19.3 NON-EMERGENCY MEDICAL TRANSPORTATION

A. Introduction

1. Funding Sources

Transportation for non-emergency medical purposes is funded through three different sources. These sources are:

- Title XIX funds for all Medicaid recipients including foster children,

- Title V funds for non-Medicaid eligible recipients of Children with Special Health Care Needs Program (CSHCN), and

- Agency administrative funds for applicants of financial or medical assistance who need a physical examination in order to complete the eligibility determination process.

2. Services Provided

Services provided under this program are:

- Transportation and certain related expenses necessary to secure medical and other services covered by the Medicaid Program including medical services under the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT).

- Transportation and certain related expenses necessary to secure medical services covered by the Children with Special Health Care Needs for non-Medicaid eligible children.

- Transportation and certain related expenses necessary to secure medical examinations required in the eligibility determination process for the financially needy and medical assistance only programs.

- Transportation and certain related expenses necessary to secure medical and other services to a specialized group of patients under the Access to Rural Transportation Project (ART). This project is operated by the Bureau for Public Health, Office of Maternal and child Health. The

project serves Medicaid-eligible patients who request benefits under the Right From The Start Program. The policy for ART is contained in a separate manual entitled, “Access to Rural Transportation” and is issued to each district Financial Office. Please refer to this manual when seeking specific policy citations. Certain of these policies will be duplicated in this chapter as deemed necessary.

B. Eligibility Requirements

1. General Eligibility Requirements

In order to be eligible for non-emergency medical transportation and certain related expenses, one must:

- Be a Medicaid recipient.(note the clarifications and exceptions below):

  * Individuals who are designated a Qualified Medicare Beneficiary (QMB), or Specified Low Income Medicare Beneficiary (SLIMB), or Qualified Disabled Working Individuals (QDWI) only are **NOT** eligible for NEMT benefits. However, these cases may also be dually eligible for Medicaid by qualifying both as a QMB, SLIMB, or QDWI and under another category listed in the State Plan. Dually eligible cases ARE eligible for NEMT benefits since they are entitled to the full range of Medicaid services.

  * All Medicaid patients designated as LTC and Alternative LTC are eligible for NEMT benefits including transportation needed to obtain the PASARR test (psychiatric evaluation) as necessary to obtain screening for admission to nursing homes.

  * All 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 are NOT eligible for NEMT. If such services are provided off-site from the school or at school during other than normal

school hours, NEMT benefits would be available.

An exception exists to the exclusion noted above for on-site school-based services. This applies to children receiving services under the Individuals with Disabilities Education Act (IDEA). However, this exception exists only when the following conditions are met:

1. The child receives transportation primarily to obtain a Medicaid-covered service, and

2. Both the Medicaid-covered service and the need for transportation are included in the child's Individualized Education Plan (IEP).

NOTE: Patients who receive treatment and services under WV CHIP are NOT eligible for NEMT benefits.

- Incur transportation and/or certain related costs for the round-trip to the medical vendor.

- Receive medical treatment or services covered by the Medicaid program. Transportation costs incurred only to obtain medicine, medical products or repairs to medical products are NOT covered.

- Receive pre-authorization in certain situations for the transportation costs as described on the application form and in this policy.

- Comply with the 60-day application submittal deadline. (Refer to E., Application Process, page 67 for specific policy.)

2. Specific Eligibility Requirements

a. Transportation Requests Which Require Prior Approval from the Bureau of Medical Services.

All requests for out-of-state transportation and certain related expenses must have prior approval
from the Bureau of Medical Services, Case Planning Unit. Certain medical providers residing in bordering states near the West Virginia state line have been granted border status. These providers are considered in-state providers and should have

a West Virginia Medicaid provider number as though they were physically located in West Virginia. If in doubt, please contact the Bureau of Medical Services, Provider Services, to determine if an out-of-state medical provider has been granted border status.

Requests to the Case Planning Unit should be made in writing if sufficient time exists. If sufficient time does not exist, the request may be made by telephone. ALL REQUESTS MUST INCLUDE THE FOLLOWING INFORMATION:

- The Medicaid recipient's name, address and Medicaid case number.

- The physician's order for the service including any necessary documentation and 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 medical provider is being used. (This is especially important if the medical service is available in the State.)

  * The Medicaid recipient's diagnosis, prognosis, and the duration of the medical service.

  * A description of the total round trip cost for transportation and any certain related expenses that must be included and if advance payment is required. When the request is approved by the Bureau of Medical Services, necessary related expenses such as food and lodging are also considered as approved. Food and lodging requirements can often be coordinated through the Social Service Departments at the hospital.

b. Transportation Requests Which Require Prior Approval from the Local or County Worker

- Transportation of an immediate family member to visit/stay with a patient at the medical facility. An immediate family member will be limited to a parent to visit/stay with a child(ren), a child to visit/stay with a parent(s) and a spouse to visit/stay with his/her spouse. The need to visit/stay must be based upon a medical necessity and be documented in writing by physician. In emergencies, verbal documentation may be accepted. In all situations, the physician must state why the visit/stay is necessary and the reason must be based upon a medical necessity. Exceptions to the definition of what constitutes family members may be granted after supervisory approval.

- Lodging plus meals as required with lodging.

- Transportation via common carrier. If the applicant, during the interview, insists upon incurring transportation costs and certain related expenses beyond that which is offered or approved by the Department, the Worker will share with the applicant that such costs will not be reimbursed by the Department.

- Request for two round trips on the same date to the same medical provider. Each request must be individually evaluated before approval may be given and the Worker MUST determine that two round trips are necessary for the patient to receive medical treatment.

  Note: Prior approval is NOT necessary for transportation requests within the state but beyond the nearest resource.

c. Routine Automobile Transportation Requests

Routine automobile transportation requests plus meals and turnpike fees may be received by eligible Medicaid recipients WITHOUT pre-authorization. If the applicant meets the NEMT eligibility guidelines as verified by the submission of an application after the trip is taken, he may be found eligible to receive these

benefits. Routine automobile transportation requests plus meals and turnpike fees may be defined as any request for travel NOT as part of or in conjunction with requests that require pre-authorization as set forth in a or b above.

If the applicant incurs more costly transportation costs than the private auto mileage rate without prior approval, he will receive reimbursement at the current private auto mileage rate unless he can show that less expensive transportation could NOT be obtained.

d. Advance Payment

Applicants approved for benefits under the Non-Emergency Medical Transportation Program are reimbursed for allowable expenses incurred for round-trip travel. However, situations may occur when the recipient/vendor may request payment in advance because of insufficient resources. The Worker is permitted to evaluate and make the decision to approve such requests. After a careful evaluation of the situation, the Worker must document the decision to deny or approve such requests by making a recording in the case record.

e. Transportation for Emergency Room Services

Situations may occur when the Medicaid recipient requests transportation to an emergency room to receive medical treatment. THE USE OF AN EMERGENCY ROOM AS A PHYSICIAN'S OFFICE IS NOT COVERED. When such requests are approved, it must be thoroughly documented in the case record that emergency room treatment was medically necessary.

f. Children with Special Health Care Needs Program (CSHCN) (Fomerly Handicapped Children's Services)

Recipients of CSHCN receive reimbursement of transportation and certain related expenses in order to obtain planned medical services. Transportation services are limited to those patients whose family income falls within the CSHCN financial guidelines.

(1) Medicaid Eligible CSHCN Recipients

CSHCN patients may also be Medicaid eligible (i.e. they are foster children or members of an WV WORKS, Medicaid or SSI benefit group). Medical services provided by CSHCN for these patients are billed to the Medicaid program.

Transportation services for these patients are also charged to the Medicaid program. Services provided due to Medicaid eligibility must meet the requirements in item B. Requests for transportation that require approval from the Bureau of Medical Services are submitted to CSHCN staff for approval.

(2) Transportation Requests which Require Prior Approval from (CSHCN)staff (Local or office staff)

In all situations when the child must secure medical care outside the state, CSHCN staff must approve the necessary transportation and certain related expenses.

(a) Medicaid-Covered and Non-Medicaid covered CSHCN Services:

In ALL situations when the child must secure medical care outside the state, CSHCN staff MUST approve the necessary transportation and certain related expenses.

(b) Non-Medicaid covered CSHCN Services:

Prior approval must be obtained from CSHCN for routine appointments to a physician's office, a clinic or to receive therapy and hospitalization UNLESS the applicant can submit written verification that the service has been approved by CSHCN. These cases must be processed through the CHET system.

(3) Advance Payment

In certain situations, advance payment may be requested by the applicant. For example,

certain types of medical care such as organ transplant services may require that the patient travel long distances with very little advance notification. All requests for advance payment must be carefully evaluated and justified by the Worker via recording on the application form. If the Worker feels that sufficient justification exists for an advance payment, approval may be made by the Worker. When the client fails to verify the trip, **NO** additional advance payments may be made.

All inquiries regarding the eligibility for transportation and certain related expenses for recipients of CSHCN must be directed to Children with Special Health Care Needs, Division of Maternal and Child Health.

g. Applicants who Require Medical Examinations

Applicants who apply for benefits under certain programs in which a medical examination is required may request transportation benefits for the trip.

In determining eligibility for these requests, the Worker should consider the following:

- The required medical examinations MUST be only for the purpose of determining eligibility for a program operated by the Department (such as AFDC-Incapacity).

- The Worker will apply the eligibility guidelines outlined under B, Eligibility Requirements, with the exception of the first and third items since the applicant is not yet a Medicaid recipient.

C. Transportation Providers

The transportation providers listed below must be used according to the priority in which they are listed. THIS MEANS THAT THE LESS EXPENSIVE METHOD OF TRANSPORTATION MUST ALWAYS BE CONSIDERED AND, IF POSSIBLE, USED FIRST:

- The patient or a member of his family, friends, interested individuals, foster parents, adult family care providers or Volunteers.

- Volunteers or paid employees of community-based service agencies such as Community Action Programs and Senior Citizen Programs.

- Common carriers (bus, train, taxi or airplane).

- An employee of the Department with Supervisory Approval ONLY AFTER IT HAS BEEN DETERMINED THAT THE PROVIDERS INDICATED ABOVE ARE NOT AVAILABLE.

Whenever patients/applicants use more expensive transportation than the private auto mileage rate without prior authorization, they must show that only the more expensive transportation was available when the trip was taken. If the patient/applicant, for example, uses a taxi to make the trip but is unable to show that automobile transportation was not available, reimbursement will be at the current mileage rate instead of the taxi fare.

1. Determining the Amount of Payment for Transportation

   Determining the amount of payment for transportation depends upon the method of transportation used and the round-trip distance to the medical facility.

   WHEN TRANSPORTATION REQUESTS ARE RECEIVED FROM RECIPIENTS OF HANDICAPPED CHILDREN'S SERVICES AND/OR MEDICAID ELIGIBLE CHILDREN FOR THE PURPOSE OF INPATIENT HOSPITALIZATION ADMITTANCE, REIMBURSEMENT IS MADE FOR UP TO THREE ROUND TRIPS PER ADMISSION. This will include one round trip on the day of admission, one round trip for the parent to be present for surgery, and one round trip on the day of discharge.

   - Automobile - Mileage is paid at the current mileage rate for one round trip. When daily double round trips are requested, please refer to B., Eligibility Requirements, #2, Specific Elibility Requirements, b. Transportation requests which require.....” (for the paragraph). If more than one patient is being transported, the Worker will make payment for only one round trip. Whenever the transportation provider is NOT the patient or someone living in the patient's household, the total cost of the round trip mileage to the medical facility will be computed from the provider's point of departure (his residence) to pick up the patient for the trip to the medical facility. The round trip will be made over that route which constitutes the SHORTEST

DISTANCE IN MILEAGE. The worker may adjust the total mileage when it is believed the provider/patient has charged excessive mileage. However, the worker must be able to justify such an adjustment with a road map or certified odometer reading. When a Department employee is the provider, the employee will be reimbursed at the rate permitted in the state travel regulations.

- Common Carrier - When a common carrier is the provider, the established round-trip fare will be paid. The cost of waiting time will be included in the payment when inter-city travel is required (travel from city to city). The patient and taxi driver must be aware that waiting time is allowed ONLY TO SECURE MEDICAL SERVICES. Prior to making payment for transportation in which the cost of waiting time is included, the Worker must obtain from the taxi company a dated and signed statement indicating the rate, elapsed time, and total charges for waiting time.

When intra-city travel is required (travel within the city limits), the cost of waiting time will not be included in the payment, and the patient(s) and taxi driver must be aware of this.

2. Car Pool

Car pooling will be maintained for all recipients when appointment dates at the same medical facility coincide for more than one patient. However, the Worker should use judgement and input from the transportation provider in determining the safe number of persons to be included in each vehicle.

In special situations, car pooling may not be appropriate for certain clients. For example, various types of physical infirmity may prohibit car pooling in order to maintain the appropriate level of safety and comfort for all involved. Judgement, and if required, verbal or written medical certification must be exercised by the Worker in determining when car pooling is appropriate.

3. Use of Volunteers as Transportation Providers

a. Definition of a Volunteer

In order to maintain the records for volunteer transportation providers, a "volunteer" will be

defined as anyone who provides assistance to clients or recipients of the Department without compensation or with reimbursement of expenses only.

b. Limitations on the Use of Volunteers as Transportation Providers

In the case of Burnsville Community Cab, Inc. vs. Alice Knicely and the Department of Human Services, the Public Service Commission has made the following adjustment in regard to the use of volunteers as transportation providers.

The Department will not reimburse any individual volunteer who provides transportation under the Non-Emergency Medical Transportation Program for eligible patients in any amount greater than 6,000 miles in any calendar year at the current rate of reimbursement.

The following EXCEPTIONS will apply to the policy above:

In areas of the state where no public transportation is available, there will be no limitation on the mileage ceiling referred to above.

On every occasion in which (1) no public transportation is available at the time of a patient's medical appointment and (2) no volunteer who has not yet provided 6,000 miles worth of reimbursable transportation during the calendar year is available to provide transportation to that patient, the Department is permitted to use a volunteer who has already exceeded the 6,000 mile ceiling in order to provide the necessary transportation to that patient.

There will be no limitation on the amount of reimbursement received by the family members or friends of individual patients who have been selected by the patient to provide the transportation.

In situations where a patient is in need of frequent regular medical treatment (such as, but not limited to, kidney dialysis or chemotherapy), there will be no limitation to the vendor who routinely provides transportation to that patient for medical treatment. THIS EXCEPTION WILL BE

GRANTED ON A CASE-BY-CASE BASIS BY LOCAL STAFF AND ONLY UPON REQUEST OF THE PATIENT.

The policy statement regarding the limitation will not apply to Transportation Remuneration Incentive Program tickets or to the reimbursement of common and contract carriers operating under the authority of the Public Service Commission.

4. Use of Certain Employees as Providers

Employees of entities that provide Medicaid services (such as but not necessarily limited to Homemaker agencies. Behavioral health center, Behavioral health rehabilitation providers) may not be reimbursed as NEMT providers when providing transportation while they “are on the clock” or otherwise during their official hours of employment.

D. Certain Related Expenses

1. Allowable Expenses

Certain related expenses will be limited only to the following items:

- Meals
- Lodging
- Turnpike Fees

2. Determining the Amount of Payment for Certain Related Expenses

a. Meals

Necessary meals at the rate of $5.00 per meal per person will be considered only in the following circumstances:

- When the time of the appointment and the length of the round trip extend through meal hour(s) during the trip **AND** the single day round trip is not less than 100 miles. Meal hours of noon for lunch and 6:00 p.m. for dinners will be observed. Breakfast is permitted only when lodging has been approved, or otherwise obtained.
- When lodging has been approved, meals will be permitted for the patient when out-patient

treatment is received and/or for one person who was approved to accompany or visit the patient plus the driver.

- Meals are permitted for the driver only when a private automobile is used.

- Meals are permitted for the patient(s) regardless of the type of transportation used.

- When an employee of the Department is the provider, the employee will observe agency regulations regarding travel and meals.

b. Lodging

IT IS MANDATORY THAT THE MOST ECONOMICAL RATE OR FACILITY BE OBTAINED FOR LODGING. Resources such as McDonald Houses and other facilities recommended by the medical facility must be used whenever possible. This will include hospital "rooming in" facilities. Therefore, necessary lodging at the MOST economical rate may be considered only in the following circumstances:

- When approval has been given for someone to stay with the patient.

- When the hour of the appointment and the length of the trip require that the patient/provider have overnight lodging to prevent undue hardship. For example, an early a.m. appointment prior to 9 a.m. and a travel time of NOT LESS THAN 4 HOURS. Lodging will be permitted in these circumstances for ONE patient and ONE provider. In most situations, this would normally involve a child who receives Handicapped Children's Services and the parent who is also the provider.

- When approval for lodging has been given by the State Office staff of Handicapped Children's Services or the Bureau of Medical Services.

- When lodging is required for the patient and one person (which must be verified in writing by the attending physician to accompany the

patient) for the completion of outpatient treatment plans.

In any of the situations above, when the driver prefers to return and not obtain lodging, the cost of the double round trip may not exceed the cost of the driver's lodging plus meals.

NOTE: When an employee of the Department is the provider and overnight lodging is required, the employee will observe for his expenses only the state travel regulations.

Ronald McDonald Houses and NEMT -
At the present time, only three Ronald McDonald Houses exist in West Virginia:

Charleston - CAMC (346-0279)
Huntington - Cabell-Huntington Hospital and St. Marys Hospital (529-1122)
Morgantown - Chestnut Ridge Hospital, Monongalia General Hospital, Ruby Memorial Hospital and Mountaineer Rehabilitation Center (598-0050)

Certain Medicaid-eligible clients arrive at Ronald McDonald Houses without being pre-approved for NEMT at the county office. These clients are referred to by Ronald McDonald staff as "emergencies." Income Maintenance personnel stationed at any of the facilities listed above will take the NEMT applications for Medicaid-eligibles designated as "Emergency" and in need of lodging benefits from the Ronald McDonald Houses. All other benefits available from NEMT, such as food and transportation, can be evaluated as well.

Otherwise, the local worker may contact the Ronald McDonald Houses listed above when referrals need to be made for NEMT patients.

c. Turnpike Fees

Turnpike fees for round-trip travel will be permitted for private automobiles only. Receipts are not necessary.

E. Application Process

The application process consists of obtaining sufficient

information required to make a decision regarding the applicant's eligibility for benefits. The application form (ES-NEMT-1) has been designed to permit the applicant to complete it without Worker assistance. This is important when the patient is requesting routine automobile transportation benefits. These requests do not require pre-authorization and may be handled through the mail.

1. Completion of Form ES-NEMT-1, Application Verification Form

   Form ES-NEMT-1 must be completed for all requests for transportation (except when the DF-67-B may be used) and certain related expenses in order to determine eligibility for NEMT benefits. (Refer to item 2 below to determine when the DF-67-B may be used.)
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   The form is divided into Sections A - Identifying Information, B -Applicant and/or Patient Responsibilities and/or Signatures, C - For Agency Use only and D - Verification of Attendance/Travel Costs.

   The form contains sufficient space to obtain verification for up to four trips per application. However, when the patient is making more than ONE TRIP PER WEEK, up to five trips/week may be verified. Each trip date must be entered in the space entitled "Date Patient Attended." In this way, a maximum of twenty round trips can be approved on one application since four verification spaces exist per application. Regardless of the number of trips included on the form, ALL trips must have occurred within the 60-day deadline (refer to “d.” below).

   The form is to be completed as follows:

   a. Identifying Information and Form Origination

      The identifying information of the person who is completing the application will be entered in this section. Case numbers will be obtained for the patient who needs the travel. Additional spaces for case numbers are provided in situations where additional cases with different numbers exist in one household.

      The form must originate from the county in which the Medicaid card was issued. If foster children are placed in foster homes located in other counties, the completed application form can be mailed by the foster parent to the Worker in the county in which the Medicaid card was issued.

b. Applicant/Patient Responsibilities/Signatures

ALL statements must be checked either "yes" or "no" and the applicant's signature and date must be entered before an eligibility decision can be rendered.

c. For Agency Use only

The Worker will use the recording space to enter any and all information as appropriate.

A space to enter the transportation vendor number is located in the upper right corner. If different vendors are used, the Worker may enter the vendor number(s) and label it/them as such on the appropriate trip. (Refer to the verification of travel page.) Finally, the Worker must sign and date the form.

The actual verification form now requests the social security number of the patient and the NEMT vendor (or tax I.D. number of the vendor). Check mark blocks for case approval or denial are provided to permit the worker to approve or deny each verification form. A space is also provided for the entry of an appointment time when eligibility for food comes into question or for some other reason.

d. Verification of Attendance/Travel Costs

The instructions are self-explanatory and are provided to assist the applicant in completing the verification form(s).

Upon receipt of the complete application form, the Worker must carefully review the verification of travel. All items that pertain to the claim must be completed. Incomplete applications must be returned to the applicant with instructions for making corrections.

Finally, the completed application which includes verification of attendance, must be submitted to the Department no later than 60 days from the date of the trip(s) for which the applicant is requesting benefits. Benefits will be DENIED if this deadline is not met. All trip dates must meet the 60-day deadline requirement.

e. Verification of Attendance/Travel Costs - ART

Verification of attendance and travel costs in the ART program will be provided via Form OIM-ART-1. As noted above, the submission deadline for these verification forms is 60 days. These forms are checked for compliance with the 60-day deadline by comparing the date of the trip with the stamped-in or received date entered upon the form. Any forms received from the ART agency not having a stamped-in or received date are returned with a request to enter that date on the form(s). Non-compliance with this request results in non-payment until the request is granted. Forms not received within the 60-day deadline date are handled as noted above.

f. Completion of Form ES-6, Notice of Information Needed

When the applicant fails to include necessary information during the intake interview or upon the application form, the Worker completes form ES-6, listing what is needed and the date by which the applicant is to return the information. A copy of the completed form is attached to the application form.