

Non-Emergency Medical Transportation



Medicaid Non-Emergency Medical Transportation Booklet for Providers





Content Summary

Medicaid non-emergency medical transportation (NEMT) is an important benefit for beneficiaries who need to get to and from medical services but have no means of transportation. The Code of Federal Regulations requires States to ensure that eligible, qualified Medicaid beneficiaries have NEMT to take them to and from providers. However, every State's Medicaid program is different. In addition, each State has the option of developing and implementing Medicaid waiver programs, which can provide coverage for additional transportation needs. Waiver program rules can also vary from State to State and even within the same State's programs. Providers are responsible for knowing and abiding by the specific rules for each State where they furnish services, and for each of the programs for which they furnish services. The booklet cites State-specific examples to illustrate the rule discussed.

This booklet summarizes the general scope of Medicaid-covered emergency transportation and NEMT benefits and reviews principles applicable to such coverage. It also explains three modes for States to provide or arrange for covered NEMT, common Medicaid transportation fraud and abuse issues, and provider tips to help prevent fraud and abuse. In addition, the booklet encourages providers to regularly check that their employees and contractors are not excluded from Federal health care programs.

Qualifying for Medicaid Non-Emergency Medical Transportation

The Code of Federal Regulations (CFR) requires States to “specify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers;” and “describe the methods that the agency will use to meet this requirement.”[1] For situations that do not involve an immediate threat to the life or health of an individual, this requirement is usually called “non-emergency medical transportation,” or NEMT.

For this booklet, an eligible beneficiary is defined as “an individual who has been determined eligible and is currently receiving Medicaid.”[2] For most individuals, these eligibility determinations are based on means-testing, by comparing an individual’s income and, for some individuals, assets against an income or resource standard. Individuals with income or resources below the standard are determined eligible. Means-testing is an objective way to determine whether someone meets the criteria for Medicaid benefits.

When beneficiaries are eligible for Medicaid benefits, they may or may not qualify for NEMT services. To qualify, States may require that there be an unmet transportation need.[3, 4] Depending on State law, a qualifying unmet need can include:

- Not having a valid driver’s license;
- Not having a working vehicle available in the household;
- Being unable to travel or wait for services alone; or
- Having a physical, cognitive, mental, or developmental limitation.[5]

Emergency and Non-Emergency Medical Transportation Defined

An emergency is any event that puts the health and life of a Medicaid beneficiary at serious risk without immediate treatment. Real emergencies occur when the medical needs of a beneficiary are immediate and due to severe symptoms. A life-threatening event such as uncontrolled bleeding, heart attack, an automobile accident, or other serious trauma may cause the symptoms.[6] Medicaid reimburses emergency transportation providers when they furnish services to eligible beneficiaries according to the rules.

The Medicaid NEMT benefit is authorized under the Social Security Act section 1902(a)(70) and 42 CFR section 440.170. Medicaid NEMT is transportation for eligible Medicaid beneficiaries to and from appointments and services for those who have a

legitimate need for the services.[7, 8] At a minimum, a State Medicaid agency (SMA) or its designated managed care entity must:

- Ensure necessary transportation to and from providers;
- Use the most appropriate form of transportation;[9] and
- Include coverage for transportation and related travel expenses necessary to secure medical examinations and treatment.[10]



As an NEMT provider, be sure to know the specific Medicaid rules for NEMT and any general State licensing or certification requirements for vehicles and drivers in the States where you furnish services, as they can be different from State to State. Most States publish a provider transportation manual. If you have questions or concerns, call the SMA for assistance.

Links to each SMA website, where specific questions and concerns can be answered, may be found at <https://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html>

on the Medicaid website. States are invested in making sure that services are appropriate and furnished in accordance with Medicaid rules, that beneficiary needs are met, and that providers are paid correctly.

Contract Agreement

States can manage the authorization of NEMT coverage or contract with another entity to manage NEMT coverage, such as a transportation broker or a managed care organization.[11] Regardless of who manages NEMT coverage, Medicaid rules require the transportation provider to have a contract with the appropriate entity before any services are furnished.[12] If the provider is not under contract, Medicaid payment will not be available even if all of the other requirements for NEMT have been met.

Prior Authorization

Once a provider has a contract agreement, many States require coverage of transportation services to be preauthorized before the beneficiaries receive transportation. States preauthorize transportation in a variety of ways. For example, one State may expect a physician to authorize the need for beneficiary transportation, another State may only want to know that the beneficiary's location drop-off was to a medical appointment, while a third State may expect the medical facility to phone in the medical transportation request before providing services.[13] Each State establishes its own preauthorization rules.

Loaded Mileage

State Medicaid payment rules may take into account loaded mileage, location, and wait times. States and contracted transportation entities may only pay fee-for-service transportation providers for loaded mileage (a managed care entity may be paid a per member per month fee [pmpm]). A typical SMA definition of loaded mileage is the time a beneficiary is actually in the vehicle.[14] If a driver arrives at a preauthorized destination for pickup and transport and the beneficiary does not show up for the appointment, then that person is a no-show, and the provider generally cannot bill for the trip. Claiming loaded mileage when the beneficiary was a no-show is a common form of fraud in NEMT, and is an illegal practice.[15] It is called “billing for services not rendered” and may be prosecuted under the False Claims Act.

Location

State Medicaid rules may require beneficiaries to be picked up at home and taken to their medical services, and then be dropped off at home after they receive services. If a trip is to a nonmedical destination like the grocery store, shopping mall, to meet a friend, or something similar, State Medicaid rules do not cover the trip. Do not bill the trip to the Medicaid agency.[16]

Wait Times

Finally, providers need to know that in most States, they cannot receive additional payment based on wait times. The costs of wait times may have been taken into account in determining overhead costs in setting transportation payment rates. Check with the State or the managing entity for any mandatory wait times in your State.[17]

Types of Transportation

The different types of vehicles that providers can use for beneficiary transport to and from covered medical services include wheelchair vans, taxis, stretcher cars, and buses. In addition, providers can use other transportation determined appropriate by the SMA. For example, other transportation options might include air transportation or an ambulette.[18]

Transportation Service Delivery Systems

There are different types of systems States can use to ensure non-emergency transportation for eligible Medicaid beneficiaries. This booklet discusses three of those systems. The three systems are: a transportation broker, transportation as a managed care benefit, and non-preauthorized contractors or vendors.



Transportation Broker

A Medicaid transportation broker contracts with an SMA to manage preauthorized NEMT services in a designated area. The broker bids for the opportunity to manage these services. The potential brokers submit bids, and the SMA evaluates them and chooses brokers based on their “experience, performance, references, resources, qualifications, and costs.”[19] States hold nongovernmental brokers accountable to their contracts and the State Medicaid rules through regular audits and monitoring.

Once a broker has obtained an NEMT contract, they must “ensure that transport personnel are licensed, qualified, competent, and courteous.”[20] This is true for any Medicaid provider that hires drivers, not just brokers.

Not all States use brokers to ensure NEMT services. Some States retain the responsibility for qualifying and authorizing beneficiaries for transportation and then contract with one or more entities to furnish the transportation services.

Transportation as a Managed Care Benefit

States may contract with a managed care plan (MCP) that is then responsible for beneficiary transportation. The MCP must meet requirements for network sufficiency, solvency, and all other managed care requirements.

Non-Preauthorized Contractor or Vendor

States can also contract with independent transportation providers. These transportation providers must be qualified to provide the transportation under applicable State law. These transportation providers may include public transit options (buses, subway), professional drivers (taxis, limousines, vans), or volunteer drivers (family, friends, State-approved volunteers).

Driver Criteria

Depending on the State, there may be special criteria drivers must meet before they transport Medicaid beneficiaries. First, they must have the appropriate, current licenses for the types of vehicles they drive when transporting others. For example, States may require a chauffeur’s license (or equivalent) for taxis and vans.

Second, a State may have qualifications for drivers that exceed the minimum to ensure that Medicaid beneficiaries receive a high quality of transportation. Standards might include limiting the number of points drivers can have against their license,[21]

certifying the health of a driver,[22] carrying vehicle liability insurance,[23] or having a criminal background check.[24] A recent OIG report found that some NEMT providers in one State had not completed the required online criminal background check.[25]

Drivers should be required to treat beneficiaries with courtesy and respect. The State, the broker, or the transportation company should monitor any complaints made by beneficiaries related to access and quality—including any complaints received about the driver’s behavior—and hold drivers accountable. In several States, two of the more frequent complaints about transportation providers concern the timeliness of the driver and the driver not showing up. Other top complaints include problems with the driver’s behavior and “other stakeholders.”[26, 27, 28]

Vehicle Criteria

It is important for transportation providers to remember that there may also be specific vehicle documentation and maintenance requirements.[29, 30] States may, for example, require providers to have documented proof the vehicle belongs to the correct entity and the identification number matches the ownership papers; the vehicle is legally licensed; the vehicle license plate is on the correct vehicle; and the vehicle is in good condition, safe for transport, and receives regular maintenance.[31] In addition, the State may require proof the vehicle has the current State-required liability insurance.

Fraud and Abuse Defined

Most transportation providers are honest and want to do the right thing. For example, a recent OIG report on California NEMT services outside of Los Angeles County found that 89 percent of sampled claims were compliant.[32] On the other hand, there are providers billing fraudulent, wasteful, or abusive claims. A provider must return any payment it receives for an improper claim to the SMA. Properly billing claims is the responsibility of everyone involved with Medicaid services. Brokers, providers, and drivers are all accountable for following Medicaid rules. Failure to comply with Medicaid transportation rules can result in penalties, fines, and prosecution, as previously discussed. Take the time to learn the definitions of fraud and abuse, understand common transportation schemes, and learn tips for preventing fraud and abuse. Check to ensure Federal health care programs do not exclude employees and contractors.

Medicaid rules define fraud as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.”[33] Fraudulent practices include billing for mileage when a beneficiary is not in the vehicle and billing for services that were never furnished.

Abuse is different from fraud. The Medicaid rules define abuse as practices “inconsistent with sound fiscal, business, or medical practices, and result 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 care.”[34]

Fraud Schemes and Results



Any person or group of persons committing fraudulent acts can be held accountable. Fraudulent acts can include a variety of simple or elaborate schemes, as illustrated by the following examples.

Independent Contractor—Parent

Some States reimburse parents, considered independent contractors, for the cost of medically necessary trips. For example, a woman in Idaho was State-approved to regularly transport her child from their home in Idaho Falls, Idaho, to Salt Lake City for necessary medical treatment. However, in late 2007 through 2010, she began billing for trips that never occurred.

The State Attorney General’s Medicaid Fraud Control Unit (MFCU) filed criminal charges against her. She was charged with three counts of Medicaid provider fraud and one count of grand theft. She pleaded guilty to two Medicaid fraud charges for falsifying her medical trip records and for receiving payment for the claims billed. On June 4, 2012, she was sentenced to jail. In addition to jail time and 5 years of probation, she was ordered to pay fines, restitution, and investigative costs of roughly \$21,500.[35]

Beneficiary Fraud

A beneficiary who transported himself to dialysis treatments pleaded guilty to conspiring with an ambulance company owner to allow him to bill Medicaid for ambulance transportation for his dialysis appointments. The beneficiary even signed ambulance run sheets and transported other patients to dialysis in his own vehicle while the ambulance company owner billed for ambulance transportation for those people as well. The beneficiary also received kickbacks for referring other patients to the ambulance service.[36]

Company Owner: Services Not Rendered

Providers should only bill for services rendered. If a beneficiary fails to show for a transportation appointment, a provider cannot bill Medicaid for the no-show. Nor should

providers misuse beneficiary information to claim services they never provided. The owner of an Indiana NEMT company was found guilty of billing for services never provided, including billing for cancelled trips, upcoding some trips, and using patients' medical identifiers without their knowledge to bill for services they never received. The fraud scheme resulted in a loss of over \$1 million to Indiana Medicaid.[37]

Providers must use the most cost-effective mode of transportation when transporting Medicaid beneficiaries. They normally use ambulettes for transporting beneficiaries with a disability or for those who are convalescing and need additional care. Beneficiaries who use a wheelchair may be transported by ambulette. It is cost prohibitive to use ambulettes for those who do not need them. In May 2015, the owner of an ambulance company was sentenced to 6 months in jail and ordered to repay \$200,000 to Medicaid. For 4 years, the owner had modified transportation request forms for a taxi to make it appear the patients needed the more expensive ambulette transportation.

Company—Qualified Drivers

Drivers must be qualified to transport Medicaid beneficiaries. Otherwise, the services are ineligible for reimbursement. On May 1, 2012, a Wisconsin specialized medical vehicle transportation company was convicted of falsifying drivers' records. The company documented that its drivers were trained and certified to furnish the services rendered to Medicaid beneficiaries. Former employees testified that the documentation was false.

The company was convicted of 18 counts of medical assistance fraud and ordered to pay a \$10,000 fine and court costs.[38]

Company Owner—Unauthorized Vehicles

Vehicles must be qualified when transporting Medicaid beneficiaries. A New York ambulette company owner was sentenced to 6 months in jail and 5 years' probation for modifying NEMT authorizations for taxi rides to ambulette services, which were 4 times more expensive. In addition to his sentencing, he also made full restitution of the \$200,000 he stole from Medicaid.[39, 40]

Taxi Driver

Beneficiaries who qualify for transportation services may only use the services for medically necessary appointments. Providers may not be reimbursed for services, even if they are furnished, if the services do not meet Medicaid rules (for example, dropping beneficiaries off at the grocery store or at a friend's home).

On December 18, 2012, a taxi driver in Alaska was convicted for violating Medicaid rules by taking beneficiaries to locations other than medical appointments, purchasing



unused vouchers from investigators, and submitting vouchers for reimbursement that did not reflect the actual services he furnished.

The Anchorage driver was convicted of committing medical assistance fraud and ordered to pay a \$500 fine and restitution. He was also sentenced to 3 years of probation and received a lifetime ban from billing for Medicaid-furnished services. [41] This action is called termination from a State Medicaid

program. Providers who are excluded from one State's Medicaid program must also, by law, be excluded from all States' Medicaid programs as well as from Medicare programs nationwide.

Fraud and Abuse Prevention Tips

Preventing Medicaid transportation fraud is the responsibility of all providers. Providers should, within the scope of their authority and job duties, document the information the State wants, document furnished services completely and accurately, verify services were furnished according to the documentation, and bill correctly. For example, brokers, company owners, and drivers each have documentation responsibilities and should be sure their documentation is complete and accurate. Only brokers and owners have responsibility for verifying services were furnished according to what was documented.

Tip 1: Document Completely and Accurately, and Maintain Records

The Social Security Act requires all Medicaid providers to keep records and furnish them to the State upon request.[42] Each State determines what must be documented, and providers are responsible for keeping the information and producing it if the State asks for it. Transportation brokers and companies typically have their own documentation requirements in addition to what the State wants. To make sure they document records accordingly, providers will want to develop and implement specific transportation policies and procedures and see that their drivers are fully trained to meet the expectations.

Policies and procedures should emphasize the importance of drivers documenting records accurately and completely and include disciplinary action, up to and including termination, for falsifying transportation records. The main goals of documentation are to submit claims that represent the services furnished and to justify the claims billed. To meet these goals, records should be accurate and complete.

At a minimum, all States require providers to document the beneficiary's name and Medicaid identifier, the pickup and drop-off locations, the date and time the services were furnished, and the number of miles traveled with the beneficiary in the vehicle. Drivers should only document the number of loaded miles, as discussed previously.

Although there is no Federal rule requiring it, some States require transportation records to be in ink instead of pencil.[43] Some providers furnish drivers with printed computer sheets and allow them to document information directly on the sheets. If you do this, include this process in your policy, so if audited, the auditor understands why there is written information on the computer-generated documents.[44]

Remember, if a service is not documented, there is no point in submitting a claim for reimbursement.

Tip 2: Verify Services

Some States and brokers require drivers to obtain the beneficiary's signature on the transport record at the end of the trip.[45] Even if the beneficiary's signature is required, it is the responsibility of management or a designee to verify documented services were furnished according to the record.[46] Do this by making random calls to beneficiaries listed on the record, and to personnel at the medical appointment location verifying beneficiary arrival and services.

Tip 3: Bill Accurately

Once services are verified, they can be billed. The claims submitted must reflect the actual services furnished. Providers normally bill State transportation services on the Centers for Medicare & Medicaid Services Form-1500 (CMS-1500). Instructions for the CMS-1500 include the following NOTICE: "Any person who knowingly files a statement of claim containing any misrepresentation of any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties,"[47] so be sure to code claims correctly and represent the services furnished. Be sure to teach drivers not to embellish their records. This is for their own well-being.

CMS offers guidelines for claims submission:

- Use an original red-ink-on-white-paper CMS-1500 claim form;
- Use dark ink on the form;
- Use lift-off correction tape if making corrections to the form;
- Avoid handwritten, printed, or stamped information on the form;
- Make sure there are no staples, clips, or tape on the claim form;
- Remove any perforated edges on the claim form; and
- Include any required documentation with the claim form.[48]

Check for Excluded Individuals and Parties

Providers should take one final action to protect themselves and their businesses from improper billings. Providers need to have a policy and procedure in place to check for



excluded individuals and parties. As part of doing business, providers should make it part of policy and procedure to be diligent in screening all employees and contractors before hiring or contracting with them, and repeat the checks monthly to determine whether they are excluded from participation in Federal health care programs.[49, 50] The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) has the authority to exclude individuals and entities from participating in Federal programs for various reasons. Reasons include being

convicted of certain crimes, losing one’s license for lack of professional competence or financial integrity, or engaging in conduct prohibited by Medicaid rules.[51] When HHS-OIG excludes individuals or entities from participation, it places their names on the List of Excluded Individuals and Entities (LEIE).[52] In the past, providers were also encouraged to check the Excluded Parties List System (EPLS). This has been replaced by the Exclusions Extract on the System for Award Management (SAM).

SAM combines the Federal procurement systems and the Catalog of Federal Domestic Assistance into one new system and includes the functionality of the Central Contractor Registry (CCR), Federal Agency Registration (Fedreg), Online Representations and Certifications Application, and the Exclusions Extract. SAM is a Federal government site intended to streamline information for providers.[53]

It is important to note that an HHS-OIG exclusion does not technically prohibit individuals or entities from participating in Federal programs, but it does prohibit them from receiving Federal payment for items or services they furnished. “Furnished” is a key word—it refers to items or services provided directly or indirectly by an excluded individual or entity.[54]

According to HHS-OIG, “The effect of an OIG exclusion is that no Federal health care program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person.”[55] All claims furnished or submitted by an excluded individual or entity may be considered overpayments subject to recoupment. In addition, the transportation entity may be liable for civil monetary penalties and possible exclusion from Medicaid and other Federal health care program participation. Almost anyone can face exclusion.

CMS has issued guidance to SMAs stating that they should require providers to screen their employees and contractors for exclusions by checking the LEIE database on a monthly basis. The guidance further advises States to require all providers to

immediately report any exclusion information discovered. States can find the guidance in State Medicaid Director Letter Number 09-001.[56] Providers should check the SAM Exclusions Extract as well.

To prevent hiring excluded individuals or entities, implement a process for exclusion screening. It is the business owner's responsibility to make sure they do not employ or contract with excluded individuals. Check for excluded individuals by visiting the LEIE at <https://oig.hhs.gov/exclusions/index.asp> on the HHS-OIG website and SAM Exclusions Extract at <https://www.sam.gov/portal/SAM/#1> on the SAM website. Visit <https://oig.hhs.gov/exclusions/tips.asp> for quick tips on how to use the HHS-OIG website. The Exclusions FAQ (frequently asked questions) section on the HHS-OIG website has additional information.[57]

Report Fraud and Abuse

Report suspected fraud or abuse! Most States do a preliminary investigation and determine whether to send the case to the MFCU. Some States may have regulatory language requiring reporting simultaneously to the SMA and MFCU. Check with your SMA for reporting procedures and document any cases reported to the SMA or MFCU.

- SMA and MFCU
https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html
- HHS-OIG
ATTN: Hotline
P.O. Box 23489
Washington, DC 20026
Phone: 1-800-447-8477 (1-800-HHS-TIPS)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: <https://forms.oig.hhs.gov/hotlineoperations/>

Conclusion

Fraud and abuse carry consequences for perpetrators. Penalties depend on the act and the intent. Those found guilty might have to repay Medicaid funds and pay fines and penalties; might be excluded from Federal programs; or might face probation, house arrest, or prison. Medicaid fraud and abuse are serious offenses; be part of the solution.

Medicaid NEMT is an important and necessary service for beneficiaries who do not have the means to get to and from their medical appointments. Everyone associated with Medicaid transportation must play their part to stop fraud and abuse. Be aware

of the rules pertaining to each State Medicaid program where services are furnished. Be sure to document furnished services and that the documentation is accurate and complete by verifying services occurred as recorded. Then bill them correctly and be sure there are no excluded individuals or entities on staff. Following the rules of Medicaid and these tips will protect the Medicaid transportation program along with the provider, the provider's employees, and the beneficiaries.

To see the electronic version of this booklet and the other products included in the "Non-Emergency Medical Transportation" Toolkit, visit the Medicaid Program Integrity Education page at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

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