## 19.3 NON-EMERGENCY MEDICAL TRANSPORTATION

A. INTRODUCTION

Recipients of Medicaid and Children with Special Health Care Needs (CSHCN) may request reimbursement for the cost of transportation associated with receiving medical services. Payments are made to the client or the transportation provider and can include meals, lodging, parking and turnpike tolls when required.

B. APPLICATION/REDETERMINATION PROCESS

1. Content Of The Interview

A face-to-face interview is not required in order to apply for non-emergency medical transportation (NEMT) reimbursement. The OFS-NEMT-1 is designed to be filled out by the applicant without the help of the Worker.

If an interview is conducted due to the need for advance payment and/or prior approval and an emergency situation exists, the Worker will obtain all information required on the OFS-NEMT-1 and as required in item M, below.

2. Agency Delays

The Worker must process applications upon receipt, provided the date of the trip for which reimbursement is being requested occurred no earlier than 60 days prior to the date of application. Delays caused by failure on the part of the agency to process an application in a timely manner is not a reason to deny payment.

3. Beginning Date Of Eligibility

Medicaid recipients are eligible for reimbursement for non-emergency medical transportation beginning the first day of the month for which Medicaid was approved, including months for which backdating occurred.

Others who qualify for reimbursement of non-emergency medical transportation expenses are eligible as determined by the program which provides the medical services.

4. Redetermination Schedule

There is no redetermination process for NEMT other than that for Medicaid. Each request for reimbursement is treated as a separate application.

5. The Benefit

Services provided under this program include reimbursement for transportation and certain related expenses necessary to secure medical services normally covered by Medicaid. Funding for this program is provided by three different sources:

- **S** Title XIX funds for all Medicaid recipients, including foster children,
- **S** Title V funds for non-Medicaid eligible recipients of the Children with Special Health Care Needs Program (CSHCN), and
- **S** Agency administrative funds for applicants for cash assistance or Medicaid who need a physical examination in order to complete the eligibility process.

Reimbursement for transportation and related expenses is available to Medicaid recipients who:

- **S** Require transportation to keep an appointment for medical services covered under the Medicaid coverage for which they were approved;
- **S** Receive scheduled Medicaid-covered services at a clinic, hospital or doctor’s office;
- **S** Receive pre-authorization as necessary; and
- **S** Comply with the 60-day application submittal deadline

Reimbursement is also available for applicants for Medicaid who must travel to obtain necessary medical examinations and tests required to determine eligibility. See item M below for specific eligibility requirements.

6. Expedited Processing

Procedures for expedited processing do not apply to NEMT.

7. The Application Process

The required form for all Medicaid recipients, including ARTS clients, is the OFS-NEMT-1 which must be completed by the recipient or by a parent, guardian or other responsible person when the recipient is a child or an incapacitated adult. The form is then mailed or dropped off at the recipient's local DHHR office.

The ART client completes the OFS-NEMT-1 and submits it to the Designated Care Coordinator (DCC) for verification and approval. The approved OFS-NEMT-1 is then forwarded to DHHR by the DCC for processing.

The form may be used for verification of up to 4 trips. Each trip date must be entered in the space titled "Date of Appointment." Regardless of the number of trips included on the form, all trips must have occurred within the 60-day period prior to the date the form is submitted to DHHR for payment.

The medical service provider or his designated representative is required to sign the section verifying that the individual had an appointment and was seen for Medicaid-covered treatment or services. Medical service providers include doctors, nurses, nurse practitioners, physicians' assistants, lab technicians, and others who perform a Medicaid-covered service.

When advance payment is being requested and/or prior approval is required, the applicant may apply in person at the local DHHR office so that the required documentation can be made and/or obtained. Coordination of the process may be facilitated by telephone and/or fax machine with BMS and the physician, as necessary.

There is no limit on the number of advance payments a client may receive. However, verification of travel and attendance is required, whenever

possible, before subsequent advances can be made.

As noted above, the submission deadline for the completed OFS-NEMT-1 is 60 days from the date of the trip(s). Compliance is determined by comparing the date of the earliest trip entered on the form with the date the application is received by DHHR for processing.

Altered forms will result in automatic denial. This includes entries that are scratched out, “whited” out, or otherwise altered in a questionable manner. This does not include valid corrections made by the client or others to correct or clarify entries. Such corrections must be initialed by the person providing the corrected information.

C. THE CASE MAINTENANCE PROCESS

1. Closures

Closure of Medicaid renders the AG ineligible for NEMT.

2. Change In Income

Changes in income that do not affect Medicaid eligibility have no effect on NEMT.

3. Update In Case Information

Updates in case information are not required for NEMT except when such changes affect Medicaid eligibility.

D. IEVS

Information in data exchanges must be entered in the case in order to correctly determine eligibility for Medicaid and for NEMT.

E. VERIFICATION

Specific requirements for verification of travel expenses are included on the OFS-NEMT-1. Forms submitted by a DCC for the ART program are considered verified and approved for payment.

Further verification is not required unless the Worker has reason to suspect misuse or abuse of the program. When deemed necessary, policy at item N applies.

F. RESOURCE DEVELOPMENT

NEMT recipients are assumed to have met requirements to develop resources under Medicaid eligibility guidelines, including application for Medicare, as appropriate.

G. CLIENT NOTIFICATION

Notification of decision on NEMT applications must be received by the client no later than 30 days following the date the application is received by DHHR.

H. COMMON ELIGIBILITY REQUIREMENTS

1. Residence

All applicants for NEMT must be residents of West Virginia.

2. Citizenship And Alien Status

Applicants must be citizens of the United States or be qualified aliens in accordance with Chapter 18.

3. Cooperation With Quality Assurance

NEMT is not reviewed by Quality Assurance. However, Medicaid recipients who fail to cooperate with QA and become medicaid-ineligible no longer qualify for NEMT.

4. Limitations On Receipt Of Other Benefits

Except for the requirement to be a Medicaid recipient or covered by the qualifying programs listed in item B,5, above, NEMT is not affected by the receipt of other benefits.

5. Non-duplication Of Benefits

Applications submitted for trips or other expenses which have already received reimbursement from any other source are denied.

6. Enumeration

A valid SSN is required.

I. ELIGIBILITY DETERMINATION GROUPS

1. The Assistance Group (AG)

The AG consists of the individual(s) for whom transportation is required.

2. The Income Group

Same as for Medicaid in each coverage group.

3. The Needs Group

Same as for Medicaid in each coverage group.

J. INCOME

There are no specific income guidelines for NEMT. Medicaid recipients and those who meet guidelines for reimbursements under other programs are considered to be income-eligible for NEMT.

K. ASSETS

There are no specific asset limits for NEMT as applicants with valid Medicaid coverage are considered to have met applicable asset tests.

L. WORK REQUIREMENTS

There are no work requirements associated with NEMT.

M. SPECIFIC ELIGIBILITY REQUIREMENTS

1. Exceptions to Eligibility

The following individuals are not eligible for NEMT:

**S** Individuals designated as Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLIMB), or Qualified

Disabled Working Individuals (QDWI) and are not dually eligible for any full-coverage Medicaid group.

**S** Medicaid public school patients being transported to schools for the primary purpose of obtaining an education, even though Medicaid-reimbursable school-based health services are received during normal school hours, except for children receiving services under the Individuals with Disabilities Education Act (IDEA) when the child receives transportation for a Medicaid-covered service and both the transportation and service are included in the child's Individualized Education Plan (IEP).

**S** WV CHIP recipients.

Reimbursement is not approved for trips to pick up medicine, eye glasses, dentures or medical supplies or for repairs or adjustments to medical equipment.

When services are paid for by any other program, or otherwise not charged to Medicaid, NEMT is not paid.

When other reimbursement is available, Medicaid will always be the payor of last resort.

Reimbursement is not approved when services are normally provided free to other individuals.

2. Transportation Requiring Prior Approval From BMS

All requests for out-of-state transportation and certain related expenses must have prior approval from the Bureau for Medical Services, Case Planning Unit, except for travel to those facilities which have been granted border status and thus are considered in-state providers. The current list of providers with border status is located at Appendix E. The Worker must contact BMS at 558-7311 for the status of any facility not listed.

Requests to the Case Planning Unit are made in writing when time permits, or by telephone, and must include the following information:

**S** The Medicaid recipient's name, address and case number;

**S** The physician's order for the service, including any necessary documentation, as well as the following related items:

- Specific medical service requested;
- Where the service is to be obtained, who will provide it, and the reason why an out-of-state provider is being used;
- The diagnosis, prognosis and expected duration of the medical service;
- Description of the total round-trip cost of transportation and any related expenses (lodging, meals, tolls, parking, etc.), and whether advance payment is required.

3. Requests Which Require Approval By The Worker

The following must be approved by the local DHHR Worker:

**S** Transportation of an immediate family member (parent, spouse, or child of the patient) to accompany and/or stay with the patient at a medical facility when the need to stay is based on medical necessity and documented by the physician. Exceptions require supervisory approval.

**S** Two round trips per hospitalization (1 for admittance and 1 for discharge) when the parent or family member chooses not to stay with the patient.

**S** Lodging.

**S** Meals only when lodging is approved.

**S** Transportation via common carrier judged to be the most economical. If the applicant insists

on incurring expenses beyond those approved by the Department, the Worker must inform the applicant that such costs will not be reimbursed.

Travel for parents/children to visit hospitalized individuals is not authorized.

4. Routine Automobile Transportation Requests

Applicants may request reimbursement for costs associated with automobile travel, such as mileage, tolls and parking fees when free parking is not available. The travel must be for scheduled appointments and treatment. Mileage is paid from the patient's home to the facility and back to the home. When comparable treatment may be obtained at a facility closer to the patient's home than the one he chooses, mileage is limited to the distance to the nearest facility. The client's statement as to the availability of a closer facility is accepted unless the information is questionable (see item N, below).

Meals are not reimbursed for any travel which does not include an overnight stay.

When travel by private automobile is an option but the applicant chooses more costly transportation, the rate of reimbursement is limited to the private auto mileage rate.

Applicants must car pool when others in the household have appointments the same day at the same facility.

Round trips are limited to 1 per household per day. Parents must make an effort to schedule appointments for children at the same time or on the same day whenever possible.

5. Requests For Transportation For Emergency Room Services

Applicants who routinely use emergency rooms as doctor's offices are not reimbursed for transportation. On those occasions when it can be documented that emergency room treatment was necessary, the Worker may approve the NEMT application and record the reason for the approval,

including whether or not the individual's physician was involved in the decision to go to the emergency room.

6. Approved Transportation Providers

The least expensive method of transportation must always be considered first and used, if available. Providers are listed below in the order in which they must be considered. Applicants who choose a more expensive method than the one available will be reimbursed at the least expensive rate.

- **S** The patient or a member of his family, friends, neighbors, interested individuals, foster parents, adult family care providers or volunteers;
- **S** Volunteers or paid employees of community-based service agencies such as Community Action and Senior Services;
- **S** Common carriers (bus, train, taxi or airplane); or
- **S** An employee of DHHR with supervisory approval only after it has been determined that no other provider is available.

7. Determining The Amount Of Payment

The amount of reimbursement for transportation expenses depends on the method of transportation, the round-trip mileage and/or whether lodging was required.

Payment may be authorized for 1 round trip per patient per day with a maximum of 2 round trips per hospital admission. Exceptions require documentation as to medical necessity and supervisory approval.

a. Mileage

Round-trip mileage from the patient's home to the medical facility is paid at the current mileage rate. If more than one patient is being transported, payment is approved for one trip only. The round trip will be made over

the shortest route as determined by a road map or certified odometer reading. The Worker may use the applicant's statement of the total mileage unless the amount appears incorrect.

The Worker is encouraged to combine trips to avoid issuing numerous checks for small amounts. A single check may be written to the applicant who is then responsible for reimbursing the drivers if they have not already been paid. Case comments must reflect that mileage claimed is for more than one trip and may be for more than one provider.

As stated above, mileage is limited to the nearest comparable facility for services such as allergy shots, blood pressure readings, etc., when the physician has not specified that a certain facility must be used.

**NOTE:** This does not include the client's choice of physician, which cannot be restricted. See item N below for further information.

b. Common Carrier

When a common carrier is the provider, the established round-trip fare is paid. The cost of waiting time is paid when travel between cities is required. This waiting time is allowed only for obtaining medical services. When waiting time is claimed, the Worker must obtain from the taxi company a dated and signed statement indicating the rate, elapsed time and total charges for the waiting time.

The cost of waiting time cannot be paid for trips within the city limits.

c. Lodging

When an overnight or longer stay is required, lodging may be paid for the patient and one additional person if the patient is not the driver. Accommodations must be obtained at the most economical facility available. Resources

such as Ronald McDonald Houses or facilities operated by the hospital must be used whenever possible.

West Virginia currently has three Ronald McDonald Houses. Their addresses, telephone numbers, and the medical facilities with which they are affiliated are as follow:

**S** Ronald McDonald House of Southern WV, Inc.
302 30th Street
Charleston, WV 25304
Telephone number: (304) 346-0279
Hospital affiliate: CAMC

**S** Ronald McDonald House
Charities of the Tri-State, Inc.
1500 17th Street
Huntington, WV 25701
Telephone number: (304) 529-2970
Hospital affiliates: Cabell-Huntington Hospital and St. Marys Hospital

**S** Ronald McDonald House of Morgantown
841 Country Club Drive
Morgantown, WV 26505
Telephone number: (304) 598-0050
Hospital affiliates: Chestnut Ridge Hospital, Monongalia General Hospital, Ruby Memorial Hospital, and Mountaineer Rehabilitation Center

Lodging is determined necessary when the appointment is for early in the morning and travel time is at least 4 hours from the patient's home to the medical facility, or when the patient is required to stay overnight to receive further treatment.

d. Meals

Reimbursement for meals is available only in conjunction with lodging and only for meals which occur during the time of the travel or the stay. Meals are permitted for the patient

and/or the person approved to stay with the patient. The rate is $5 per meal per person, regardless of which meals the reimbursement is meant to cover. In order to determine which

meals to include, the Worker will have to know the time the trip started and when the patient returned home.

e. Related Expenses

Reimbursement may be made for other expenses associated with travel, such as turnpike tolls and parking fees. Parking is limited to $3 per day when free parking is not available within reasonable walking distance of the facility, and a receipt is required. Metered parking is limited to $2 per day (no receipt required).

f. Limitations and Restrictions

Anyone may volunteer to provide transportation for Medicaid recipients for reimbursement of expenses only. However, DHHR will not reimburse any individual for more than 6,000 miles in any calendar year except as follows:

- **S** No public transportation is available and the recipient does not drive and has no one else who can provide transportation; and/or
- **S** The patient requires frequent medical treatment (such as dialysis, chemotherapy, etc.) and local staff has approved the continued use of the same provider.

Employees of entities that provide Medicaid services (homemaker, behavioral health, rehabilitation providers, etc.) may not be reimbursed as NEMT providers when transporting individuals while “on the clock” or otherwise during their official business hours.

N. BENEFIT REPAYMENT

There is currently no repayment procedure in place for NEMT. However, recipients must be informed that fraudulent claims will result in denial of subsequent

requests up to the amount of the claim and could result in permanent ineligibility for NEMT.

Workers who become aware that a client may be obtaining NEMT reimbursements to which he is not entitled must monitor all applications from the client to determine if misuse or abuse of the program is actually taking place. Any information deemed questionable must be verified, even if not routinely required.

If the Worker has reason to suspect that reimbursement is being requested for trips that were not taken, he or she must contact the medical provider(s) listed and verify appointment dates and whether or not the appointments were kept.

Unless the Worker has sufficient reason to suspect misuse or abuse, and/or finds reasonable proof that misuse or abuse has occurred, properly completed and signed applications will be assumed to be correct.

O. BENEFIT REPLACEMENT

Replacement of lost checks follows the procedure found in Chapter 20 for the replacement of WV WORKS check. The DF-36 must reflect that the check is for NEMT.