2910 MEDICAID TRANSPORTATION
REVISED 01/01/15 – CHANGE NO. 01-15

I. ACRONYMS

A/B – Applicant/Beneficiary of Medicaid

CAP – Community Alternatives Program

CAP-MR/DD – Community Alternatives Program for Mental Retardation/Developmental Disabilities

CTSP – Community Transportation Services Plan

DMV – Division of Motor Vehicles
EPSDT – Early and Periodic Screening, Diagnosis and Treatment
EPSDT – Early and Periodic Screening, Diagnosis and Treatment

FTA – Federal Transit Authority

FRP – Financially responsible person

IMC – Income Maintenance Caseworker

MEU – Medicaid Eligibility Unit

MH/SA – Mental Health/Substance Abuse

MQB – Medicare Qualified Beneficiaries

NCDOT – North Carolina Department of Transportation

NCHC – North Carolina Health Choice

NEMT – Non-Emergency Medical Transportation

POC – Plan of Care

II. DEFINITIONS

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

(II.)

Case Head – The person whose name appears next to "Case Head" on the "home" tab of NCFAST and on minor's Medicaid identification cards.

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.

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. A CAP beneficiary, who is eligible for Non-Emergency Medicaid Transportation, may be transported to any service listed in the Medicaid column in the CAP plan of care (see IV.C.6. for exceptions).

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). See IV.D.

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.

DMV Search – The county DSS 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.

Dually Eligible – Individuals who are eligible for both Medicare and full Medicaid.

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)**.**

(II.)

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.

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.

Gas Voucher – A voucher that is issued to the beneficiary/FRP or other driver with which he may purchase gasoline at a contracted station.

Least Expensive Means – Most cost effective mode of transportation.

Medically Necessary Ambulance Transport – Medically necessary means the beneficiary's condition requires ambulance transportation and any other means of transportation would endanger the beneficiary's health or life.

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.

Mental Health/Substance Abuse (MH/SA) Enhanced Benefits – A list of services covered by Medicaid for which the cost of transport is included in the provider reimbursement rates. These services are not eligible for Medicaid transportation assistance. (See IV.C.6.b.)

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.

Mobility Device – wheelchair, scooter or other device used to aid personal mobility.

Non-Emergency Medical Necessity – The need for ambulance-type transport due to a medical or physical condition that precludes transport in a regular motor vehicle. This involves a person who is bed-confined and must be transported on a stretcher via ground transport.

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.

(II.)

Normal Service Area is the geographical area within which Medicaid consumers and the general population in the county routinely access Medicaid services. The normal service area can cross a county or state border.

North Carolina Health Choice (NCHC) – A medical coverage program for individuals under age 19. Beneficiaries of NCHC are not eligible for Medicaid transportation assistance. Verify the program with the Income Maintenance Caseworker or in the Eligibility Information System (EIS).

No-Shows/No-Show Policy – A no-show occurs when a Medicaid beneficiary is scheduled for a trip to a medical service and fails to show up to be transported. A no-show policy consists of rules governing missed transportation pick-ups.

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.

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

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.

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

Review/Reenrollment – Medicaid cases are reviewed at the end of each certification period to re-determine eligibility for the Medicaid programs.

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.

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

(II.)

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

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.

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.).

Vendor No-Show – The failure of a transportation vendor to pick-up a beneficiary for a scheduled trip.

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

Voucher – A document exchangeable for goods or services.

III. BACKGROUND

Title XIX of the Social Security Act requires that state Medicaid programs fulfill administrative requirements necessary to operate the Medicaid program efficiently. Among these administrative requirements is the mandate that State Plans "specify that the Medicaid agency will ensure necessary transportation for beneficiary to and from providers" (See 42 CFR 43l.53).

IV. POLICY PRINCIPLES

Transportation to and from providers is a critical component for Medicaid beneficiary to obtain necessary health care. Non-Emergency Medical Transportation (NEMT) services consist of arranging and/or paying for transportation. When the beneficiary has access to a suitable mode of transportation, but lacks the means to use it, the county must assist with the means through gas vouchers, mileage reimbursement, etc. When the beneficiary lacks both means and mode, the county is responsible for arranging transportation at a cost within allowable Medicaid regulations. However, the obligation to provide transportation is not without qualifications.

(IV.)

A. Transportation Criteria

Federal regulations require that the state assure necessary transportation (see 42 CFR 431.53). Necessary means no other appropriate transportation resources are available to the beneficiary.

Medicaid only pays for transportation:

1. By the least expensive mode available and appropriate for the beneficiary (see VIII.C.1.),

2. To the nearest appropriate medical provider (see VIII.B.);

3. For a Medicaid-covered service (see VIII.A.) provided by a NC enrolled Medicaid provider.

B. 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**).**

The county DSS must arrange for or provide transportation to children meeting EPSDT requirements for necessary services that might not be covered under the Medicaid state plan but are covered under EPSDT. When EPSDT beneficiaries request transportation for a non-covered service, verify with the provider that prior approval was obtained. If unable to obtain a copy of the approval letter from the provider, call the DMA Clinical Policy section to verify prior approval. Clinical Policy can be reached by calling (919) 855-4260.

C. Beneficiaries Not Eligible for Transportation Assistance

1. MQB-Q, B, or E beneficiaries (Note that dually eligible individuals are entitled to transportation assistance, including transportation to pick up prescriptions, even though Medicaid does not pay for their prescription drugs).

(IV.C.)

2. Beneficiaries in deductible status. An applicant/ beneficiary is not eligible for Medicaid transportation assistance until his deductible is met.

3. North Carolina Health Choice (NCHC) beneficiaries

4. Nursing home beneficiaries (see X.D.)

5. Certain mental health services have transportation costs included in the Medicaid provider's fee; therefore beneficiaries are not eligible for NEMT to these services.

   a. The following Community Alternative Program – Mental Retardation/Developmental Disabilities (CAP-MR/DD) Waiver covered services have transportation included in the Medicaid provider's fee:

CAP-MR/DD SERVICE	CODE
Day Supports – Individual	T2021
Day Supports – Group	T2021HQ
Supported Employment – Individual	H2025
Supported Employment – Group	H2025HQ

   b. The following Mental Health/Substance Abuse (MH/SA) Benefits covered services have transportation included in the Medicaid provider's fee:

MENTAL HEALTH/SUBSTANCE (MH/SA) ABUSE ENHANCED SERVICE	CODE
Assertive Community Treatment Team (ACTT)	H0040
Intensive In-Home Services	H2022
Mobile Crisis	H2011
Multi-systemic Therapy (MST) (for ages 7-17)	H2033

MH/SA BENEFIT SERVICE	CODE
Professional Treatment Services in Facility-Based Crisis Program	S9484
Substance Abuse Medically Monitored Residential Treatment	H0013
Substance Abuse Non-Medical Community Residential Treatment	H0012HB
Medically Supervised Detoxification/Crisis Stabilization	H2036
Non-Hospital Medical Detoxification	H0010

D. County Participation in Community Transportation Services Plan (CTSP)

Every county has an approved Community Transportation Services Plan (CTSP) which must be updated periodically. The purpose of a CTSP includes:

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.

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

V. Beneficiary's Rights and Responsibilities

A. Rights of the Beneficiary

1. To be informed of the availability of Medicaid transportation. (See VI.A.1.).

2. To have the transportation policy explained including: how to request a trip or cancel a trip, limitations on transportation, suspensions for 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 (See VIII.C.).

   b. To arrive at medical provider in time for his 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 his needs in the most efficient and effective manner.

2. To travel to the requested location and receive a Medicaid covered service.

3. To make timely requests for transportation assistance (See VII.F. for what constitutes a timely request).

4. To be ready and at the designated place for transportation pick-up or cancel the transportation request timely (See VII.G.1.b. below for what constitutes timely cancellation).

5. To follow the instructions of the driver.

6. To respect the rights of other passengers and the driver, such as not creating a disturbance or engaging in threatening behavior.

VI. County's Responsibilities (also see IX Safety and Risk Management)

A. Inform A/B of Right to Transportation Assistance

1. The county must give or mail the DMA-5046, Medical Transportation Assistance – Notice of Rights/Responsibilities to the A/B at each Medicaid application and Medicaid reenrollment. 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 DMA-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. Notice and Appeal Rights

   a. Explain that the A/B has the right to a written response if his request for transportation assistance is denied.

   b. Explain that the beneficiary has the right to appeal at a local hearing if his request for transportation assistance has been denied or if he disagrees with the particular mode of transportation for which he has been approved.

(VI.)

B. Coordination of Transportation

1. The county must ensure that transportation services are coordinated.

   The county must have an individual who is responsible for:

   a. Receiving transportation trip requests;

   b. Completing the DMA-2056, Transportation Log, or equivalent form that captures all of the DMA-2056 data fields, to track each trip request from intake through disposition.

   c. Arranging and coordinating transportation services.

   d. Providing DMA, Medicaid Eligibility Unit (919-855-4000) the county transportation coordinator's name and contact information and contacting DMA at the above number when the designation changes; and

   e. Developing and maintaining an automated and print ready list of the various modes of NEMT available in the county ranked from no cost options, such as community resources, to the most costly. Community resources include: civic, religious and volunteer agencies, as well as public transportation systems and private transportation businesses.

   f. Maintaining the transportation file (see VI.C.)

2. Communication between income maintenance and transportation staff

   a. The IMC is responsible for handing or mailing the DMA-5046, Medicaid Transportation Assistance -- Notice of Rights and Responsibilities to beneficiaries who are potentially eligible for NEMT (MAF-C, MIC, MAA, MAB, MAD) at each application and reenrollment;

   b. If the IMC does the assessment, the IMC must forward a copy of the DMA-5046, Medical Transportation Assistance Notice of Rights/Responsibilities, the DMA-5047, Medicaid Transportation Assessment, and the DMA-5024, Transportation Assessment Notification to the transportation coordinator.

c. When a trip request is made, the transportation coordinator or the coordinator's designee must verify Medicaid eligibility.

C. Documentation and Forms

1. The county must maintain a transportation file for each eligible individual or family, labeled with the casehead's name. The transportation coordinator must assure that the file contains the following documents:

   a. A copy of the DMA-5046, Medical Transportation Assistance Notice of Rights/Responsibilities, unless documented that it was mailed to the beneficiary (see VI.A.1.);

   b. DMA-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;

   c. DMA-5048, Medicaid Transportation Exception Verification form (when applicable);

   d. A copy of each prior approval letter (including EPSDT service prior approvals) or name of individual at DMA Clinical Policy or MEU who verified prior approval (when applicable);

   e. DMA-5024, Transportation Assessment Notification.

   f. DMA-5125, Medicaid Transportation No-show, First Notice, DMA-5125A, Medicaid Transportation No-show, Final Notice, DMA-5125B, Medicaid Transportation Suspension Notice (when applicable).

2. Tracking trip requests.

   The county must track each trip request from intake through disposition.

   a. Each trip request made by a Medicaid beneficiary must be logged on the DMA-2056, Transportation Log, or equivalent form which captures all of the DMA-2056 data fields.

b. If administration of NEMT is contracted out, the vendor is required to carry out all the responsibilities placed upon the county by NEMT policy. The Contractor must log all trips using the DMA-2056 or equivalent documentation. The contractor must submit a detailed invoice to the county such that the county can compare the amount billed to the corresponding trip.

Note: The county DSS shall not use a vendor's invoice as the log, or use the invoice to complete the **DMA**-2056 after the fact, except to record trip costs reported by the vendor.

D. Hours of Operation

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

2. The county 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.

E. Compliance with Transportation Policy

The providence of Medicaid transportation services to those who are in need of those services and the proper utilization of those services by beneficiaries are important goals of Medicaid transportation policy. In order to attain these goals, the county must randomly sample 2% of the trips, or 200 trips whichever is less, on the DMA-2056, Transportation Log, or equivalent form, per quarter. For monitoring purposes, a trip is transportation of a beneficiary to and from one provider. Trips billed as administrative cost on the DSS-1571 must be included in the random sample. If an equivalent form is used, that form must capture all of the data fields contained in the DMA-2056. All modes of transportation must be included in the sample.

Use the DMA-5078, Medicaid Transportation Monitoring Report to document findings. The following aspects of each file must be reviewed:

1. Was the beneficiary authorized for Medicaid on the date of the trip?

(VI.E.)

2. Was the beneficiary in an eligible Medicaid category program category?

3. Was the beneficiary transported to a Medicaid enrolled provider?

4. Did the beneficiary receive a Medicaid covered service?

   a. Contact the provider and determine if the beneficiary received a medical service on the trip date.

   b. Verify that the service received is a Medicaid covered service (see VIII.A.).

5. Is there a current DMA-5048, Transportation Exception Verification Form in the file?

6. Is there a current DMA-5046, Notice of Rights in the file?

7. Is there a current DMA-5047, Medicaid Transportation Assessment, in the file?

8. Is there a current DMA-5024, Transportation Assessment Notification, in the file?

9. Was the calculation of the reimbursement for the trip/related expenses done correctly?

10. Was a DMA-5119, Denial of Transportation Request, provided to the beneficiary (if applicable)?

11. Was the trip coded correctly for reimbursement on the DMA-2056, Transportation Log?

VII. Procedure

When a request for transportation is made, follow the procedures below.

A. Assessment of Need

A DMA-5047, Medical Transportation Assessment, must be completed in its entirety at the initial request for transportation assistance, once a year thereafter and when there is a change in circumstances which may impact the need for transportation assistance, and to coincide with each Medicaid review or reenrollment, if the beneficiary is still in need of services. An assessment must be completed at least every twelve months for SSI beneficiaries or as needed when a reported change in circumstances may impact the beneficiary's need for transportation services.

Follow the same NEMT policy for foster children. A foster parent is classified as a non-financially responsible relative friend. An assessment must be done to determine whether the foster care parent has the means to transport the beneficiary to medical appointments. Note; foster parents are required to have a working vehicle as part of the foster care agreement.

Assess how medical transportation has previously been provided and why it is not available now (Section B of DMA-5047).

1. Does the A/B have access to a vehicle that can be used to get to and from medical appointments?

    a. Beneficiary's vehicle

    Ask the A/B and/or financially responsible person if he has a working car or truck.

    b. Friend, relative, neighbor

    Ask A/B if he has friends, relatives or neighbors who would be willing to transport him to medical appointments.

    c. If it is determined that the A/B is able to provide his own transportation, his request should be denied on the DMA-5024.

2. Ask the A/B how he has 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. Agency provides transportation.

      Document the name of the agency

3. Ask if there is a reason the A/B can no longer use the source he had been using for transportation to get to medical appointments.

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

   b. Ask the beneficiary if he has any physical and/or mental impediments which limit his ability to use available transportation. If physical or mental impediments are claimed, complete the DMA-5048 following instructions in VII.C.2.

   c. If the A/B states that he cannot afford to pay (for gas, bus fare, car repairs, insurance, vehicle registration, cab fare, etc.) accept his statement.

4. Community based transportation resources

   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 is able 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 his utilizing them, complete a DMA-5024 and deny his request.

(VII.)

B. Assessment by Other Entities

The county may subcontract with other entities to have transportation assessments completed. However, before any assistance can be provided the county DSS is responsible for assuring that

1. The subcontractor meets all the assessment requirements, including completion of the DMA-5047; and

2. Documentation of the assessment decisions, copies of notices, authorizations, etc. are received by DSS and comply with guidelines.

C. Special Needs (Section C of DMA-5047)

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

   a. An attendant (required for children under age 18 unless they are emancipated), who may or may not be a parent. Other beneficiaries may need attendants due to special medical, physical or mental impediments;

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

   c. Cane/crutches/walker;

   d. Portable oxygen tank;

   e. Service animal;

Or

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

2. DMA-5048, Medicaid Transportation Exception Verification Form

   When the A/B requests transportation assistance and 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, complete the DMA-5048, Medicaid Transportation Exception Verification Form.

(VII.C.2.)

The DMA-5048 is also used when the A/B alleges a need for transportation to a provider outside the local area. The provider must furnish a medical explanation as to why transportation at a greater distance is required (see VIII.B). When a beneficiary is referred to a specialist out of the county, the referring provider must complete the DMA-5048,

Example 1: The beneficiary who is being assessed in person is sitting in a wheelchair. There is no need to complete the DMA-5048.

Example 2: The beneficiary alleges that she is unable to sit for extended periods of time and therefore requires any vehicle in which she is riding to stop every fifteen minutes so she can walk and stretch. Complete the DMA-5048 and fax or mail it to her provider for verification.

a. Complete section 1.

b. Have the A/B complete, sign and date section 2 of the form.

c. Mail or fax the DMA-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 DMA-5048 to the provider.

d. When the form is returned, note any durational limitations or impediments to using available or public transportation in the transportation file.

3. Ask the A/B if he has other special needs

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

b. Car seat?

If so, ask the age of the child to determine the type.

c. Accompanying translator?

D. Method of Transportation (Section D of DMA-5047)

Refer to County list of available NEMT modes ranked from least to most expensive (see VI.B.1.e.). Provide a detailed explanation of any special needs used to determine "suitable" transportation.

(VII.)

E. Assessment of Need

Document on the DMA-5047, Medicaid Transportation Assessment Form:

1. Whether the request for transportation assistance is approved or denied (section D on the DMA-5047);

2. If applicable, document why it is necessary to transport the beneficiary to a provider outside of the county on a routine basis (Section D on the DMA-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 DMA-5047);

4. Time limitations on need for transportation special needs assistance, if any (Section D on the DMA-5047);

   Example: Beneficiary is in above the knee cast and will need van transportation for six months.

5. Date DMA-5048 is received when applicable;

6. A/B has been notified (DMA-5024, Transportation Assessment Notification). Notification must contain the following elements:

   a. Assessment result,

   b. Approval from and to dates,

   c. Notice of appeal rights.

7. Attach to the DMA-5024, Transportation Assessment Notification:

   a. Transportation request instructions informing the beneficiary who to contact for trip requests and the telephone number to use (see VII.F.),

   and

   b. No-show and conduct policies (see VII.G and H.).

8. Send the DMA-5024, Transportation Assessment Notification, to the beneficiary after each assessment is completed.

(VII.)

F. Advance Notice Policy

The county cannot require the beneficiary to make transportation requests in person. 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 for in county trips and five business days prior to their scheduled appointment for out-of-county trips. Urgent transportation services are exempt from any advance notice requirement. The county must make an attempt to satisfy any urgent request for transportation. The beneficiary must be informed in writing of the advance notice policy at each transportation assessment.

G. No-show Policy

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

1. The county 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 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.

    c. 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 DMA-5125, Medicaid Transportation No-Show Notice for counseling letter.

    d. 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 in the beneficiary's NEMT file. See DMA-5125A, Medicaid Transportation No-Show Final Notice for warning letter.

e. 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 DMA-5125B, Medicaid Transportation Suspension Notice.

f. 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. 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.

H. Conduct Policy

The county 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.

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.

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.

(VII.)

I. Which County is Responsible

The county where the beneficiary resides is responsible for arranging, providing and requesting reimbursement for transportation.

In certain circumstances, such as foster care cases and SSI cases where the Social Security Administration has the incorrect county of residence, or in instances where the beneficiary is temporarily residing out of the county, the county where the beneficiary is physically located is responsible for transportation and will be reimbursed for it. The county where the Medicaid case is located and the county where the individual is physically located must work together to assure the beneficiary receives necessary transportation services in a timely manner. The county that arranges the transportation must request reimbursement from DMA.

VIII. ARRANGING TRANSPORTATION TO MEDICAL CARE

A. Medicaid Covered Services

1. Medicaid transportation is only provided for Medicaid covered services and when the primary reason for the trip is medical care. To determine what services are covered, see MA-2905/3540 Covered Services, or consult the Medicaid Clinical Coverage and Provider Manuals index for information on the service in question (http://www.ncdhhs.gov/dma/mp/index.htm).

   Example 1: Beneficiary participates in a sheltered workshop program at a facility that provides medical services. Because the primary reason for his trip is to participate in the sheltered workshop program, transportation would not be provided even though a medical service is provided 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.

   Note: Some Medicaid covered services, for example organ transplants and gastric bypass surgery, have a medical requirement that the patient attend classes 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.

2. CAP (Community Alternative Program)

A beneficiary of CAP is entitled to transportation to any service included in the Medicaid column of his plan of care cost summary (see IV.C.6. for CAP services that have transportation included in the provider fee). 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. Verification Requirements

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

b. The county is responsible for verifying with the health care provider that the beneficiary will be receiving, or has received, a Medicaid covered service. To meet this responsibility, a minimum of 10% of trips must be pre-verified and a minimum of 10% of trips must be post-verified. Verification can be accomplished by:

(1) Phone call to the providers. Document the date of the call, the person to whom you spoke and what was verified.

(2) Utilizing the DMA-5118A, Verification of Receipt of Medicaid Covered Service, form (use DMA-5118B only if provider requires a signed release). The responsibility for getting the 5118 signed and returned to dss can be placed upon the beneficiary or the transportation vendor.

(3) Any other method sufficient to elicit the information. Document the method and result in the file.

B. Nearest NC Enrolled Medicaid Provider

DSS is required to arrange transportation to medical services which are closest to the beneficiary's place of residence. This can include a bordering county in North Carolina or a neighboring state. Transportation is not provided to a provider at significantly greater distance when the needed services can be obtained in the community (see exceptions below). Medicaid may not pay for transportation if a beneficiary chooses a provider at a greater distance unless the following applies:

1. Service cannot be obtained locally or local providers will not accept Medicaid beneficiaries.

2. The beneficiary's provider gives a medical reason why the beneficiary must be transported to the provider at a greater distance. Medical reasons can include:

    a. The beneficiary is undergoing an established course of treatment which must be completed, such as chemotherapy or surgical follow-ups;

    b. The beneficiary would be harmed by disruption of an established provider/patient relationship;

3. The beneficiary's Carolina ACCESS/CCNC provider is located in a neighboring county.

If the beneficiary requests transportation at a greater distance, use the DMA-5048, Medicaid Transportation Exception Verification form to obtain a written statement from the provider as justification for providing transportation at a greater distance. Note, never deny the beneficiary this right. Fax the DMA-5048, to the provider and give the provider ten (10) days to return form to the county. For specialists, the form must be signed by the referring physician. For primary care providers, the form must be signed by the primary care provider. The completed DMA-5048 must be filed in the transportation file.

C. 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 needs and individual circumstances.

1. Least Expensive Means

    When determining the least expensive means of transportation the county must take into account all travel related expenses.

2. Suitable to Needs (refer to section VII. above for eligibility assessment procedures)

    When arranging transportation that is suitable to the needs of the beneficiary:

    a. Review the information on the DMA-5047, Medical Transportation Assessment.

b. Determine from the beneficiary if there has been any change in his condition which impacts the appropriate mode of transportation.

c. Determine if there are any special factors impacting the trip. This may include attendant responsibilities, accompaniment of children, public transportation schedule incompatible with appointment and/or conflicting work schedules.

d. Determine if there are any physical/medical conditions that can impact the trip. This may include physical/mental disabilities, physical stamina, and the need to transport medical equipment. Refer to DMA-5048, Medicaid Transportation Exception Verification, if completed.

Note: The EPSDT unit in the Clinical Policy section of DMA may approve an EPSDT participant for a specific mode of transportation. When this occurs, the county DSS must make arrangements, provide and request reimbursement for the means of transport identified as appropriate by the EPSDT unit.

3. 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

a. The beneficiary states that he lives within walking distance of a bus or van route and either

b. States that he can use public transportation; or

c. A physician indicates on the DMA-5048, Medicaid Transportation Exception Verification Form, the beneficiary is capable of using public transportation (see VII.C.2. above for instructions on when and how to use the DMA-5048). Be sure to note any limitations on walking distance and, if necessary, verify distance from beneficiary's home to the nearest bus stop. For those that the forms of fixed route transportation cannot reasonably accommodate, explore the demand responsive public transportation options available.

4. Ambulance Transportation

Most ambulance transportation is a Medicaid covered service and not arranged by the county.

a. Medically Necessary Ambulance Transportation

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.

Medically Necessary ambulance transportation may be emergency or non-emergency.

(1) Emergency medically necessary ambulance transportation

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

(a) Basic Life Support (BLS)

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

(b) Advanced Life Support (ALS)

An ALS 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.

(2) Non-emergency medically necessary ambulance transportation

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. 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

b. Ambulance transportation that is not medically necessary

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 described in a. above. To accommodate such beneficiaries, the county must contract with an ambulance company or negotiate a trip cost with the ambulance company on an as needed basis.

In either case, the county 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.

Because the ambulance company is not providing a "medical service" in this instance, it does not directly bill the fiscal agent. DSS reimburses the ambulance transportation provider and is reimbursed by DMA. The beneficiary's record must be documented to show why this method of transportation was needed. Complete a DMA-5048 if the need for this type of transport is not evident. Use billing code A0999 on the DMA-2056, Transportation Log.

5. Air Ambulance Transportation

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. Transportation must be to the nearest hospital with appropriate facilities. The air ambulance provider must submit a claim to the Medicaid fiscal agent for reimbursement.

Examples of medical conditions which may require air ambulance transport include: intracranial bleeding requiring neurological intervention, cardiogenic shock, burns requiring treatment at a burn center, multiple severe life threatening injuries, life threatening trauma.

(VIII.)

D. Logging Trips

1. Timing and Documentation of Request

a. 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.

b. All requests for medical transportation by Medicaid beneficiaries 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, provided that the individual is eligible in some Medicaid program.

Example 1: Individual calls and requests transportation to his doctor for a March 9th appointment. IMC verifies eligibility and determines that the individual receives MQB-B. 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.

(1) The outcome of the trip request (approved/denied and reason for denial) must be entered on the DMA-2056, Transportation Log.

(2) If the request is approved, the DMA-2056, Transportation Log, 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 DMA-2056, Transportation Log, must indicate why the request was denied and the date that a notice of denial was sent to the beneficiary

(VIII.D.)

2. Logging the Trip from Request to Completion

Record each trip on the DMA-2056, Transportation Log, or equivalent form that captures all of the DMA-2056 data fields.

a. The following information is required on the DMA-2056;

(1) Date of request,

(2) Date of trip,

(3) The name of the beneficiary,

(4) Medicaid Identification Number of the individual obtaining a Medicaid covered service (do not provide the MID of anyone traveling with this individual),

(5) Destination (name of medical provider/business and address),

(6) Whether the trip is approved and, if not, the date notice was sent,

(7) Date Denial Notice Sent (if applicable),

(8) Number of one way trips,

(9) Trip cost,

(10) The billing code for the mode of transportation or transportation-related service provided (see b. below). 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.

(11) Medicaid reimbursement amount,

(VIII.D.2.)

b. Billing codes for DMA-2056 Transportation Log

(1) Mileage reimbursement to volunteers billing code A0080

(2) Mileage reimbursement to beneficiary, financially responsible individual, family member, neighbor, etc. A0090

(3) Taxis, billing code A0100.

(2) Bus fares on intra or interstate carriers, billing code A0110.

(4) Van service (except wheelchair van), public and private transportation systems, billing code A0120.

(4) Wheel-chair vans, billing code A0130.

If there is not a medical or physical reason for a wheel chair or van to be used to transport the beneficiary and/or attendant, but a wheel chair van is employed, use billing code A0120. Use billing code A0130 when there is a medical or physical reason for using the wheelchair van.

(5) Non-emergency air travel (private or commercial) intra or inter-state, billing code A0140,

(6) Mileage paid to caseworker or social worker.

(7) Ancillary costs including Attendant Pay, parking fees, tolls, etc. A0170.

(8) Beneficiary lodging A0180.

(9) Beneficiary meals A0190.

(10) Attendant lodging A0200.

(11) Attendant Meals A0210.

(12) Ambulance Service (stretcher transport, no life support) A0999.

(VIII.)

E. Types of approvals

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

1. Beneficiary Medical Trips

Approve trips to medical services as needed for beneficiaries that meet requirements for transportation assistance. Send a DMA-5119, Denial of Transportation Request(s), for each request that is denied. If so, only one DMA-5119, Denial of Transportation Request(s), is needed to deny one or all of those trips. Do not send the DMA-5119 for trip approvals.

In order 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.

The beneficiary must contact the transportation coordinator to request assistance for all medical visits during the designated period of time. 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.

If the beneficiary is approved for an extended period or series of visits, send a referral to the transportation vendor identifying the scheduled appointments. The referral document should include the beneficiary's eligibility dates and program category.

(VIII.)

F. Notification of Trip Approval/Denial

1. Approvals

   The beneficiary must be notified, either verbally or in writing, of trip approvals.

2. Denials

   Use the DMA-5119, Denial of Transportation Request(s), to notify the beneficiary that his request for transportation assistance has been denied.

   a. Document on the DMA-5119, Denial of Transportation Request(s), the reasons for the county's decision(s) on the A/B's request for assistance.

   b. If multiple beneficiaries in a household are denied, all beneficiaries can be listed on the same DMA-5119.

   c. Retain a copy in the transportation file.

   d. The beneficiary has the right to request a hearing if he disagrees with a decision made on his transportation request. Follow guidelines in MA-2420/MA-3430, Notice and Hearing Process.

IX. Safety and Risk Management

DSS must assure that all contracted 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/FRPs who seek reimbursement for mileage.

A. County Responsibilities for Safety and Risk Management Monitoring

1. Ensure contracts with vendors include all provisions specified in IX.I.

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

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

4. Maintain a file for agency staff, agency-approved volunteers, and beneficiary relatives and friends who are reimbursed directly by the county.

   a. For agency staff and agency approved volunteers, the file must include the following:

      (1) Driver's License;

      (2) Current vehicle registration/inspection;

      (3) Current driving record;

      (4) Liability insurance;

      (5) An agreement stating that the staff/agency volunteers will report all changes;

b. For beneficiary relatives and friends, the file must contain the following:

(1) Driver's License;

(2) Current vehicle registration/inspection;

(3) Liability insurance;

(4) An agreement stating that the staff/volunteers/ beneficiary relatives and friends will report all changes;

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

B. 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).

1. Commercial Vehicles

a. Agencies should also require contract transportation vendors to carry increased liability limits beyond the minimum statutory requirements.

b. 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 DSS 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.

2. "For Hire" Vehicles

"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.

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 and $5 million coverage for vehicles designed to transport more than 15 passengers, including the driver.

3. Taxi Cabs

Liability insurance requirements are set by local ordinances and can vary widely from county to county. DSS must ensure that any Taxi service it uses for NEMT carries at least the minimum liability insurance coverage for their vehicle's particular classification (for minimum liability requirements for passenger vehicles, see http://www.ncdot.org/dmv/vehicle/title/).

4. Agency Owned Vehicles

Agencies that use their own vehicles to provide beneficiary 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.

5. Non-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.

6. Staff and Volunteers

Staff, agency-approved volunteers (including foster care parents) who transport beneficiaries for mileage reimbursement must maintain minimum liability insurance coverage for their vehicle's particular 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.

(IX.)

C. Licensed Operator

The DSS is required to ensure that all drivers (including county employees, contractors, contractor employees, and volunteers) are at least 18 years of age and properly licensed to operate the specific vehicle used to transport beneficiaries. This applies to family members, friends, etc., reimbursed by the agency to transport the beneficiary, but not to beneficiaries and financially responsible persons.

D. State Inspection

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

E. Alcohol and Drug Testing

DSS 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 http://www.access.gpo.gov/nara/cfr/waisidx_09/49cfr655_09.html). The vendors shall be contractually obligated to pay for the alcohol and drug testing program.

F. Background Checks

The county and its vendors (with the exception of public transportation vendors) 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:

1. Murder,

2. Rape or aggravated sexual abuse,

3. Kidnapping or hostage taking,

4. Assault inflicting serious bodily injury,

(IX.F.)

5. A federal crime of terrorism,

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

7. Unlawful possession, use, sale, distribution, or manufacture of a weapon,

8. Elder abuse/exploitation,

9. Child abuse/neglect,

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

11. Conspiracy to commit any of the above.

G. Driving Records

The county is required to have a driver screening policy. The driving records of all drivers (see below for exception), including agency employees who transport beneficiaries and contract transportation vendors, shall be reviewed every 12 months. 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.

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. Driving records may be obtained from the Department of Motor Vehicles (DMV). Accept the DMV information provided by the applicant unless questionable.

The driver screening policy does not apply to beneficiaries, financially responsible persons, or family and friends of the beneficiary.

(IX.)

H Medicaid and Medicare Exclusions

The county must check the following state and federal data bases to assure that each **transportation vendor**, including the vendor's owners and managers, **is** not excluded from participation in federal health care programs. https://providertracking.dhhs.state.nc.us/default.aspx and http://oig.hhs.gov/exclusions/index.asp). Any vendor, owner or manager that has been excluded from participation **in Medicaid** or Medicare cannot be a Medicaid transportation vendor. Federal and state **exclusion inquiries must be completed when negotiating a contract, on a monthly basis after contract has been awarded, and when a contracted vendor reports a change.**

1. Each transportation vendor must furnish information to allow the county to complete the Medicaid/Medicare Exclusion Inquiries prior to the vendor entering into a contractual agreement to provide NEMT services, during the contract renewal process, and within 35 days after any change in ownership of the vendor. Any transportation vendor that subcontracts with another vendor to supply all or part of the contracted NEMT service is responsible for obtaining and furnishing the information from the subcontractor **to the county DSS.**

a. The name and address of each person (individual or corporation) with an ownership or control interest in the vendor or in any subcontractor in which the vendor has direct or indirect ownership of 5% or more. The phrase "Ownership and Control" in the public transit context refers to any director, chief executive officer, deputy director and/or chief financial officer, or those in equivalent positions. If uncertain of whether the reporting requirements apply to a particular individual, contact DMA for clarification

b. List any relationship that may exists between any persons named in a. above as it relates to kinship as spouse, parent, child or sibling.

c. The name of any NEMT vendor in which an owner of the disclosing vendor has an ownership or control interest.

d. The name, address, date of birth and Social Security Number of any managing employee of the vendor.

(IX.H.)

Document this information on the DMA-5124, Non-Emergency Medical Transportation Provider Documentation form and get the vendor to provide his signature and the current date.

2. Check all organization/business names, owner's names and/or managers' names by utilizing the following instructions:

   a. Office of Inspector General (OIG) Database

      (1) Access the federal website at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

      (2) Click on "online searchable database" located on the right side of the webpage.

      (3) Enter the individual's name, (Last, First) or the business name and click on "Search" (the spelling of names must be correct).

      (4) Results will display, **and if a match is found**, print the screen for the vendor's file.

      (5) To determine if the vendor is the same individual/business as the one displayed as excluded, click on the "SSN/EIN" field at the far left. Enter the SSN of the Individual or the Employer ID Number (EIN) in this screen and click "Verify". Print this screen for the vendor file.

      (6) Enter **the results of the inquiry** on the DMA-5124, Medical Transportation Provider Documentation form.

      (7) If a vendor **is excluded from participation in the Medicaid Transportation program due to Medicaid or** Medicare exclusion, notify the vendor in writing and place a copy **of the notification** in the vendor's file.

(IX.H.2)

b. NC DHHS Provider Penalty Tracking Database (PPTD)

The NC DHHS Provider Penalty Tracking Database is available to a county designated user. The designated user must have access to OLV. To gain access to SB926, complete the DMA-5086 and fax it to the DMA Transportation Coordinator at (919) 715-0801. The PPTD database is labeled "SB926" in the WIRM portal. Matches are completed using the owner's Social Security Number and using the owner's full name.

(1) Sign on to the WIRM portal and click on SB926. Owner's information will be entered on the lower right side of the page.

(2) Enter the owner's SSN and complete the match**. Results will display, and if a match is found, print the screen for the vendor's file.**

(3) Enter the owner's name (first and last) and complete the match again. **Results will display, and if a match is found, print the screen for the vendor's file.**

(4) For initial search or when a change is reported, record findings from the match process on the DMA-5124, Medical Transportation Provider Documentation form.

(5) If no match is found, document this on the DMA-5124, Medical Transportation Provider Documentation form.

(6) Complete the DMA-5124A, Medical Transportation Provider Documentation Addendum form when completing the monthly matches.

(7) If a vendor is excluded from participation in the Medicaid Transportation program due to Medicaid or Medicare exclusion, notify the vendor in writing and place a copy of the notification in the vendor's file.

3. State and County officials, employees and their agents may visit vendor facilities to make certification and compliance surveys, inspections, and audits of business records. Such visits including unannounced visits must be allowed at any time during normal hours of operation. Failure to grant immediate access upon reasonable request may result in termination of the contract.

(IX.)

I. Transportation Contract

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

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

2. An obligation to maintain records documenting compliance with all vehicle and employee requirements specified in B through G 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 course of 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 provide names of all owners, managers, management entities, and subcontractors;

6. An obligation to disclose the name of any individual who has ownership or control interest in the vendor, or is an agent or managing employee of the vendor, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or CHIP since the inception of those programs.

7. An obligation to furnish, within 35 days of the date on a request, full and complete information related to business transactions about:

   a. The ownership of any subcontractor with whom the vendor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

   b. Any significant business transactions between the vendor and any wholly owned supplier, or between the vendor and any subcontractor, during the 5-year period ending on the date of the request.

8. An obligation to report any changes such as insurance provider, business ownership or management or exclusion from participation in Medicare;

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

10. An obligation to report all no-shows on a daily basis and cancellations on a monthly basis;

11. If the county 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 transportation reimbursable costs;

12. 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.

13. 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,

14. An obligation to use the provided transportation billing codes on invoices to the county DSS for reimbursements.

X. Reimbursement

DMA reimburses the county for the Federal and State share of certain transportation costs for direct services provided to beneficiaries. The FMAP rate is subject to change every year. Staff administrative costs are reimbursed at 50% of the administrative cost.

A. Reimbursement for Transportation Costs (Other than Travel Related Expenses)

1. Fares for public transportation (taxis, buses, rail or contracted service provided by Federal Transit Administration funded Community Transportation Systems;

    a. Reimbursement for taxi fares, use billing code A0100 on the DMA-2055, Reimbursement Request Form.

    b. Reimbursement for bus fares on intra or interstate carriers, use billing code A0110 on the DMA-2055, Reimbursement Request Form.

(X.A.1.)

c. Reimbursement for mini-bus, mountain area transports or other transportation systems, use billing code A0120 on the DMA-2055, Reimbursement Request Form.

d. Reimbursement for wheel-chair vans, use billing code A0130 on the DMA-2055, Reimbursement Request Form.

2. Operating costs per passenger trip with agency owned vehicles or vehicles in the county's coordinated transportation system as described in the CTSP;

3. Reimbursement for mileage costs

a. Mileage costs incurred by non-financially responsible family members or friends shall not exceed the current IRS business rate (see Standard Mileage Rates) when payment is made directly to the friend or relative. Use billing code A0090 on the DMA-2055, Reimbursement Request Form;

b. Mileage costs incurred by beneficiaries and FRPS shall not exceed half the current IRS business rate (see Standard Mileage Rates). Use billing code 0090 on the DMA-2055, Reimbursement Request Form.

c. Mileage costs incurred by DSS staff using private vehicles, or volunteers appointed by the county. The county may negotiate the reimbursement rate for its staff and volunteers.

(1) For DSS staff, use billing code A0160 on the DMA-2055, Reimbursement Request Form.

(2) For agency volunteers who provide their own vehicle, use billing code A0080 on the DMA-2055, Reimbursement Request Form.

5. Salary compensation for transportation aides employed by DSS (although the State and Federal share is reimbursed for this service, you must claim reimbursement on DSS-1571).

6. Attendants

a. 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;

(X.A.6.)

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

(1) Non-medical professionals

The county, 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;

(2) Medical professionals serving as attendants

(a) 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.

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

7. Vendor delivery charges for prescriptions as long as it meets least expensive criteria;

8. Reimbursement for travel for parents/guardians to care for, or be taught how to care for, an in-patient child (necessity verified on DMA-5048);

9. Gas Vouchers and Mileage Reimbursement

Vouchers are issued to eligible beneficiaries who can use their own car or a friend or relative's car for transportation to a Medicaid covered service. Vouchers can be redeemed at local gas stations. Mileage reimbursement may not exceed half the current IRS business rate (see Standard Mileage Rates) unless the gas provider requires a minimum rate (see 3. above). Both mileage reimbursement and gas vouchers must be provided in an amount sufficient to cover the cost of gas. 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. Use billing code A0090 on the DMA-2055, Reimbursement Request Form.

(X.)

B. Maximum Reimbursement for Travel Related Expenses

Reimbursement for related travel expenses may not exceed the state mileage, subsistence and lodging reimbursement rates. The rates can be found in section 5.1, Travel Policies for State Employees, of the linked document: http://www.osbm.state.nc.us/files/pdf_files/BudgetManual.pdf.

The county department has the option of providing money for travel related expenses to the beneficiary in advance or after the trip is completed. If the worker feels that verification of the appointment is necessary, he should request the appointment card or contact the provider.

1. Breakfast

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

2. Lunch

   Reimbursement for lunch is only allowable on overnight stays. If a day trip will last from morning through afternoon the county department should counsel the beneficiary to make arrangements for lunch. At the county's discretion, lunch may be provided for the beneficiary and attendant. However, reimbursement from DMA is not allowable.

3. Dinner

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

4. Billing Codes for Meals

   a. For beneficiary meals, use billing code 0190 on the DMA-2055, Reimbursement Request Form.

   b. For attendant meals, use billing code 0210 on the DMA-2055, Reimbursement Request Form.

6. 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. Use billing code A0170 for parking fees and tolls on the DMA-2055, Reimbursement Request Form.

(X.B.)

7. Overnight Lodging

When the medical service is available only in another county, city, or state, medical condition, travel time and distance may warrant staying overnight. Allowable expenses include overnight lodging and meals for eligible beneficiaries while in transit to and from the medical resource. Lodging and transportation to and from the lodging must be determined to be less expensive than daily travel from home (unless deemed medically necessary).

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

a. For beneficiary's lodging, use billing code A0180 on the DMA-2055, Reimbursement Request Form.

b. For attendant's lodging, use billing code A0200 on the DMA-2055, Reimbursement Request Form.

C. Transportation Costs Reimbursed at 50% Administrative Rate

Staff Administrative Costs - Reimbursed by DSS, as reported on the DSS-1571.

D. Reimbursement to Nursing Facilities

1. Direct Reimbursement

DMA 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. This reimbursement is included in the total cost of care paid to the facility. 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. It is not necessary for DSS to have the DMA-5046, Notice of Rights/Responsibilities signed for applications and redeterminations since nursing homes provide their own transportation.

(X.D.)

2. Arranging Transportation

The facility will be responsible for arranging and/or providing non-ambulance transportation for all Medicaid beneficiaries (even if DSS has guardianship) who do not have family assistance. The facility may contract with providers (including local county services) to provide transportation or may provide transportation services using its own vehicles, whichever is more cost effective.

3. Ambulance Transportation

Ambulance transportation for nursing home residents is permitted only by medical necessity as specified in Section VIII.C.4. 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 his family for non-covered services

E. Reimbursement to Adult Care Homes

1. Arranging Transportation

The county DSS is responsible for arranging and/or providing non-ambulance transportation for Adult Care Home (ACH) beneficiaries with no other appropriate means of transportation available.

Facilities may contact local county social services to request transportation services on behalf of Medicaid beneficiaries residing in an adult care homes.

If the facility possesses an appropriate mode of transportation, they must enter into contract with the county DSS before they can be utilized as a non-emergency medical transportation vendor. Please refer to IX for Safety and Risk Management procedures.

(X.E.)

2 Ambulance Transportation

Ambulance transportation for adult care home residents is permitted only by medical necessity as specified in Section VIII.C.4. above.

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.

F. The County may not request reimbursement for the following:

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. Private or public vendor costs which are higher than appropriate when less expensive means of transportation are 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 trips.

   Miles to or from a transportation vendor's office/home/garage to or from the Medicaid beneficiary's residence are not compensated by Medicaid. Medicaid only pays from point of pickup to the point of drop off. The cost of empty trips should be factored in the total cost in setting mileage rates.

9. Ambulance transportation of a deceased person.

XI. REPORTING TRANSPORTATION COST

Direct payment to Medicaid beneficiaries for transportation and travel-related expenses as well as transportation services purchased for Medicaid beneficiaries are reported on the DMA-2055. Refer to A below for instructions on how to report such costs. All other costs, such as staff administrative cost and operating agency vehicles are reported on the DSS-1571. Please refer to chart below.

	Agency Costs	**Direct Payment for Services**
Forms	DSS-1571	DMA-2055
Reported Costs	**Medically related transportation of Medicaid** beneficiaries**.** 1. Operation of agency owned vehicle. 2. Operation of DSS staff owned vehicle. 3. DSS staff time used in directly providing transportation. 4. Operation and Maintenance costs for agency vehicles. 5. Purchase price of a vehicle purchased by the agency for sole purpose of providing Medicaid transportation.	**Medically related transportation of Medicaid** beneficiaries**.** 1. Direct payments to Medicaid beneficiaries for Medical transportation. 2. Cost for medically related transportation services purchased for Medicaid beneficiaries.

A. Completing the DMA-2055, Reimbursement Request Form

When completing the DMA-2055, include only one month of transportation per form. The month should be the month in which the transportation occurred.

1. Purchased Medical Transportation Service Costs Include:

   a. Fares for public transportation purchased for beneficiaries.

   b. Transportation services purchased for beneficiaries, FRPs, friends, or volunteers to transport Medicaid beneficiaries.

   c. The purchase of gas vouchers as long as it meets the least expensive criteria. See VIII.C.

   d. Attendant expenses.

   e. Transportation of caretakers.

2. Unduplicated Beneficiaries

   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.

3. 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.

4. Enter the appropriate billing code using the code list on the DMA-2055, Reimbursement Request Form.

5. Enter the total amount of reimbursement requested.

B. Time Limitation for County Reimbursement

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