MANUAL MATERIAL TRANSMITTED					
MANUAL: INCOME MAINTENANCE			CHANGE NUMBER: 88		
DELETE			INSERT OR CHANGE		
PAGES	CHAPTER	DATED	PAGES	CHAPTER	DATED
56	19	12/96	56-58a	19	11/97
57	19	4/96			
58	19	1/96			
63	19	12/96	63	19	11/97
65-67	19	1/96	65-67-67a	19	11/97
69-70-70a	19	12/96	69-70-70a	19	11/97
DATE: November, 1997			TO: All Income Maintenance Manual Holders		

Please refer to the explanations below which outline the revisions referred to above:

Page 56 - A clarification statement has been added to the eligibility requirement of "Receive medical treatment or services covered by the Medicaid Program." This refers to patients who incur transportation costs to purchase only medicine, supplies or equipment or repairs to equipment. In 2-a, "Bureau of Medical Services" replaced "Office of Medical Services."

Page 57 - Under Item #2, Specific Eligibility Requirements, a clarification has been added on page 57 which instructs the worker to contact the Bureau of Medical Services when in doubt about the status of a vendor who is located near the state border.

Page 58-58a - Under "b" on page 58 and 58a, clarification is provided for situations involving two round trips to the same vendor on the same date. Also, a statement has been added in this section to indicate that in-state requests for transportation beyond the nearest resource do NOT require prior authorization. This policy has been in effect for several years. The written narrative which required the nearest resource (or vendor) to be used was deleted from the manual with an explanation thereof included on the DW-17 some time ago. However, several request have been made to write this revised policy in the manual.

Page 63 - In the paragraph which describes how mileage is computed for private automobiles, new policy has been added to insure that the round-trip will be made over that route which constitutes the shortest mileage.

Page 65 - A new section (Item #4) has been added on page 65 and 65a which contains new policy concerning persons who are employed as Medicaid providers yet wish to perform as NEMT providers during their hours of employment.

Page 66 - Under the meal policy, clarification has been added to provide meals for the driver during overnight lodging.

Page 67 - In the last paragraph on the page, new policy indicates a limitation on the cost of the driver's lodging plus meals as compared with a double round trip when the driver wishes not to stay overnight.

Page 69 - 70a - Revisions to the NEMT form are noted here. (See below for specifics). As conversion continues in RAPIDS and when almost all NEMT cases are being processed via RAPIDS, the revision of this manual section will continue until all previous references and instructions regarding the CHET system and the DF-67-B form will be obsoleted. At the present time, a substantial amount of case processing and payment of benefits continue within the CHET system. However, it was believed that the revisions contained herein could be made to the NEMT-1 form without creating confusion for those counties still using CHET and the DF-67-B form. In other words, the revised NEMT-1 form can be used with the CHET system.

REVISIONS TO THE ES-NEMT-1 FORM

Revisions to the ES-NEMT-1 form were necessary to make it more compatible with RAPIDS and for policy clarifications:

PAGE ONE AND TWO

Three lines were added in the space to list additional numbers if necessary and the statement above this space contains a reference to the eleven digit number from the RAPIDS-generated Medicaid card.

The explanation located below Item "B," APPLICANT/PATIENT RESPONSIBILITIES now contains a reference to contract carriers.

The statement certifying the applicant has read and understands the statements on the form, formerly #1, is now, #11.

On the old ES-NEMT-1 form, (10-94) #11 has been combined with #9 on the new form. Item #9 indicates the now-in-writing policy that the shortest route mileage must be used when computing the cost for private autos.

PAGE THREE

In the upper right corner, a space has been made to enter the "Transportation Vendor Number" if desired for RAPIDS entry.

Statement #4 and items a. and b. contain different terms to reflect changes on the form, especially on the verification pages.

PAGE FOUR AND FIVE (Verification pages)

A social security number has been added for the patient. For the NEMT provider, space is provided for the social security number/tax I. D. number as needed for RAPIDS entries.

A statement at the top of this page warns the Medicaid provider not to sign the form if the service is not covered by Medicaid.

A space to enter the appointment time has been added to these pages.

At the bottom right of each of the four sheets, space is provided to permit the worker to approve (appr.) or deny (Denied) the trip.

Processing of the old (10-94) NEMT-1 form may continue until 60 days after November 1, 1997. Use of the revised form MUST begin no later than November 1, 1997 when the manual revisions become effective. Applicants who have been given advance supplies of the old NEMT-1 form must be contacted and informed that use of the new form must begin as indicated above.

Please contact Robert Kent at 558-8290 if you have any questions or comments.

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).

- 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.

- Have an appointment or plan for the medical treatment or service.

- Comply with the 60-day application submittal deadline.

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 for two appointments to the same medical provider on the same date. Each request

must be individually evaluated before approval may be given.

Transportation requests within the state but are beyond the nearest resource do NOT require prior or any other approval from the county worker.

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.

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. 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.

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 Employees of Entities That Provide Medicaid Services During Their Hours of Employment.

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 -

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.)

The form is divided into Sections A - Identifying Information, B -Applicant and/or Patient Responsibilities 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.

2. Completion of Form DF-67-B as the Application Form for EPSDT, Handicapped Children's and Other Approved Clinics