unless:
  - a. Local providers are not available or refuse to see the beneficiary,
  - b. The transportation is to their CCNC Primary Care Provider,
  - c. The beneficiary reports that DHB has prior approved a service for a provider at a significantly greater distance.

If unable to verify prior approval with the provider, contact DHB Clinical Policy at 919-855-4260.

- d. Document in the transportation file.
4. DHB-5048, Medicaid Transportation Exception Verification form
  - a. When the beneficiary requests transportation at a distance greater than 30 miles and it does not meet one of the situations in 3 above, use the DHB-5048, Medicaid Transportation Exception Verification form to obtain a written statement from the provider as justification for providing transportation at a greater distance.
  - b. The beneficiary's provider must give a medical reason why the beneficiary must be transported to the provider at a greater distance. Never deny the beneficiary this right.
  - c. Medical reasons may include:
    - (1) The beneficiary is undergoing an established course of treatment which must be completed, such as chemotherapy or surgical

follow-up visits.

- (2) The beneficiary would be harmed by disruption of an established provider/patient relationship.

## **B. Procedures**

1. Fax the DHB-5048 to the provider.
2. For specialists, the form must be signed by the referring physician.
3. For primary care providers, the form must be signed by the primary care provider.
4. For specialists referred by another specialist, the form can be completed by the referring specialist.

Note: the DHB-5048 can also be completed by a qualified medical staff in the office. (e.g., Nurse Practitioner, Physician's assistant)

5. Set an appropriate time frame for returning the form.
6. The completed DHB-5048 must be filed in the transportation file.
7. If unable to obtain to obtain information over the phone, follow procedures above.

## **VI. LOCAL AGENCY RESPONSIBILITIES**

### **A. Inform the applicant/beneficiary of Right to Transportation Assistance**

1. The local agency must give or mail the DHB-5046, Medical Transportation Assistance – Notice of Rights/Responsibilities, to the A/B at each Medicaid application and Medicaid recertification. This includes all types of eligibility except: Medicare Qualified Beneficiaries (MQB); North Carolina Health Choice, and those beneficiaries who reside in long-term care facilities.
2. It is not necessary to have a copy filed in the record if the documentation indicates that the DHB-5046 was mailed to the beneficiary.
3. Explain that a transportation assessment may be made in person, by telephone or by mail.
4. Explain the procedure for making a trip request, including the advance notice policy.
5. The applicant/beneficiary has the right to a written response if their request for transportation assistance is denied. The written response must contain the following:
  - a. Trip Information, such as the date and destination

- b. The reason for the denial
  - c. Appeal rights
6. Explain that the beneficiary has the right to appeal at a local hearing if their request for transportation assistance has been denied or if he disagrees with the mode of transportation for which he has been approved.
  7. Inform the applicant that he may request assistance with transportation to medical appointments in order to establish disability if Disability Determination Services (DDS) requires a consultative examination (See IX, Arranging Non-Emergency Medical Transportation).

## **B. Coordination of Transportation**

The local agency must ensure that transportation services are coordinated. The local agency must have an individual who is responsible for:

1. Receiving transportation requests;
2. Completing the [DHB-2056](#), Transportation Log, or equivalent form that captures all the [DHB-2056](#) data fields, to track each trip request from intake through disposition.
3. Arranging and coordinating transportation services.
4. Ensuring the transportation coordinator or designated individual uploading payment authorizations and reviewing Response Files is properly provisioned in NCTracks.
5. Ensuring payment authorizations are uploaded accurately and timely in NCTracks to avoid underpayments and overpayments to the providers.
6. Providing DHB, Eligibility Services (919-813-5340) the name of each newly enrolled provider.
7. Providing DHB, Eligibility Services (919-813-5340) the local agency transportation coordinator or designated individual's name and contact information and contacting DHB at the above number when the designation changes.
8. Developing and maintaining an automated and print ready list of the various modes of transportation available in the local agency ranked from no cost options, such as community resources, to the costliest. Community resources include:
  - a. Civic, religious, and volunteer agencies
  - b. Public transportation systems and

- c. Private transportation businesses
9. Maintaining the transportation file (see VI. C, Documentation and Forms, below)
10. Handling or mailing the DHB-5046, Medicaid Transportation Assistance, Notice of Rights and Responsibilities, to beneficiaries who are potentially eligible for NEMT at each application and recertification. If the Income Maintenance Caseworker (IMC) does the assessment, the IMC must forward to the transportation coordinator a copy of:
  - a. The DHB-5046, Medical Transportation Assistance Notice of Rights/Responsibilities,
  - b. The DHB-5047, Medicaid Transportation Assessment, and
  - c. The DHB-5024, Transportation Assessment Notification
11. The transportation coordinator or the designated individual must verify Medicaid eligibility when a trip request is made and prior to providing services.
12. The local agency must develop an adequate network to meet the needs of the beneficiaries.

### C. Documentation and Forms

The local agency must maintain a **transportation file** (electronic or paper) for each eligible beneficiary or family, labeled with the case head's name. The file must be readily available when requested by authorized outside entities such as auditors and/or DHB. The transportation coordinator must assure that the file contains the following documents:

1. Copy of the DHB-5046, Medical Transportation Assistance Notice of Rights/Responsibilities, unless documented that it was mailed to the beneficiary, and
2. DHB -5047, Medicaid Transportation Assessment, completed during the current certification period or within the past 12 months, which reflects the beneficiary's most current circumstances and needs and all supporting documentation, and
3. DHB -5048, Medicaid Transportation Exception Verification form (when applicable), and
4. Copy of each prior approval letter (including EPSDT service prior approvals) or name of individual at DHB Clinical Policy or MEU who verified prior approval (when applicable), and
5. DHB-5024, Transportation Assessment Notification, and

6. [DHB -5125](#), Medicaid Transportation No-show, First Notice, [DHB-5125A](#), Medicaid Transportation No-show, Final Notice, [DHB-5125B](#), Medicaid Transportation Suspension Notice (when applicable), and
7. [DHB-5118A/DHB-5118B](#), if applicable.

**D. Which Local Agency is Responsible?**

1. The local agency where the Medicaid beneficiary is physically located is responsible for arranging, providing, requesting reimbursement for transportation, or authorizing the trip. Reimbursement for NEMT is not dependent on which county is the Medicaid County of residence (this includes those residing in an Adult Care Home).
2. In certain circumstances, the county where the individual is physically located will be different than the Medicaid County of residence.
3. Local agencies must work together to assure the beneficiary receives necessary transportation services in a timely manner. Transportation services must not be delayed or denied due to responsibility disputes. The local agency that arranges the transportation must request reimbursement from DHB or authorize the trip in NCTracks.

**E. Tracking Trip Requests**

1. The local agency must track each trip request from intake through disposition.
2. Each trip request made by a Medicaid beneficiary must be logged on the [DHB-2056](#), Transportation Log, or equivalent form which captures all the [DHB-2056](#) data fields.
3. If administration of NEMT is contracted out, the vendor is required to carry out all the responsibilities placed upon the local agency by NEMT policy. The contractor must log all trips using the [DHB-2056](#) or equivalent as documentation. The contractor must submit a detailed invoice to the local agency such that the local agency can compare the amount billed to the corresponding trip.
4. The local agency shall not use a vendor's invoice as the log or use the invoice to complete the [DHB-2056](#) after the fact, except to record trip costs reported by the vendor.

**F. Hours of Operation**

1. The local agency shall provide transportation after normal business hours when the medical service required by the beneficiary is available only during those hours.
2. The local agency 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.

### **G. Compliance with Transportation Policy (self-auditing)**

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

1. The local agency must randomly sample 2% of the trips, or 200 trips whichever is less, on the [DHB-2056](#), Transportation Log, or equivalent form, per calendar quarter.
2. For monitoring purposes, a trip is transportation of a beneficiary to and from one provider.
3. Trips billed as administrative cost on the DSS-1571 must be included in the random sample.
4. If an equivalent form is used, that form must capture all the data fields contained in the [DHB-2056](#).
5. All modes of transportation must be included in the sample.
6. Use the [DHB-5078](#), Medicaid Transportation Monitoring Report, to document findings.
7. Corrective Action Plan (CAP)

To ensure timely and accurate identification and correction of deficiencies in NEMT, the local agency must implement a CAP from the self-audit results.

- a. The [DHB Tracking Spreadsheet](#) should be completed with all required information, including corrective action plan, if applicable, and forwarded to the Quality Assurance Analyst assigned to your agency on a quarterly basis on the 20<sup>th</sup> of the month following the last month of the calendar quarter reviewed.

**Example:** April thru June quarterly results are due by July 20<sup>th</sup>.

- b. The local agency should maintain a control file with findings of the quarterly review and documentation of any corrective action taken.

### **H. Payment Authorization Response File**

The local agency is responsible for reviewing the Payment Authorization Response file and making appropriate corrections in NCTracks to ensure that accurate Payment

Authorizations are issued for NEMT provider claims.

**I. Provider Enrollment**

The local agency must notify contract vendors of the requirement for enrolling in NCTracks prior to providing NEMT services.

**J. Reporting Fraud, Waste and Abuse**

Ensure all providers, beneficiaries receiving transportation services, and families have been made aware of how to report suspected fraud, waste, and abuse (see XIV, Reporting Fraud, Waste and Abuse).

**VI. BENEFICIARY RIGHTS AND RESPONSIBILITIES**

**A. Rights of the Beneficiary**

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, and 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 Beneficiary**

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

## VIII. DETERMINING NEED FOR TRANSPORTATION SERVICES

### A. Assessment

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

### B. When to complete an assessment

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 beneficiary is still in need of services
2. For SSI beneficiaries an assessment must be completed:
  - a. At least once every twelve months.
  - b. When a reported change in situation may impact the beneficiary's need for transportation services.

### C. Completing the assessment

1. Use the [DHB-5047](#), Medical Transportation Assessment form.
2. Assess how medical transportation has previously been provided and why it is not available now (Section B of [DHB-5047](#)).
  - a. Does the A/B have access to a vehicle that can be used to get to and from medical appointments?
  - b. Ask the A/B and/or financially responsible person if they have a working vehicle?
  - c. Ask A/B if they have friends, relatives or neighbors who would be willing to assist the a/b with transportation to medical appointments?

**Note:** foster parents are required to have a working vehicle as part of the foster care agreement.

3. Ask the A/B how they have been getting to the store and to medical appointments.
  - a. Drives self.
  - b. Friend/relative/neighbor provides transportation
  - c. Takes a bus
  - d. Takes a cab
  - e. An agency provides transportation. Document the name of the agency.
4. Ask if there is a reason the A/B can no longer use the source they had been using for transportation to get to medical appointments.
  - a. If the a/b has access to a vehicle:
    - (1) Ask why that vehicle cannot currently be used for transportation to medical appointments.
    - (2) If a/b states they cannot afford to pay for gas, explain that gas reimbursement is available.
  - b. If the A/B states they cannot afford to pay (for gas, bus fare, car repairs, insurance, vehicle registration, cab fare, etc.) accept their statement.
  - c. Ask the beneficiary if they have any physical and/or mental impediments which limit their ability to use available transportation. If physical or mental impediments are claimed, complete the DHB-5048, Medicaid Transportations Exception form.
5. If it is determined that the A/B can provide their own transportation, the request should be denied on the DHB-5024, Transportation Assessment Notification.
6. Community-based transportation resource

Community-based transportation resources include civic, religious, and volunteer agencies, as well as public transportation systems. These resources must be exhausted before using paid transportation.

  - a. Check resource listing(s) to determine if the beneficiary has access to individual or community-based transportation and has the ability to get to the pickup location.
  - b. If community-based transportation resources, such as that offered by the

Council on Aging, are available to the A/B and there is no impediment to utilizing them, complete a [DHB-5024](#) and deny the request for NEMT.

7. Assessment by Other Entities

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

- a. The subcontractor meets all the assessment requirements, including completion of the [DHB-5047](#); and
- b. Documentation of the assessment decisions, copies of notices, authorizations, etc. are received by the local agency and comply with guidelines.

**D. Determining Mode**

1. Special Needs (Section C of [DHB-5047](#))

- a. Ask the A/B about special needs or impediments to using certain forms of transportation. Does the A/B use/require:

- (1) An attendant (required for children under age 18 unless they are emancipated), who may or may not be a parent. Other beneficiaries may need an attendant due to special medical, physical, or mental impediment.
- (2) Mobility Device – ask what type of mobility device is used (wheelchair, scooter, etc.),
- (3) Cane/crutches/walker,
- (4) Portable oxygen tank,
- (5) Service animal, or
- (6) Have a condition, such as blindness, deafness or disorientation which can impact transportation options.

- b. Ask the A/B if there are other special needs such as:

- (1) Beneficiary is a minor child that needs to be accompanied by an adult?
- (2) The need for a car seat? If so, ask the age of the child to determine the type.
- (3) An accompanying translator?

2. When to use the [DHB-5048](#), Medicaid Transportation Exception Verification Form

Use the [DHB-5048](#) in the following situations:

- a. The A/B alleges a physical or mental impediment that prevents the use of an available resource, and that impediment is not obvious to the individual performing the assessment.

**Example:** The beneficiary who is being assessed in person is sitting in a wheelchair. There is no need to complete the [DHB-5048](#).

- b. The A/B alleges a need for transportation to a provider at a significantly greater distance.
  - (1) The provider must furnish a medical explanation as to why transportation at a significantly greater distance is required.
  - (2) When a beneficiary is referred to a specialist at a significantly greater distance, the referring provider must complete the [DHB-5048](#). Refer to D.2.c.(3) below.
  - (3) Refer to section V. Nearest NC Provider, above.
- c. Completing the [DHB-5048](#)
  - (1) Complete section 1.
  - (2) Have the a/b complete, sign and date section 2 of the form.
  - (3) Mail or fax the [DHB-5048](#) to the provider identified by the beneficiary for completion of section 3 of the form or call the provider and document the provider's statement. Do not allow the beneficiary to carry the [DHB-5048](#) to the provider.

#### **E. Failure to complete the assessment**

If a beneficiary makes a request for transportation and fails to complete the assessment:

1. Determine if there was good cause. If there was no good cause, continue with number 2. below.
2. The local agency must make every effort to contact the beneficiary to complete the assessment.
3. Send a [DHB-5119](#), Denial of Transportation Request(s), to deny the request.

#### **F. Documentation**

Document the following information in the transportation file:

1. Whether the request for transportation assistance is approved or denied (section D on the [DHB-5047](#).)

2. If applicable, document why it is necessary to transport the beneficiary to a provider at a greater distance on a routine basis (section D on the [DHB-5047](#)).
3. Determine number of additional riders that will need to accompany the beneficiary on a routine basis, e.g. parent for health care for the child, attendant, interpreter (section C on the [DHB-5047](#)).
4. Time limitations on need for transportation special needs assistance, if any (section D on the [DHB-5047](#))
5. Date [DHB-5048](#) is received, when applicable
6. Notify the A/B using the [DHB-5024](#), Transportation Assessment Notification. The [DHB-5024](#) must include the assessment results, approval from and to dates, and notice of appeal rights.
7. Attach to the [DHB-5024](#):
  - a. Transportation request instructions informing the beneficiary who to contact for trip requests and the telephone number to use, and
  - b. No-show and conduct policies
8. All other supporting documentation including the denial notice for failure to complete assessment

#### **G. Method of Transportation**

The method of transportation arranged for the beneficiary must be the least expensive means suitable to the needs of the beneficiary. In addition, the provider must be appropriate to the beneficiary's medical need and individual circumstances. Refer to the local agency's list of available NEMT modes ranked from least to most expensive (Section D on the [DHB-5047](#)).

1. When determining the least expensive means of transportation the local agency must consider all travel related expenses.
2. When arranging transportation that is suitable to the needs of the beneficiary:
  - a. Review the information on the [DHB-5047](#), Medical Transportation Assessment.
  - b. Determine from the beneficiary if there has been any change in their condition which impacts the appropriate mode of transportation.
  - c. Determine if there are any special factors impacting the trip.

This may include:

- (1) Attendant responsibilities,

- (2) Accompaniment of children,
  - (3) Public transportation schedule incompatible with appointment
  - (4) Conflicting work schedules.
- d. Determine if there are any physical/medical conditions that can impact the trip. Refer to [DHB-5048](#), Medicaid Transportation Exception Verification, if completed.

This may include:

- (1) Physical/mental disabilities,
  - (2) Physical stamina, and
  - (3) the need to transport medical equipment.
- e. The EPSDT unit in the Clinical Policy section of DHB may approve an EPSDT participant for a specific mode of transportation. When this occurs, the local agency must make arrangements, provide, and authorize or request reimbursement for the means of transport identified as appropriate by the EPSDT unit (see IV. Medicaid Covered Services).
- f. Provide a detailed explanation of any special needs used to determine “suitable” Transportation.

## **H. Public Transportation**

For individuals who do not have access to a vehicle or community-based transportation, public transportation shall be considered. Choose public transportation where available and the beneficiary states they live within walking distance of a bus or van route, and either:

1. States they can use public transportation, or
2. A physician indicates on the [DHB-5048](#), the beneficiary can use public transportation.
  - a. Be sure to note any limitations on walking distance and, if necessary, verify distance from beneficiary’s home to the nearest bus stop.
  - b. For those that the forms of fixed route transportation cannot reasonably accommodate, explore the demand responsive public transportation options available.

## **I. Ambulance Transportation that is not arranged by the local agency**

1. Ambulance Transportation that is medically necessary is not arranged by the local agency.

2. Medically necessary means: the beneficiary's condition requires ambulance transportation, and any other means of transportation would endanger the beneficiary's health or life. The ambulance provider must submit a claim to the Medicaid fiscal agent for reimbursement.
3. Medically Necessary Ambulance Transportation may be emergency or non-emergency.

- a. Emergency

There are two types of emergency medically necessary ambulance transportation: Basic Life Support and Advanced Life Support.

- (1) Basic Life Support (BLS)

Basic Life Support includes the necessary equipment and staff to treat basic services when transport requires a stretcher.

- (2) Advanced Life Support (ALS)

An Advanced 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 medically necessary ambulance transportation is covered for care which cannot be rendered in the place of residence and when it is medically necessary that the beneficiary be transported by ambulance due to a medical/physical condition.

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

4. Air Ambulance Transportation (emergency)

- a. Emergency Air Ambulance is not arranged by the local agency
- b. Air transportation by helicopter and fixed wing aircraft is a Medicaid covered service when the beneficiary's medical condition requires immediate and rapid transportation that cannot be provided by ground ambulance.
- c. Transportation must be to the nearest hospital with appropriate facilities.
- d. The air ambulance provider must submit a claim to the Medicaid fiscal agent for reimbursement.

- e. Examples of medical conditions which may require air ambulance transport include:
  - (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.

**J. Ambulance Transportation arranged by the local agency**

- 1. Ambulance transportation that is not medically necessary is arranged by the local agency.
- 2. On very rare occasions, an ambulance is the only means of transport for a beneficiary who does not meet the criteria for medically necessary ambulance transportation.
- 3. To accommodate such beneficiaries, the local agency must contract with an ambulance company or negotiate a trip cost with the ambulance company on an as needed basis.
- 4. The local agency must negotiate a rate for ambulance transport that does not include basic life support or advanced life support services.

**Example:** Individual is morbidly obese to the point of not being able to walk or climb stairs. The ambulance company is not providing a “medical service” in this instance; therefore, they will submit a claim as a NEMT ambulance transportation, not medically necessary.

- 5. The local agency:
  - a. Is responsible for uploading the payment authorization for this claim.
  - b. Must document the beneficiary’s case to show why this method of transportation was needed.
  - c. Complete a [DHB-5048](#) if the need for this type of transport is not evident.
  - d. Use billing code A0999 on the [DHB-2056](#), Transportation Log.
  - e. The ambulance company would use billing code A0999.

**IX. ARRANGING NON-EMERGENCY MEDICAL TRANSPORTATION**

## **A. Transportation Requests**

1. The beneficiary must contact the transportation coordinator to request assistance for all medical service trips during the certification period. The request may include multiple trips.
2. All requests for medical transportation by Medicaid beneficiaries, regardless of program, 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.

**Example 1:** Individual calls and requests transportation to their doctor for a March 9<sup>th</sup> appointment. IMC verifies eligibility and determines that the individual receives MQB-B only. The trip request must be logged.

**Example 2:** Individual calls and requests to be transported to the pharmacy on April 16. IMC determines that this individual is not currently eligible in any Medicaid program. There is no need to log this trip request.

## **B. Logging Trips (all trip requests)**

1. Log all trip requests and the outcome of the trip request (approved/denied and reason for denial) must be entered on the DHB-2056, Transportation Log or equivalent.
2. If the request is approved, the DHB-2056 must indicate that transportation was scheduled, the mode of transportation deemed appropriate and whether the beneficiary was picked-up.
3. If the request is denied, the DHB-2056 must indicate why the request was denied and the date that a notice of denial was sent to the beneficiary.
4. Record each trip on the DHB-2056 or equivalent form that captures all the DHB-2056 data fields. The following information is required:
  - a. Date of request,
  - b. Date of trip,
  - c. The name of the beneficiary,
  - d. Medicaid Identification Number of the individual obtaining a Medicaid covered service (do not provide the MID of anyone traveling with this individual),
  - e. Destination (name of medical provider/business and address),
  - f. Whether the trip is approved and, if not, the date notice was sent,
  - g. Date denial notice sent (if applicable),

- h. Number of one-way trips,
- i. Trip cost,
- j. The billing code for the mode of transportation or transportation-related service provided. If there is more than one billing code associated with a trip, use separate lines for each billing code. For trips, which are reimbursed at the administrative rate, note that the trip is being expensed on the DSS-1571.
- k. Medicaid claim/reimbursement amount

## A. Types of Approvals

The local agency may approve transportation in one of the following manners based on the beneficiary's situation and needs:

1. Individual medical Trips
  - a. Approve trips to medical services as needed for beneficiaries that meet requirements for transportation assistance.
  - b. To avoid providing services to ineligible beneficiaries, 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 by Medicaid. The transportation coordinator must verify the series of appointments with the provider.

- a. The beneficiary 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.

**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.

- c. If the beneficiary is approved for an extended period or series of visits, send a referral to the transportation vendor identifying the scheduled

appointments. But if future months are included, vendor should check eligibility. The referral document should include the beneficiary's eligibility dates and program category.

**B. Notification of Trip Approval/Denial**

1. Approvals

The beneficiary must be notified, either verbally or in writing, of trip approvals. The [DHB-5024](#), Medicaid Transportation Assessment Notification form, can be used if notifying the beneficiary in writing.

2. Denials

- a. The DHB-5119, Denial of Transportation Request(s) should be used to notify the beneficiary that their request for transportation assistance has been denied. A copy of the DHB-5119 must be provided to the beneficiary for each request that is denied. If a series of appointments are requested, only one [DHB- 5119](#), Denial of Transportation Request(s), is needed to deny one or all those trips.
- b. Document on the [DHB-5119](#) the reasons for the local agency's decision(s).
- c. If multiple beneficiaries in a household are denied, all beneficiaries can be listed on the same [DHB-5119](#)
- d. Retain a copy in the transportation file.
- e. Do not deny a transportation request when the beneficiary fails to comply with the advance notice policy, but services are provided on a different date, or a gas voucher is issued.
- f. Do not deny a transportation request due to the local agency's lack of resources. The local agency must develop an adequate network to meet the needs of the beneficiaries.

The beneficiary has the right to request a hearing if they disagree with a decision made on their transportation request. Follow guidelines in [MA-2420/MA-3430](#), Notice and Hearing Process.

**C. Transportation for Medicaid for the Disabled (MAD) Applicants to Establish Disability**

- 1. The local agency is responsible for providing transportation to applicants to medical appointments that are required to establish disability.
- 2. Regular Medicaid (Title XIX) transportation reimbursement is unavailable because the applicant is not authorized for Medicaid.

3. The local agency will reimburse the vendor for the trip. **These trips are not submitted through NCTracks for reimbursement. A Payment Authorization is not required.**
4. Disability Determination Services (DDS) will reimburse the local agency for travel charges that are greater than \$2.00. No payments may be made for travel by means other than train, bus, or private automobile unless approved in advance by DDS. Taxi costs in excess of \$14.00 must also be approved in advance.
5. Complete the Authorization and Request for Reimbursement of Travel Costs, form for reimbursement. The form may be requested from DDS by contacting the DDS Medicaid Unit associated with the application.
6. Either the local agency or the applicant may use the Authorization and Request for Reimbursement of Travel Costs, form for reimbursement, depending on whether the transportation is provided by the local agency or arranged for the applicant.
7. Submit the completed Authorization and Request for Reimbursement of Travel Costs, form for reimbursement.

## **X. ADVANCE NOTICE, NO-SHOW, AND CONDUCT POLICIES**

### **A. Advance Notice Policy**

1. The local agency cannot require the beneficiary to make transportation requests in person.
2. While beneficiaries should be encouraged to make transportation requests as far in advance as possible, they cannot be **required** to make such requests more than three 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 local agency must make an attempt to satisfy any urgent request for transportation.

Example: the doctor refers the beneficiary for a test that must be completed within days.

4. The beneficiary must be informed in writing of the advance notice policy at each transportation assessment.

### **B. No-Show Policy**

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

1. The local agency is required to explain the following no-show policy and provide a written copy of it to the beneficiary:
  - a. The beneficiary must be ready and at the designated place for pick up at the time required by the transportation vendor.
  - b. The beneficiary must complete their trip when issue a gas voucher for mileage cost in advance.
  - c. The beneficiary 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 beneficiary 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 beneficiary’s NEMT file. See [DHB-5125](#), Medicaid Transportation No-Show Notice for counseling letter.
  - e. A second missed trip within three months of the first missed trip will result in a telephone call (or letter if the beneficiary 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 beneficiary’s NEMT file. See [DHB-5125A](#), Medicaid Transportation No-Show Final Notice for warning letter.
  - f. A third missed trip within three months of the first missed trip will result in a suspension notice informing the beneficiary that transportation services have been suspended for 30 days. See [DHB-5125B](#), Medicaid Transportation Suspension Notice.
  - g. Continue to follow the 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 for May 16 through June 14. Raven requests transportation services for an appointment on June 18. Untrue to her last name, 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.

2. Good Cause

Good cause consists of illness of the A/B, or illness/death of the A/B’s spouse, child, or parent.

3. Exception to suspension for critical needs beneficiaries.

Critical needs beneficiaries, 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

The local agency is required to explain the following conduct policy and provide a written copy of it to the beneficiary:

1. Any conduct which jeopardizes the safety of other passengers and/or the driver will result in suspension of transportation services by the local agency for 30 days.
2. Public transit systems and other NEMT vendors shall have conduct policies. NEMT riders are subject to the conduct policies of the transportation vendors. 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.
3. Any beneficiary who has been suspended from transportation services due to violation of the conduct policy shall be provided a gas voucher or mileage reimbursement for trips to Medicaid covered services as long as he remains otherwise eligible for transportation assistance.

## XI. SAFETY AND RISK MANAGEMENT

The local agency must assure that all contract transportation vendors, agency staff, agency-approved volunteers, relatives, and friends who transport beneficiaries for mileage reimbursement (including foster care parents) are in compliance with all the following risk management procedures. **These requirements do not apply to beneficiaries/financially responsible persons who seek reimbursement for mileage.**

### A. Local Agency Responsibilities for Safety and Risk Management Monitoring

1. Ensure contracts with vendors include all provisions specified in this policy.
2. Ensure all appropriate contract vendors 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. Maintain a file for agency staff, agency-approved volunteers, and beneficiary relatives and friends who are reimbursed directly by the local agency. The local agency is required to review these files monthly to assure that all

information is current.

6. For agency staff and agency approved volunteers, the file must include the following:
  - a. Driver's License,
  - b. Current vehicle registration/inspection,
  - c. Current driving record,
  - d. Liability insurance, and
  - e. An agreement stating that the staff/agency volunteers will report all changes.
7. For beneficiary relatives and friends, the file must contain the following:
  - a. Driver's License,
  - b. Current vehicle registration/inspection,
  - c. Liability insurance, and
  - d. An agreement stating that the staff/volunteers/ beneficiary relatives and friends will report all changes.

The local agency is required to review these files monthly to assure that all information is current.

8. Liability Insurance

Sufficient insurance coverage is necessary to adequately protect the agency and the beneficiaries 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
  - (1) Agencies should require contract transportation vendors to carry liability at the minimum statutory requirements.
  - (2) When commercial vehicles (16 passengers or more) are used to provide beneficiary transportation services, agencies should obtain a copy of the private contractor's Certificate of Insurance documenting that the local agency Director 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

- (1) “For Hire” passenger vehicles are defined as vehicles used for compensation to transport the general public as well as human service beneficiaries 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.
- (2) Transportation vendors 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. The local agency must ensure that any taxi service it uses for NEMT carries at least the minimum liability insurance coverage for their vehicle's classification (for minimum liability requirements for passenger vehicles, see <https://www.ncdot.gov/dmv/title-registration/insurance-requirements/Pages/default.aspx> ).

d. Agency Owned Vehicles

Agencies that use their own vehicles to provide beneficiaries transportation must carry “Symbol 1,” insurance which provides additional protection in the event of a lawsuit over a vehicle accident involving a volunteer or employee.

e. Non-Agency owned Auto Coverage

Agencies that do not own vehicles used to provide Medicaid transportation must carry “Symbol 9 – Non-Owned Auto Coverage,” insurance which protects the agency in the event of a lawsuit over a vehicle accident involving a volunteer, employee or contract transportation vendor.

f. Agency Staff and Volunteers

Agency Staff, agency-approved volunteers (including foster care parents) who transport beneficiaries for mileage reimbursement must maintain minimum liability insurance coverage for their vehicle's classification (for minimum liability requirements for passenger vehicles, see <http://www.ncdot.org/dmv/vehicle/title/>). This applies to family members, friends, etc., paid by the agency to transport the beneficiary.

9. Licensed Operator

- a. The local agency is required to attest that contract vendors 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. The vendors must be required to periodically provide to the local agency a sample of their reviews.
- b. The local agency is required to ensure that all drivers (local agency employees, and volunteers) are at least 18 years of age and properly licensed to operate the specific vehicle used to transport beneficiaries. This also applies to family members, friends, etc., reimbursed by the agency to transport the beneficiary, but not to beneficiaries and financially responsible persons.

10. State Inspection

The local agency is required to ensure that all vehicles used to transport beneficiaries (whether owned by the local agency, local agency employees, contractor, contractor employees, or volunteers) have valid State registration and State inspection. This also applies to family members, friends, etc., reimbursed by the agency to transport the beneficiary, but not to beneficiaries and financially responsible persons.

11. Alcohol and Drug Testing

The local agency shall require both private and public contract transportation vendors 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 vendors shall be contractually obligated to pay for the alcohol and drug testing program.

12. Background Checks

The local agency shall perform a criminal background check 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.
13. Driving Record
- a. The local agency is required to have a driver screening policy for agency employees, and volunteers who transport beneficiaries.
  - 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.
  - d. Drivers with more than two chargeable accidents or moving violations in 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.
  - e. 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.
  - f. Driving records may be obtained from the Department of Motor Vehicles (DMV). Accept the DMV information provided by the applicant unless questionable.
  - g. The driver screening policy does not apply to beneficiaries, financially responsible persons, or family and friends of the beneficiary.

## **B. Transportation Contract**

A written contract, signed by the vendor, must be obtained by the agency when purchasing private transportation. The contract 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 beneficiary drop off to their appointment per month (past the beneficiary's appointment time),
5. An obligation to report any changes such as insurance provider, business ownership, provider enrollment status,
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 local agency 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 beneficiary 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 beneficiary complains about the speed of the vehicle in which he was transported. This complaint must be logged.  
  
**Example 2:** A beneficiary complains that the driver was late. This complaint must be logged.  
  
**Example 3:** A beneficiary 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,
11. An obligation to use the provided transportation billing codes on invoices to the local agency for reimbursements or filing claims, and
12. An obligation to meet all Provider Enrollment requirements.

### C. Reporting Requirements

The local agency is required to:

1. Report to DHB the results of the agency’s annual review of its contractors’ compliance with contract requirements on an annual basis or at the request of DHB.
2. Submit the results of the agency’s annual review via (annual NEMT review/questionnaire for NC counties) to DHB.

Local agencies will be notified annually by DHB when the annual review submission is due to DHB.

**XII. REIMBURSEMENT**

The local agency provides direct services to beneficiaries through contract transportation vendors (does not include volunteers). These vendors submit claims and are paid through the state’s MMIS system, NCTracks. Payment of claims are subject to payment authorizations by the local agency.

The local agency also provides transportation services through volunteers, agency staff, and reimbursement to beneficiaries and family/friends. The local agency submits these costs to DHB on the [DHB-2055](#) for reimbursement. These services may also include travel-related expenses.

**A. Direct Services to Beneficiaries by Contract Transportation Vendors**

1. Contract transportation vendors include public transportation, taxis, vans, and non-medically necessary ambulance transportation.
2. Claims are submitted by vendors and subsequently paid through NCTracks.
3. Prior to payment to the vendor, the local agency must authorize payment through a payment authorizations process (see XIII. Provider Enrollment /Payment Authorization).
4. Billing Codes

For transportation costs, use the following billing codes on the Payment Authorization batch file:

COST	BILLING CODE
Taxi fares	A0100
Bus fares on intra or interstate carriers	A0110
Minibus, vans, Mountain area transports or other transportation systems	A0120
Wheel-chair vans	A0130
Wheel-chair vans (not medically necessary)	A0120
Ambulance Transport-not medically necessary	A0999

**B. Other Transportation Services Provided by the Local Agencies**

1. Volunteers and local agency staff using their own vehicles,
2. Direct payments such as gas vouchers and mileage reimbursement to beneficiaries, family members and friends (see C., 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 for local agency staff
6. Non-Emergency Air Travel
7. These costs are reported on the [DHB-2055](#) and reimbursed by DHB.
8. Billing Codes

For transportation costs use the following billing code on the [DHB-2055](#)

COST	BILLING CODE
Incurring by non-financially responsible family members or friends shall not exceed the current IRS business rate when payment is made directly to the friend or relative	A0090
Incurring by beneficiaries and financially responsible persons shall not exceed half the IRS business rate	A0090
Mileage costs incurred by the local staff using private vehicles, or volunteers appointed by the local agency. The local agency may negotiate the reimbursement rate for its staff and volunteers.	Local Agency Staff-A0160 Agency volunteers who provide their own vehicle-A0080
Beneficiary meals	A0190
Beneficiary lodging	A0180
Parking fees/tolls/includes local agency staff (Ancillary Costs)	A0170
Attendants Meals	A0210
Attendant Pay (Ancillary costs)	A0170

Attendant Lodging	A0200
Non-Emergency Air Travel	A0140
Attendant Pay for local agency staff (reported as 217 on the DSS-1571)	T2001
Operation of local agency staff vehicles (reported as 218 on the DSS-1571)	A0170DSS
Incurred by non-financially responsible family members or friends shall not exceed the current IRS business rate when payment is made directly to the friend or relative	A0090

**C. Gas Vouchers and Mileage Reimbursement**

1. Gas vouchers are issued to eligible beneficiaries 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 beneficiaries 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.

**D. 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 beneficiary’s circumstances, including reimbursement for return trips with or without the beneficiary. This may include:
  - a. Attendants, other than family members, may charge for their time.
  - b. Non-medical professionals

The local agency, 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. Vendor delivery charges for prescriptions as long as it meets least expensive criteria
3. Reimbursement for travel for parents/guardians to care for, or be taught how to care for, an in-patient child (necessity verified on [DHB-5048](#));
4. If both parents are accompanying the child, reimbursement for the other parent must be necessity verified.

**E. 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 : <https://www.osbm.nc.gov/budget/budget-manual#Sect52>
2. The local agency has the option of providing money for travel related expenses to the beneficiary 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 beneficiary 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 local agency should counsel the beneficiary to make arrangements for lunch. At the local agency's discretion, lunch may be provided for the beneficiary and attendant. However, reimbursement from DHB is not allowable.
6. Dinner  
Reimbursement for dinner is allowable if the beneficiary 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 beneficiaries 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 local agency’s discretion, the county reimbursement rate if higher, can be reimbursed. If the county per diem is higher than the state per diem, the local agency may choose, but is not required to use the higher reimbursement rate.

**In-State and Out-of-State Per Diem Rates**

Expense	In-State	Out-of-State
Breakfast	\$10.60	\$10.60
Lunch	\$14.00	\$14.00
Dinner	\$24.40	\$27.70
Lodging (actual, up to)	\$94.10	\$111.10
<b>Maximum Allowed Daily Subsistence</b>	<b>\$143.10</b>	<b>\$163.40</b>

**Mileage Effective (1/1/2026)**

In-State	Out-of-State
72.5 cents per mile	72.5 cents per mile

**F. Reimbursement for Nursing Facilities**

1. DHB directly reimburses long term care facilities for non-ambulance transportation of Medicaid eligible patients to receive medical care that cannot be provided in the facility.
2. This reimbursement is included in the total cost of care paid to the facility.
3. Family members are encouraged to provide transportation when they can as a means of providing critical family and social support to the patient. Costs for routine transportation may not be charged to the family or to the patient's funds.
4. It is not necessary for the local agency to have the [DHB-5046](#), Notice of

Rights/Responsibilities signed for applications and recertifications since nursing homes provide their own transportation.

5. The facility will be responsible for arranging and/or providing non-ambulance transportation for all Medicaid beneficiaries (even if the local agency has guardianship) who do not have family assistance. The facility may contract with providers (including local agency services) to provide transportation or may provide transportation services using its own vehicles, whichever is more cost effective.
6. Ambulance transportation for nursing home residents is permitted only by medical necessity as specified in Section XII. Determining Need for Transportation Services above.

If a nursing facility schedules non-emergency ambulance transportation for a Medicaid beneficiary and the claim is denied due to lack of justification for medical necessity (the beneficiary's medical/physical condition did not warrant stretcher transport), the nursing facility is responsible for payment. The facility **cannot** bill the patient or their family for non-covered services.

#### **G. Transportation for Adult Care Home residents**

1. The local agency is responsible for arranging and/or providing non-ambulance transportation for Adult Care Home (ACH) beneficiaries with no other appropriate means of transportation available.
2. Facilities may contact the local agency to request transportation services on behalf of Medicaid beneficiaries residing in an adult care home.
3. Facilities may provide transportation directly to their residents
  - a. If the facility possesses an appropriate mode of transportation, they must enter into contract with the local agency and add Non-Emergency Medical Transportation to their provider profile before they can be utilized as a NEMT vendor.
  - b. The facility submits claims and are subsequently paid through NCTracks.
  - c. Facilities are not reimbursed by the local agency unless they are contracted with the local agency as a NEMT provider and providing transportation.
4. Ambulance transportation for adult care home residents is permitted only for medical necessity as specified in section XIII. Determining Need for Transportation Services. If an adult care home schedules non-emergency ambulance transportation for a Medicaid beneficiary and the claim is denied due to lack of justification for medical necessity (the beneficiary'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.

5. Attendants employed by the facility cannot be reimbursed by Medicaid for attendant costs.

## **H. Non-Reimbursable costs**

1. Expenses of an attendant to sit and wait following beneficiary 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. Transportation of a beneficiary in deductible status.
8. Empty miles.
  - a. Miles to or from a transportation vendor's office/home/garage to or from the Medicaid beneficiary's residence are not compensated by Medicaid.
  - b. Medicaid only pays from point of 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
    - (1) For Public Transportation systems, a "share ride" system can be implemented to ensure a cost-effective utilization of public transportation systems.
    - (2) 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.
9. Ambulance transportation of a deceased person.
10. Transportation costs incurred by a vendor not contracted with the local agency.
11. Trips to the emergency room  
Note: a beneficiary may have taken an ambulance to the emergency room but

once they are stabilized, they can be transported home by the local agency by regular means.

12. Trips when the beneficiary is not seen by the provider due to the fault of the beneficiary (e.g. beneficiary did not bring proper documentation, x-rays, etc.).
13. No-Shows (refer to section X. Advance Notice, No-Show and Conduct Policies).

**I. Reporting Transportation Costs**

1. DHB reimburses the local agency for the Federal and State share of NEMT costs. The Federal Medical Assistance Percentage (FMAP) rate is subject to change every year.
2. Staff administrative costs are reimbursed at 50% of the administrative cost. These costs include operation and maintenance costs for agency vehicles and purchase price of a vehicle for Medicaid transportation.
3. For cost allocation purpose, the local agency will continue to submit APP codes 217 and 218 on the DSS-1571 as non-reimbursable. Submit these costs on the [DHB-2055](#) as T2001 (217) and A0170DSS (218). Do not report these costs on the [DHB-2055](#) until after the DSS-1571 has been submitted.
4. Direct payment to Medicaid beneficiaries for transportation, travel-related expense and staff time used indirectly providing transportation and volunteers, are reported on the [DHB-2055](#).

	<b>Agency Costs</b>	<b>Direct Payment for Services</b>
Forms	DSS-1571	<a href="#">DHB-2055</a>
Reported Costs	<p><b>Medically related transportation of Medicaid beneficiaries.</b></p> <p>1. Operation and Maintenance costs for agency vehicles.</p> <p>2. Purchase price of a vehicle purchased by the agency for sole purpose of providing Medicaid transportation.</p>	<p><b>Medically related transportation of Medicaid beneficiaries.</b></p> <p>1. Direct payments to Medicaid beneficiaries for Medical transportation.</p> <p>2. Cost for medically related transportation services purchased for Medicaid beneficiaries (does not include contract</p>

		vendors). 3. Operation of the local agency staff owned vehicle. 4. The local agency staff time used indirectly providing transportation.
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5. Refer to A below for instructions on how to report such costs.

**J. DHB-2055, Reimbursement Request Form**

1. Completing the [DHB-2055](#), Reimbursement Request Form  
 When completing the [DHB-2055](#), include only one month of transportation per form. The month should be the month in which the transportation occurred. Medical Transportation Service Costs Include:
  - a. Direct payments to beneficiaries, family, friends, or volunteers for transporting Medicaid beneficiaries.
  - b. The purchase of gas vouchers and bus tokens, as long as it meets the least expensive criteria.
  - c. Attendant expenses.
  - d. Transportation of caretakers, attendants.
  - e. Operation of the local agency staff owned vehicle.
  - f. The local agency staff time used indirectly providing transportation
2. Unduplicated Beneficiaries
  - a. Enter the total number of unduplicated Medicaid beneficiaries. “Unduplicated beneficiaries” means the number of distinct individuals provided transportation during the month. A beneficiary who has had multiple trips during the month counts as one unduplicated beneficiary.
  - b. Enter the total number of one-way passenger trips. A one-way passenger trip consists of one passenger pick-up and drop-off. Count the total number of trips, not the number of distinct individuals transported.
  - c. Enter the appropriate billing code using the code list on the [DHB-2055](#), Reimbursement Request Form.
  - d. Enter the total amount of reimbursement requested.

**K. Time Limitation for Local Agency Reimbursement**

Counties must submit claims for reimbursement to DHB within one year of the date of service.

### **XIII. PROVIDER ENROLLMENT/PAYMENT AUTHORIZATION**

Non-Emergency Medical Transportation (NEMT) vendors (excluding volunteers) contracted with the local agency must be enrolled as a Medicaid provider. Claims for NEMT services are submitted and paid through NCTracks to enrolled NEMT providers.

The local agency is responsible for authorizing any NEMT trips through a Payment Authorization (PA) process before a claim will pay.

#### **A. Provider Enrollment**

NEMT vendors contracted with the local agency must enroll as a Medicaid provider by completing a Provider Enrollment application online at [www.nctracks.nc.gov](http://www.nctracks.nc.gov)

1. Affordable Care Act fee and a North Carolina application fee are required.
2. Only in-state providers can enroll as a NEMT provider.
3. NEMT providers can enroll with a National Provider Identifier (NPI) or enroll as Atypical providers. Obtaining a NPI is not required.
4. Online training and a site visit are required.
5. No certification, accreditation or license is required.

#### **B. Provider Billing in NCTracks**

Providers (excluding volunteers) contracted with the Local agency are required to submit professional claims in NCTracks on completed trips.

1. All claims must be authorized by the local agency through a Payment Authorization (PA) process before the provider can receive reimbursement. **The local agency does not submit claims in NCTracks on behalf of a NEMT provider.**
2. The PA from the authorizing local agency is required prior to claim submission.
  - a. Claims will be priced using the amount authorized by the local agency.
  - b. Provider, beneficiary and trip information in the claim must match the information authorized by the local agency, e.g. beneficiary and provider ID, procedure (billing) code, amount and date of service.
  - c. Questions regarding payment authorization should be directed to the local agency from which transportation request originated.

3. An ICD-10-CM diagnosis code is required on all claims. Diagnosis code Z76.89 is recommended.
4. The provider must use the following procedure (billing) codes:
  - a. A0100 - nonemergency transportation; taxi
  - b. A0110 - nonemergency transportation and bus, intra or interstate carrier
  - c. A0120 - nonemergency transportation: mini-bus, mountain area transports, or other transportation systems
  - d. A0130 - nonemergency transportation: wheelchair van
  - e. A0140 - nonemergency transportation and air travel (private or commercial) intra- or interstate
  - f. A0999- unlisted ambulance service
5. The Place of Service (POC) code is required on all claims. Choose the appropriate code from the following:
  - a. 99 for taxi, bus, mini-bus, van, car
  - b. 41 for ambulance-land
  - c. 42 for ambulance
6. A provider taxonomy is required on all claims. Use taxonomy 343900000X- Non-Emergency Medical Transport.
7. Units of service as well as dates of service are required on all details. Dates of service must always include a from date and to date.
  - a. Example: If the beneficiary is transported from home to a dialysis clinic, 1 unit is billed.
  - b. Example: when multiple transports for a single procedure code and provider on the same date, the units should reflect the number of trips. If the beneficiary is transported by taxi from home to a dialysis clinic, then later the same day the beneficiary is transported by taxi from the dialysis clinic to home, the claim detail line will reflect A0100 and 2 units of service.
  - c. Date spans on a claim detail are not allowed. Services for each date of service should be billed on a separate detail line.
8. For training and complete information on claim submission, please refer your contract vendors to the NCTracks website [www.nctracks.nc.gov](http://www.nctracks.nc.gov) or their call center, 1-800-688-6696.

### C. Payment Authorization (PA)

Any claims submitted by the NEMT provider must be authorized by the local agency. Once the local agency and the provider agree upon a trip and the trip is completed, the local agency will create a Payment Authorization Batch file containing trip information and upload in NCTracks to match with the provider's claim. This will allow NCTracks to pay the claim.

1. The file must be created using Microsoft Excel and saved as a Comma Separated Values (Comma- delimited) file type.
2. The file will contain fourteen elements related to the beneficiary and the trip. The elements include:
  - a. County Provider ID-This may be an NPI, or Atypical ID based on how the local agency enrolled in NCTracks.
  - b. County Code-The County Code for your local agency. The valid values for this field will be 001 □ 100
  - c. Transmission Supplier Number (TSN)-The TSN was issued when the local agency enrolled with Trading Partner capabilities.
  - d. File Submit Date-The date the file is transferred to NCTracks. The valid date format is YYYY-MM-DD.
  - e. Action Code-The valid values for this field will be: "0" (zero) if this is the first submission of the authorization (first submissions require a new and unique Payment Authorization Tracking number), or "1" if it is updating an existing authorization. If you are updating an existing authorization, the Payment Authorization Tracking number will already be in the system and will need to match.
  - f. PA Tracking ID-Each new authorization requires its own unique Tracking ID number. The unique Payment Authorization identification number will be created by the local agency and will be used to search for records in the NCTracks Operations portal.
    - (1) The ID format begins with the 3-digit County code; this can be a combination of alpha and numeric characters; no special characters and a 14-character maximum. The number must be **unique** for that record and not used again for another record.
    - (2) In NCTracks, the tracking number is considered a unique record identifier and should be associated with a single authorization record. If a tracking number assigned to a record is used again for a different record, the authorization details submitted in the second record replace the original authorization. This will cause vendor claims to not be paid properly. It is very important to not recycle tracking numbers. A new and unique number must be assigned to

each new authorization record.

- g. Recipient ID-The Recipient ID (RID) of the beneficiary receiving NEMT services. The RID must be in NCTracks.
  - h. NEMT Provider ID-This will be the NPI or atypical ID of the provider performing NEMT services. The NPI is 10 digits, and the atypical ID is 8 digits.
  - i. NEMT Provider Location- During the NEMT provider enrollment process, providers are advised that there was not a need to add additional service locations to their record since all the counties they service could be captured under the primary service
  - j. PA Begin Date-The begin date of the authorization. The valid values are YYYY-MM-DD.
  - k. PA End Date-The end date of the authorization. The valid values are YYYY-MM-DD.
  - l. Procedure (billing) Code-Identifies the services that were rendered.
  - m. Amount-Amount approved for payment. The value must be greater than zero. Do not include the dollar sign. The format includes 2 places after the decimal.
  - n. PA Status-The valid values are “A” for Approved or “V” for Void. Most records will have an “Approved” Payment Authorization status. If an error was made in submitting the record, the status can be updated to “Void” so that no claims will pay against it. This is because PA records cannot be deleted once they have been created in NCTracks.
3. PA batch files should only include confirmed NEMT trips.
  4. For each approved NEMT service entered on the Payment Authorization batch file, the PA Begin Date should be the same as the PA End Date.

County Provider ID	County Code	TSN	File Submit Date	Action Code	PA Tracking ID	Recipient ID	NEMT Provider ID	NEMT Provider Location	PA Begin Date	PA End Date	Proc Code	Amount	PA Status
52001943	092	X916	2016-06-20	0	092TC101	123456789Z	3408404	003	2016-06-23	2016-06-27	A0100	45.34	A
52001943	092	X916	2016-06-20	0	092TC102	234567890Z	3408404	003	2016-07-01	2016-07-04	A0110	1234.56	A
52001943	092	X916	2016-06-20	0	092TC103	345678901Z	1053679399	003	2016-06-10	2016-06-20	A0120	76.23	A
52001943	092	X916	2016-06-20	0	092TC104	456789012Z	1053679399	003	2016-06-20	2016-07-11	A0120	2341.54	A

5. Once the Payment Authorization batch file is created, it must be saved as a Comma-Separated Values (CSV) comma-delimited file.
  - a. Select “Save As” from the Excel File menu.
  - b. The file will default as Excel workbook. Select the “save as type:” drop-down arrow and select the type that is CSV (comma-delimited).

- c. The file name should have the naming format as:  
**PA\_NEMT\_CountyProviderID\_CountyCode\_YYYYMMDD.**  
Example: PA\_NEMT\_1234567890\_003\_20170501

#### **D. Batch Transfer Process**

Once the Payment Authorization batch file has been created and saved, it is ready to be transmitted to NCTracks through a Batch Transfer Process.

1. Navigate to the Trading Partner menu tab (Provider Portal) at the top of the page and select the “Batch Transfer” option.
2. Log in to the “Move IT NCTracks File Transfer” system. The properly provisioned user will log in with their NCID and password. This will take the user to the batch transfer home page which contains two main sections:
  - a. Home/Provider-The Mailbox that contains folders where the user will find records sent to NCTracks as well as Response files received from NCTracks.
  - b. Upload Files-selection for uploading files
3. The Upload Files section of this page, the user will select “CLICK HERE to Launch the Upload/Download Wizard.” There are four steps in the batch upload process:
  - a. Select Add File button to fetch the file from its saved location. The selected file displays in the Filename section of the NCTracks Upload Wizard screen.
  - b. Select Next
  - c. In the next step, the user is confirming the default “Upload Option” of “Upload files individually”, by selecting Next. Once this confirmed, the file will transmit.
  - d. Confirm that the file transfer is complete.
4. Review the Mailbox on the File Upload Home Page (see XIII. D.2. a. Batch Transfer Process, above).

From the Home page, the user will have access to the Response File that had information on the rejected authorizations and the “In” folder that contains the file the user has sent to NCTracks. Expanding the “In” folder provides the ability to see the files that have already been transmitted.

Please refer to [www.nctracks.nc.gov](http://www.nctracks.nc.gov) on the Operations page for training on creating and uploading the Payment Authorization batch files in NCTracks.

## E. Response File

A Response File is a file in NCTracks that contains rejected records from the Payment Authorization batch file uploaded the previous day. The user can view these files and make corrections on the next batch file transfer. When a Payment Authorization is uploaded, a Response File will be received in the provider's Batch Transfer Page mailbox the following day with any rejections. The Response File can be recognized in the folder with "RESP." The most recent file received from the user will be processed.

1. A Response File is generated daily to each local agency user authorized in the NCTracks Provider portal. The file is posted in the Response folder of the user's mailbox once the Batch Transfer process is completed.
2. NCTracks will only process one Authorization file upload daily. The most recent file received from the local agency will be processed and replied to with a Response file.
3. If multiple users are provisioned of a local agency, all users will receive the response, regardless of which user uploaded the file.
4. The Response File can be downloaded and saved to view details.
5. The response File contains rejected records from the file uploaded the previous day. The record contains all values originally submitted in the Payment Authorization file, with the status of '9' for Rejected in column N and the reject reason value in column O.
6. An empty Response File indicates all records in the file uploaded the previous day have been processed as approved or no file was received.
7. Prior to making corrections to the records, the user must determine the rejected reason by reviewing the Prior Approval in the Operations Portal in NCTracks.
  - a. Select "PA search" to perform a Prior Approval search from the Prior Approval menu tab at the top of the page.
  - b. The prior approval search will allow the user to search for the Payment Authorizations using multiple search criteria, such as Tracking Number or Recipient ID and PA Type of A50, NEMT Non-Emergency Medical Transportation services.
  - c. By selecting Find, the search results will display. The user must select the Prior Approval Number hyperlink of a rejected file to view the Prior Approval details. PA information cannot be updated or changed on the Prior Approval detail pages.
  - d. The Prior Approval Edits section (bottom of the page) will provide information on why the authorization was rejected.

8. If an update is needed to correct a rejected record, the local agency can include the record in their next Payment Authorization file upload with the corrected values. For the updated record, the action code is 1 to represent an update to an existing record. The action code of zero represents submission of a new authorization record.
9. It will not be until the Prior Approval is in an “Approved” status that the NEMT provider’s claim adjudicates and pays appropriately.
10. It is important to check your Response Files and keep records of your Payment Authorization (PA) spreadsheets since the system automatically deletes response files after 28 days. Having a system to keep track of PA spreadsheets is necessary in case there are any issues or discrepancies with the transportation providers’ claims in the future.

**F. NEMT PA Reject Reason Codes in NCTracks**

Code	Description
A	The submitting vendor ID is invalid
A1	Pre-Admission Screening and Annual Resident Review Number is invalid
A2	Missing or invalid transmission record count
A3	Invalid maintenance of service indicator
A4	Claim or Prior Authorization Approval PA Line Number is invalid
A5	PA Rendering Provider Atypical Provider ID is invalid
A6	Transmit/Sent Date is required
A7	Procedure Code and modifier Code combination invalid for PA type PCS (Personal Care Services)
A8	Line Begin Date of Service Date is invalid
A9	Line End Date of Service Date is invalid
B	Service Type Code is not valid
B1	Invalid Approved Amount
B2	Invalid PA Line Status Code
B3	Prior Authorization/Approval Status Date is invalid
B4	Duplicate PA Found
B5	Invalid County Code
B6	Local procedure code not allowed for PA type.
B7	Local Agency provider number is not on file
B8	Transmission Provider Number is not on file
B9	PA tracking number does not begin with county code value
C	PA Type Code is not valid
C1	Begin and end dates must be the same for NEMT records.

D	Payer Identifier is not valid
E	Recipient ID not on CSRA database
F	Benefit Plan Identifier is not valid
G	Header Status Date is missing or invalid
I	PA starting date is not a valid date
J	The PA ending date is missing, invalid, or greater than 1 year from the start date
K	Approved units are invalid
L	No PA number present
M	EPSDT Exceeds Policy Limits Indicator is invalid.
N	Billing Provider Number NPI is missing
O	Billing Provider Number is not on file
P	The Rendering Provider Number is not on file
Q	1st Diagnosis Code is missing or invalid
R	2ND Diagnosis Code is invalid
S	3rd ,4th, 5th, or 6th Diagnosis Code are invalid
T	The Procedure Code or modifier is missing or invalid
U	0 - New Record; 1 – Update; if Update, Tracking Number should be already present on the PA database; if New Tracking number should not be on the PA database; if present must match the PA Start date; PA start date is not allowed to change.
V	PA Status is not: A-approved, D-denied, M-modified approved, R-reduction, T-terminated, V-void
W	Adult Non-Covered Service Indicator is invalid
X	Prepayment Review Indicator is invalid
Y	Rendering Provider taxonomy must be valid
Z	Health Plan Identifier is invalid
1	Rendering Provider Location Code must be valid
2	Invalid EPSDT Indicator or EPSDT Indicator is not valid
3	PA Billing Provider Atypical Provider ID is invalid
4	PA Billing Provider taxonomy code is invalid
5	PA Billing Provider Locator Code is invalid
6	PA Requesting Provider NPI is invalid
7	PA Requesting Provider Atypical Provider ID is invalid
8	PA Requesting Provider taxonomy code is invalid
9	PA Requesting Provider Locator Code is invalid

Please refer to [www.nctracks.nc.gov](http://www.nctracks.nc.gov) on the Operations page for training on Response Files in NCTracks.

**G. Provisioning**

To upload Payment Authorizations and review Response Files in NCTracks, the appropriate staff in the local agency must have access to the appropriate portals in NCTracks. Uploading PAs requires access to the Provider Portal. To review Payment Authorization in NCTracks, a staff member must have access to the Operations Portal.

The provisioning for the local agency NEMT Coordinators and Medicaid workers to obtain access in NCTracks is as follows:

1. Provider Portal access:
  - a. Provisioned by the Office Administrator on the agency's enrollment application with NCTracks.
  - b. Access is for designated NEMT or Finance/Budget staff who will upload the Payment Authorizations into NC Tracks. This person does not have to be the NEMT coordinator. In many counties, if there is only one person available, the designated person may be the Finance/Budget staff member.
2. Operations Portal access:
  - a. Provisioned by the Security Officer in the local agency.
  - b. Access may be for Medicaid workers or NEMT coordinator/staff. NEMT coordinator is provisioned in the Operations Portal to view payment Authorization details that were uploaded in NCTracks. This will assist with answering provider questions on why their claim may not have paid. For instance, you can see the amount authorized and used, the NPI, and the billing code. These are all items that must match for the claim to pay.

#### **XIV. 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 beneficiaries in the NC Medicaid Program.

##### **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 reported to the Office of Compliance and Program Integrity (OCPI).
2. Division of Social Services, Non-Emergency Medical Transportation (NEMT) Coordinator and Program Integrity staff shall work collaboratively to ensure that all referrals get routed to the appropriate contacts.
3. NEMT Coordinators shall ensure all providers, beneficiaries receiving transportation services, and families 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 fraud and abuse:**

1. An individual does not report all income when applying for Medicaid
2. An individual does not report other insurance when applying for Medicaid
3. A non-beneficiary uses a beneficiary's card with or without the beneficiary's knowledge
4. A provider's credentials are not accurate
5. A provider bills for services that were not rendered
6. A provider performs and bills for services not medically necessary

## **D. Reporting**

Report complaints by accessing one of the following methods:

1. Medicaid Fraud, Waste and Program Abuse Tip-Line  
Phone: (919) 814-0181, or
2. Online Confidential Complaint Form: <https://medicaid.ncdhhs.gov/get-involved/report-fraud-waste-or-abuse/complaint-form>

## **XV. DEFINITIONS**

- A. Attendant** – A person whose presence is needed to assist the beneficiary during transport.

- B. Case Head** – The person whose name appears next to “Case Head” on the “home” tab of NCFASST and on minor’s Medicaid identification cards.
- C. 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.
- D. Community Alternatives Program (CAP)** – The Community Alternative Programs (CAP) provide sets of services (called “waiver services”) not normally covered under the NC Medicaid programs. The waivers allow individuals who are in need of institutional care to remain in the home.
- E. Community Transportation Plan (CTP)** – a five-year plan to address transportation needs and resources of the community transit system designated to provide coordinated transportation at the County level. Every county has an approved Community Transportation Services Plan (CTSP).
- F. Deductible** – A Medicaid deductible is an amount of medical expenses that must be incurred before Medicaid can be authorized when a Medicaid applicant’s income exceeds the limit.
- G. DMV Search** – The local agency has access to the Division of Motor Vehicles data base. Income Maintenance Caseworkers conduct inquiries (searches) in this data base when determining eligibility for Medicaid programs.
- H. Dually Eligible** – Individuals who are eligible for both Medicare and full Medicaid.
- I. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** – A federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries 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).
- J. Family Members & Friends** – Family members other than spouses and parents of minor children, as well as other non-related individuals, who comprise a Medicaid beneficiary’s potential support for transportation needs.
- K. Financially Responsible Person (FRP)** – For Medicaid purposes, including NEMT, spouses are financially responsible for one another, and parents are financially responsible for their minor children.
- L. Gas Voucher** – A voucher that is issued to the beneficiary/FRP or other drivers with which he may purchase gasoline at a contracted station.
- M. Least Expensive Means** – Most cost-effective mode of transportation.
- N. Local Agency**-County Department of Social Services

- O. **Medicare Qualified Beneficiary** – MQB (Q, B or E) –Medicaid programs for Medicare beneficiaries that offer limited benefits. MQB beneficiaries are not eligible for Medicaid transportation assistance.
- P. **Mileage Reimbursement** – Reimbursement to a Medicaid beneficiary/FRP and/or other driver based on a specific rate per mile driven to allow a Medicaid beneficiary to receive covered services.
- Q. **Mobility Device** – Wheelchair, scooter or other device used to aid personal mobility.
- R. **NCTracks**- Medicaid Management Information System (MMIS). North Carolina’s Medicaid billing system
- S. **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 beneficiaries are addressed by the county Medicaid transportation coordinator when requested.
- T. **Payment Authorization**-An approval process for NEMT provider claims submitted in NCTracks.
- U. **Plan of Care (POC)** – A document which summarizes the CAP evaluation and assessment information into a statement of how the beneficiary’s needs are to be met; outlines goals and objectives; and indicates the specific services needed, both formal and informal.
- V. **Provider** – An individual or entity that provides a medical service, such as a doctor, hospital, pharmacy, or transportation.
- W. **Provider Enrollment**-The application process to become a NC Medicaid provider for the purpose of rendering services.
- X. **Provisioning**- The process of providing users with appropriate access to data in a computer system.
- Y. **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.
- Z. **Response File**-A file in NCTracks that contains rejected records from the payment authorization file uploaded the previous day.
- AA. **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.
- BB. **“Significantly Greater Distance”**-a one-way trip that is over 30 miles from the beneficiary’s pick-

up location.

**CC. Suitable Transportation** – The mode of transportation that is appropriate to the Medicaid beneficiary’s medical and other identified needs.

**DD. Transportation Coordinator** – The person designated by the local agency to coordinate Medicaid transportation trips. This person may be employed by the agency or by an entity under contract with the agency to arrange transportation.

**EE. Transportation Vendors** consist of businesses with which the local agency contracts to provide Non-Emergency Medical Transportation. Vendors may be public, such as local transit systems, or private, such as private van services.

They are also referred to as providers.

**FF. Trip** – A NEMT “trip” consists of the length between one pick-up and drop-off. For example, picking up a beneficiary at his home and driving him to a doctor’s office is one trip. If the same beneficiary 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 beneficiary is driven to a drug store that would constitute a third trip.

**GG. 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 acute illnesses and non-emergent injuries, as well as necessary medical care that cannot be rescheduled to another time (i.e., due to provider availability, etc.).

**HH. Volunteers/Volunteer Drivers** – Individuals screened and approved by the local agency to transport Medicaid beneficiary, either in their own vehicles or in agency vehicles.