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 **Provider Enrollment at (888) 483-0793** 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:

- 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.).

NOTE: Individuals who receive both Medicare and Medicaid do not require prior approval for out-of-state transportation.

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 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.

When the applicant chooses to rent an automobile and submits the costs of the rental and connected fees, when the total is less than the private mileage rate, the lower cost is paid.

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