27.5 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 allowed in certain circumstances 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 AUTHORIZATION

- All requests for out-of-state transportation and certain related expenses must have prior approval from the broker, except for travel to those facilities which have been granted in-network status. Facilities granted in-network status are considered in-state providers. Members are required to contact the broker to schedule the travel for all medical appointments or visits, regardless of the in-network or out-of-network status.

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

- 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 BMS approval.
- Two round trips per scheduled 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 member insists on incurring expenses beyond those approved by the broker, 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. Exceptions require BMS approval.

C. ROUTINE AUTOMOBILE TRANSPORTATION REQUESTS

Members 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 Determining the Amount of Payment 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 member chooses more costly transportation, the rate of reimbursement is limited to the private auto mileage rate.

When the member 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.

Members 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.

D. REQUESTS FOR TRANSPORTATION FOR EMERGENCY ROOM SERVICES

Members who use emergency rooms for routine medical care are not reimbursed for transportation. When the broker documents that emergency room treatment was necessary, the broker may approve the transport for the member to return home from the emergency room.

E. APPROVED TRANSPORTATION PROVIDERS

The least expensive method of transportation must always be considered first and used, if available.

Providers are listed below. Members 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)

F. 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 BMS approval.

1. Mileage

   Round-trip mileage from the patient's home to the medical facility is paid. The round trip must be made over the shortest route, as determined by the broker.

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

2. Common Carrier

   The cost of waiting time is paid only when travel between cities is required. This waiting time is permitted only for obtaining medical services. When waiting time is claimed, the broker 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 may invoice the broker 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. Mary's 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 BMS approval.

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. Determination of which meals to include is based upon 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, the broker 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 (personal attendant, behavioral health, rehabilitation providers, Aged and Disabled, Traumatic Brain Injury or Intellectual/Developmental Disability Waiver (IDD), etc.) cannot be reimbursed as an NEMT provider when transporting individuals while being paid by that Medicaid Provider, i.e., being on the clock and being paid for NEMT at the same time.

IDD Waiver providers must bill NEMT for Medicaid approved services unless training is occurring during the transportation time. If a provider is billing another State Plane Medicaid service, then the provider must utilize NEMT for transportation costs.