Clinical Policy: Non-Emergency Medical Transportation

Reference Number: WNC.CP.262 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Non-Emergency Medical Transportation (NEMT) is transportation to and from medical services on a non-emergent basis. Non-emergency ambulance transport is a medically necessary transport for a member to obtain medical services that cannot be provided when needed at the member's location, such as computed tomography (CT) scans, magnetic resonance imaging (MRI), endoscopies, radiation therapy, and dialysis.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that:

A. NEMT is a covered benefit for Medicaid members per NC Medicaid contract and is value-added benefit offered by WellCare of North Carolina® for members as defined in NC BML and documented in NC NEMT Policy #NC35-CS-039 Medicaid Non-Emergent Transportation Assistance. The benefit is administered through our transportation vendor MTM. Utilization management, denials, and member grievances and appeals are handled by WellCare as they are NOT delegated to MTM. In addition, for high-risk members, services requiring prior authorization, and member conduct/no show issues, NC care management will be engaged to assist in coordination of care.

1. As documented in NC NEMT Policy #NC35-CS-039, Medicaid Non-Emergent Transportation Assistance, ***services requiring prior authorization are*** trips over 75 miles one-way, out-of-state trips (40+ miles over border), air ambulance, and trips requiring hotel, flight, and/or meals. In addition, if MTM is not able to approve a wheelchair or stretcher van (level of need) services for a member, UM will review the medical necessity for these services. NABD letters are required for all denied services, including suspension of transportation services for member conduct/no show issues, and prior approval and level of need denials. Denials because the caller is not eligible for Medicaid do NOT require a NABD letter.

   Note*: Members for whom transportation services are suspended will be offered mileage reimbursement as an alternative benefit.*

2. Services requiring prior authorization and level of need determination will be reviewed for medical necessity as well as all requirements defined in the State Contract and MMC NEMT policy. Specifically, NEMT will be available if the recipient receives a Medicaid covered service, including services carved-out of Medicaid managed care that are provided by a qualified Medicaid provider (enrolled as North Carolina Medicaid provider). Medicaid pays for the least expensive means suitable to the recipient's needs and to the nearest appropriate medical providers. NEMT includes an option for mileage reimbursement when the trip is scheduled in advance with MTM.
3. WellCare of North Carolina® will provide coverage for ***an attendant to travel*** with the member when:
    a. Member is under the age of eighteen (18), unless the member meets the exception criteria below:
        i. Exceptions to the requirement that a minor child be accompanied by an adult during NEMT trips include:
            a) If the minor is emancipated by petition (documentation should be requested and kept on file once obtained), or
            b) If the minor is accessing medical services for the prevention, diagnosis, and treatment for any of the following conditions:
                1) Venereal disease (STD), HIV, or other reportable infectious diseases for NC at https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/reportable_diseases.html,
                2) Pregnancy,
                3) Abuse of controlled substances or alcohol,
                4) Emotional disturbance (including but not limited to anxiety and depression), **OR**
                5) Abortion services WHEN the minor has obtained a waiver of parental consent from a district court judge, and a copy of the waiver of parental consent order has been provided to the Plan. OR
    b. Member has special medical, physical or mental impediments. The attendant may or may not be the parent and is included at no additional cost to the member or attendant. In addition, for non-emergency ambulance transportation clinical coverage guidelines refer to NC Medicaid Ambulance Services policy at https://files.nc.gov/ncdma/documents/files/15_4.pdf

B. ***Non-emergency medically necessary ambulance or stretcher van transport*** is covered for Medicaid members **only** in the following situations:

1. The use of other means of transportation is medically contraindicated. This refers to members whose medical condition requires transport by stretcher; **OR**
2. The member is in need of medical services that cannot be provided in the place of residence; **OR**
3. When return transportation is provided from a facility that can provide total care for every aspect of an injury or disease to a facility that has fewer resources to offer highly specialized care.

***Note**: A provider shall move a bed-confined member by stretcher for:*

- Contractures creating non-ambulatory status and the member cannot sit;
- Immobility of lower extremities (spica cast, fixed hip joints) and unable to be moved by wheelchair; **OR**
- Return (back) transport, such as when a newborn is transported to a tertiary hospital for necessary care and services and, when stabilized, is transported back to the referring hospital to receive a lower level of services.

***Note**: For a member to be considered bed-confined, the following criteria must be met:*

- The member is unable to get up from bed without assistance
- The member is unable to ambulate
- The member is unable to sit in a chair or wheelchair

C. Medical necessity criteria for trips over 75 miles one-way, at least one of the following applies to the member:

1. Member has a diagnosis of end stage renal disease and there is no dialysis center within 75 miles of member's home; OR,
2. Member is receiving cancer treatment (chemotherapy/radiation therapy) greater than 75 miles from their home; OR
3. Member must see a specialist and there are no available, participating specialists who meet the member's specific medical needs, within 75 miles of member's home.

D. Medical necessity criteria for out-of-state trips (40+ miles over border), at least one of the following applies to the member:

1. Member has a diagnosis of end stage renal disease and there is no in-network dialysis center in the state or within 40 miles of the border with an adjacent state that is available to serve the member; **OR**
2. Member is receiving cancer treatment (Chemotherapy/radiation therapy) and is either already established with the out-of-state provider during transition of care period, **OR**
3. For whom there is not an appropriate in-network oncologist or radiation therapist who meets the member's specific medical needs, in the state or within 40 miles of the border with an adjacent state.

E. Medical necessity criteria for trips requiring hotel, flight, and/or meals:

1. Coverage will be provided for breakfast if the member is traveling to a covered service and has to leave home prior to 6:00 am.
2. Coverage will be provided for dinner if the member is traveling to a covered service and will be returning to home after 8:00 pm.
3. Coverage for lunch will only be provided when the member has an overnight stay. Member should be encouraged to plan ahead to make arrangements for lunch.

4. Coverage will be provided for two meals and one overnight stay if the member is going to a covered service and is traveling at least 75 miles one way, for a service that is expected to be completed in a single visit.
5. Coverage will be provided when a member is required to travel to a hospital at least 50 miles from their home for ongoing treatment (examples include but are not limited to transplants and cancer therapy) where they must remain local to the hospital but are not inpatient in the facility.
6. Coverage will be provided for meals and lodging for one companion when the member is inpatient in a hospital at least 50 miles from the member's home.
7. Coverage will be provided for one caregiver when the member lives at least 10 miles from a facility and is in critical condition (for example, neo-natal intensive care, pediatric intensive care, or intensive care) and a companion needs to remain close to the facility.

NOTE: *For items 6 and 7 above, if approved by WellCare of NC utilization management, the following apply:*

- One companion may travel with the member;
- Housing will be arranged by the NEMT vendor (MTM) if not provided at no cost by the treating facility;
- Standard meal allowances will be available for the (non-inpatient) member and one companion.

II. It is the policy of WellCare of North Carolina® that:

A. Members **not eligible** to receive NEMT Services include:

1. NC Medicaid Direct members
2. Members in a Nursing home -The facility is responsible for providing transportation to their patients
3. Members transferring between facilities and/or hospitals.

Background[1]

The method of transportation arranged for the member must be the least expensive means suitable to the needs of the member, including their medical needs and individual circumstances. When determining the least expensive means of transportation, all travel related expenses must be considered. There are situations when prolonged ground transportation would not be appropriate for a particular member's clinical circumstances or may be more costly than air transportation. In those circumstances, air transportation can be approved for coverage.
NEMT mode of transportation services shall include:

- Public transportation
- Taxis
- Van
- Wheel-chair vans
- Minibus

- Mountain area transports or other transportation systems and non-emergency ambulance transportation.
- Other transportation services including volunteers, family members and friends as well as non-emergency air travel.

I. ***Scheduling Non-Emergency Medical Transportation:***

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

B. The member should be able to contact the Member Services Department or transportation coordinator at health plan to request assistance for all medical service trips during their health plan enrollment period. The request may include multiple trips.

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

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

1. Members under the age of eighteen (18), unless emancipated, at no additional cost to the member or attendant. The attendant may or may not be the parent.
2. Members with special medical, physical or mental impediments, at no additional cost to the member or attendant. The attendant may or may not be the parent.

II. ***Driver and Vehicle Requirements:***

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

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. Ensure that member relatives and friends providing NEMT services via reimbursement possess the following:

1. Driver's License;
2. Current vehicle registration/inspection;
3. Liability insurance;
4. An agreement stating that the staff/volunteers/ member relatives and friends will report all changes;
5. These files are required to be reviewed at time of initial member request for a relative/friend to provide transportation when member changes the relative/friend providing transport and annually thereafter to assure that all information is current.

C. ***Ensure Liability Insurance Is Met For The Following***:

Sufficient insurance coverage is necessary to adequately protect the contracted NEMT provider and the members transported. A guide for minimum coverage shall be the

amount required for common carrier passenger vehicles by the North Carolina Utilities Commission (see http://www.ncuc.net/ncrules/chapter02.pdf , Rule 02-36).

1. **Commercial Vehicles**
   a. The health plan should require contracted transportation providers to carry liability at the minimum statutory requirements.
   b. When commercial vehicles (16 passengers or more) are used to provide member transportation services, the health plan should obtain a copy of the private contractor's Certificate of Insurance documenting that the health plan transportation coordinator or designee is an "additional insured." The party identified as an "additional insured" will be notified 30 days in advance of a contractor dropping any coverage.
2. "**For Hire" Vehicles**
   a. "For Hire" passenger vehicles are defined as vehicles used for compensation to transport the general public as well as human service members and are, therefore, subject to the regulations of the N.C. Public Utilities Commission. Taxi cabs and public transportation systems do not fall into this category.
   b. Transportation providers licensed as "For Hire" public conveyance operators must meet statutory requirements for their classification and operator responsibilities. Currently, $1.5 million liability insurance coverage is required on vehicles with a seating capacity of 15 passengers or less, including the driver, and $5 million coverage for vehicles designed to transport more than 15 passengers, including the driver.
3. **Taxi Cabs** – Liability insurance requirements are set by local ordinances and can vary widely from county to county. Any taxi service used for NEMT must carry at least the minimum liability insurance coverage for their vehicle's classification for their local ordinance (for minimum liability requirements for passenger vehicles, see Official NCDMV: Vehicle Insurance Requirements (ncdot.gov).

D. Ensure The Validity Of Licensed Operators

1. The health plan and/or designated entity is required to attest that contracted NEMT providers are meeting all contractual requirements by periodically reviewing driver licenses and verifying all drivers are at least 18 years of age and properly licensed to operate a vehicle and driving records are reviewed every 12 months. If the review is performed by a designated entity, the designated entity is required to periodically (at the discretion of the health plan) provide to the health plan a sample of their reviews.
2. The health plan is required to ensure that all drivers are at least 18 years of age and properly licensed to operate the specific vehicle used to transport Members. This also applies to family members, friends, etc., reimbursed to transport the Member, but not to Members and financially responsible persons.

E. Ensure That Vehicle State Inspections Are Valid - The health plan and/or designated entity is required to ensure that all vehicles used to transport members have valid State registration and State inspection. This also applies to family members, friends, etc., reimbursed by the agency to transport the Member, but not to Member and financially responsible persons.

F. Alcohol and Drug Testing - The health plan and/or designated entity shall ensure both private and public contract transportation providers to participate in a random alcohol and drug testing program which meets the requirements of the Federal Transit Authority (FTA) (see Federal Transit Administration Drug & Alcohol Program). The providers shall be contractually obligated to pay for the alcohol and drug testing program.

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

1. Murder
2. Rape or aggravated sexual abuse,
3. Kidnapping or hostage taking,
4. Assault inflicting serious bodily injury,
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.

H. Driving Record

1. The health plan and/or designated entity is required to ensure the NEMT providers have a driver screening policy for employees, and volunteers who transport members.
2. The driving records of all drivers shall be reviewed every 12 months.
3. 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.
4. 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.
5. Driving records may be obtained from the Department of Motor Vehicles (DMV). Accept the DMV information provided by the applicant unless questionable.
6. The driver screening policy does not apply to members, financially responsible persons, or family and friends of the member.

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

A. Assessment Process

1. An assessment must be completed in its entirety:
    a. At the initial request for transportation assistance
    b. At least once a year after initial request
    c. When there is a change in situation which may impact the need for transportation assistance
    d. To coincide with each Medicaid recertification, if the member is still in need of services
2. The assessment process should assess the amount, duration, and scope that the member has previously had or to establish current need for transportation services. Considerations should be given to the following areas listed below:
    a. Assess how medical transportation has previously been provided and why it is not available now.
        i. Does the enrolled/eligible member have access to a vehicle that can be used to get to and from medical appointments?
        ii. Ask the enrolled/eligible member and/or authorized representative if she/he has a working vehicle.
        iii. Ask the enrolled/eligible member and/or parent, guardian, legally authorized representative, advocate if he/she has friends, relatives or neighbors who would be willing to transport him/her to medical appointments.
    b. Ask the enrolled/eligible member and/or parent, guardian, legally authorized representative, advocate how he/she has been getting to medically necessary appointments.
        i. Drives self
        ii. Friend/relative/neighbor provides transportation
        iii. Takes a bus
        iv. Takes a cab
        v. Other; document who (e.g., organization name, DSS Agency, non-profit)
    c. Ask if there is a reason the member can no longer use the source, he/she had been using for transportation to get to medical appointments.
        i. If the member has access to a vehicle, find out why that vehicle cannot currently be used to transport him to medical appointments. If Member states that he cannot afford to pay for gas, explain that gas reimbursement is available.
        ii. If the member states that he cannot afford to pay (for gas, bus fare, car repairs, insurance, vehicle registration, cab fare, etc.) accept their statement.
    d. If it is determined that the member can provide their own transportation, the request should be denied.

IV. Member Rights and Responsibilities:

A. Rights of the Member

1. To be informed of the availability of Medicaid transportation
2. To have the transportation policy explained including how to request a trip or cancel a trip, limitations on transportation, personal conduct, and no-shows

3. To be transported to medical appointments if unable to arrange or pay for transportation
    a. By means appropriate to circumstances
    b. To arrive at medical provider in time for their scheduled appointment
4. To request a hearing if the request for transportation assistance is denied

B. Responsibilities of the Member

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

V. Hours of Operation:

A. The health plan shall provide transportation after normal business hours when the medical service required by the member is available only during those hours.

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

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description
A0021	Ambulance service, outside state per mile (Medicaid only)
A0080	Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization) with no vested interest
A0090	Non-emergency transportation, per mile – vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Non-emergency transportation, taxi
A0110	Non-emergency transportation and bus, intra or interstate carrier

HCPCS ®* Codes	Description
A0120	Non-emergency transportation; mini-bus, mountain area transports or other transportation systems
A0130	Non-emergency transportation: wheel-chair van
A0140	Non-emergency transportation and air travel (private or commercial) intra or interstate
A0160	Non-emergency transportation: per mile – case worker or social worker
A0170	Transportation ancillary – parking fees, tolls, other
A0180	Non-emergency transportation – ancillary – lodging – recipient
A0190	Non-emergency transportation – ancillary – meals- recipient
A0200	Non-emergency transportation – ancillary – lodging- escort
A0210	Non-emergency transportation – ancillary – meals – escort
A0380	BLS mileage (per mile)
A0382	BLS routine disposable supplies
A0384	BLS specialized service disposable supplies, defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation BLS ambulances)
A0390	ALS mileage (per mile)
A0392	ALS specialized service disposable supplies, defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulance)
A0394	ALS specialized service disposable supplies – IV drug therapy
A0396	ALS specialized service disposable supplies – esophageal intubation
A0398	ALS routine disposable supplies
A0420	Ambulance waiting time (ALS or BLS) one half (1/2) hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra Ambulance Attendant, ground (ALS or BLS) or air (fixed or rotary winged); requires medical review
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0432	Paramedic intercept (PI) rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers
A0433	Advanced life support, level 2 (ALS 2)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0999	Unlisted ambulance service
S0215	Non-emergency transportation; Mileage , per mile

HCPCS ®* Codes	Description
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
S9975	Transplant related lodging, meals, and transportation, per diem
S9976	Lodging, per diem, not otherwise classified
S9977	Meals, per diem, not otherwise specified
S9992	Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion
T2001	Non-emergency transportation; patient attendant/escort
T2002	Non-emergency transportation; per diem
T2003	Non-emergency transportation; encounter/trip
T2004	Non-emergency transport; commercial carrier, multi-pass
T2005	Non-emergency transportation; stretcher van
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments
T2049	Non-emergency transportation; stretcher van, mileage; per mile

Reviews, Revisions, and Approval	Reviewed Date	Approval Date
Original approval date	07/21	08/21
Updated vendor information.	04/22	05/22
Revised Criteria I.E.4. (4. Coverage will be provided for two meals and one overnight stay if the member is going to a covered service and has to be away from home for at least eight hours and is traveling at least 200 miles one way, Added verbiage "for a service that is expected to be completed in a single visit." Added Criteria I.E.5. 5. Coverage will be provided when a member is required to travel to a hospital at least 50 miles from their home for ongoing treatment (examples include but are not limited to transplants and cancer therapy) where they must remain local to the hospital but are not inpatient in the facility. If approved by WellCare of NC utilization management, the following apply: a. a companion may travel with them b. housing will be arranged by the NEMT vendor (MTM) if not provided at no cost by the treating facility c. standard meal allowances will be available for the member and one companion	06/22	08/22
Changed miles from 75 in I.1. ": trips over 75 miles one-way," I.C., "Medical necessity criteria for trips over *75 miles one-way," I.C.1."* diagnosis of end stage renal disease and there is no dialysis center within 75 miles of member's home," I.C.2., "receiving	11/22	11/22

Reviews, Revisions, and Approval	Reviewed Date	Approval Date
cancer treatment (chemotherapy/radiation therapy) greater than 75 miles from their home;" I.C.3. "see a specialist and there are no available, participating specialists who meet the member's specific medical needs, within 75 miles of member's home." I.B.1. & I.B.4. Verbiage changed with no effect on criteria. I.E.4. Deleted verbiage "has to be away from home for at least eight hours and" Changed mileage from 200 to 75 "Coverage will be provided for two meals and one overnight stay if the member is going to a covered service and is traveling at least 75 miles one way, for a service that is expected to be completed in a single visit." HCPCS S0215 description updated "Non-emergency transportation; MILEAGE , per mile"		
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. Added Criteria I.E.6 "Coverage will be provided for meals and lodging for one companion when the member is inpatient in a hospital at least 50 miles from the member's home." Added Criteria I.E.7. "Coverage will be provided for one caregiver when the member lives at least 10 miles from a facility and is in critical condition (for example, neo-natal intensive care, pediatric intensive care or intensive care) and a companion needs to remain close to the facility." And "For items 6 and 7 above, if approved by WellCare of NC utilization management, the following apply: i. one companion may travel with the member; ii. housing will be arranged by the NEMT vendor (MTM) if not provided at no cost by the treating facility; iii. standard meal allowances will be available for the (non-inpatient) member and one companion." Removed ICD-10-Code box.	11/23	11/23
Annual Review. CPT code box removed. Removed Medicaid & health choice verbiage from policy.	11/24	11/24
Annual Review. Under NC Guidance/Claims related information, updated state web address.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 15 Ambulance Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2023. Accessed August 1, 2025.
2. Medicaid Managed Care Non-Emergency Medical Transportation Policy Guidance. North Carolina Department of Health and Human Services. https://medicaid.ncdhhs.gov/. Published February 18, 2020. Accessed August 1, 2025.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

I. that is unsafe, ineffective, or experimental or investigational.
II. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

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

EPSDT and Prior Approval Requirements

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

A. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service
  CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
  HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.