

## 27.13 SPECIFIC ELIGIBILITY REQUIREMENTS

### A. EXCEPTIONS TO ELIGIBILITY

The following individuals are not eligible for NEMT:

- Individuals designated only as Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLIMB), or Qualified Disabled Working Individuals (QDWI) and who are not dually eligible for any full-coverage Medicaid group.
- 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).
- 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 approved.

When other reimbursement is available, Medicaid **is** always the **last** payer.

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

### B. 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. **Facilities granted border status** are considered in-state providers. The current list of providers with border status is located in **Chapter 27**, Appendix **A**. The Worker must contact BMS at **(304) 558-1700** 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:

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- The Medicaid recipient's name, address and case number;
- The physician's order for the service, including any necessary documentation, as well as the following related items:
  - **The specific** medical service requested
  - Where the service will 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; and
  - **A description** of the total round-trip cost of transportation and any related expenses (lodging, meals, tolls, parking, etc.).

**C. REQUESTS WHICH REQUIRE APPROVAL BY THE WORKER**

The following must be approved by the local DHHR Worker:

- 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.
- 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
- Lodging
- Meals only when lodging is approved
- 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 or participate in a treatment plan for hospitalized individuals is not authorized when it does not coincide with the patient's travel.

**D. ROUTINE AUTOMOBILE TRANSPORTATION REQUESTS**

Applicants may request reimbursement for costs related to automobile travel, such as mileage, tolls, and parking fees when free parking is not available. The

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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 reimbursed is limited to the distance to the nearest facility. The client's statement about 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.

#### **E. REQUESTS FOR TRANSPORTATION FOR EMERGENCY ROOM SERVICES**

Applicants who use emergency rooms for routine medical care are not reimbursed for transportation. When **the Worker documents** that emergency room treatment was necessary, **he** 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.

#### **F. 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 **are** reimbursed at the least expensive rate.

- The patient or a member of his family, friends, neighbors, interested individuals, foster parents, adult family care providers or volunteers
- Volunteers or paid employees of community-based service agencies such as Community Action and Senior Services
- Common carriers (bus, train, taxi or airplane)

- An employee of DHHR, with supervisory approval only, after it is determined that no other provider is available

**NOTE:** If the status of a provider is questionable, contact the Policy Unit for assistance.

## **G. 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 of medical necessity and Supervisory approval.

### **1. Mileage**

Round-trip mileage from the patient's home to the medical facility is paid at the current state mileage reimbursement rate. If more than one patient **was** transported, payment is approved for one trip only. The round trip **must** 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 applications for 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 for routine services such as allergy shots, blood pressure readings, etc., when the physician has not specified that a specific facility must be paid.

**NOTE:** The client's choice of physician cannot be restricted. See **Section 27.13,D** below for additional information.

### **2. Common Carrier**

When a common carrier is the provider, the established round-trip fare is paid. The cost of waiting time is paid only when travel between cities is required. This waiting time is permitted only for obtaining medical

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services. When waiting time is claimed, the Worker must obtain a dated and signed statement from the taxi company indicating the rate, elapsed time, and total charges for the waiting time.

### 3. 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 **which invoice the Department directly for payment. The client must not be reimbursed unless he provides a receipt to verify he made the payment.** Their addresses, telephone numbers, and the medical facilities with which they are affiliated are as follows:

- Ronald McDonald House of Southern WV, Inc.  
302 - 30th Street  
Charleston, WV 25304  
Telephone Number: (304) 346-0279  
Hospital affiliate: CAMC
- 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
- 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 prior to the day of the appointment is determined necessary when the appointment is scheduled for 8:00 a.m. or earlier and travel time to the facility is 2 hours or more from the patient's home. It may also be determined necessary when the patient is required to stay overnight to receive **additional** treatment. Exceptions require Supervisory approval.

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**4.** 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 covers. In order to determine which meals to include, the Worker must know the time the trip started and when the patient returned home.

**5.** Related Expenses

Reimbursement may be made for other travel-related expenses, 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. A receipt is required. Metered parking is limited to \$2 per day with no receipt required.

**6.** Limitations and Restrictions

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

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

**NOTE: A volunteer is a person, other than the client, his family or friends, that provides transportation to medical appointments for Medicaid recipients. The 6,000 mile limit does not apply to family or friends who have been selected by the Medicaid recipient to provide the transportation. The limit does not apply to common carriers.**

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