APPENDIX A
NEMT POLICY OBSOLETE AFTER OCTOBER 1, 2014

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27.1 INTRODUCTION

Non-emergency medical transportation (NEMT) is a reimbursement program for recipients of Medicaid and Children with Special Health Care Needs (CSHCN) for the cost of transportation and other expenses associated with receiving medical services.

Since the program is intended for reimbursement only, payment in advance of a scheduled appointment is not appropriate and cannot be issued from RAPIDS.

27.2 APPLICATION/REDETERMINATION PROCESS

A. CONTENT OF THE INTERVIEW

A face-to-face interview is not required in order to apply for NEMT reimbursement. The DFA-NEMT-1 is designed to be completed by the applicant.

If an interview is conducted due to the need for prior approval and an emergency situation exists, the Worker obtains all information required on the DFA-NEMT-1 and as required in Section 27.13.

B. AGENCY DELAYS

The Worker must process applications received for travel upon receipt, provided the date for which reimbursement is being requested occurred no earlier than 60 days prior to the date of application. Delay caused by failure on the part of the agency to process an application in a timely manner, is not a reason to deny payment.

C. BEGINNING DATE OF ELIGIBILITY

Medicaid recipients are eligible for NEMT beginning the first day of the month for which Medicaid is approved, including months for which backdating occurred. Applicants awaiting approval must be instructed to apply for NEMT within the 60-day time limit, but applications must be held by the Worker until Medicaid is approved except for transportation expenses related to an appointment(s) scheduled by the Worker and/or requested by MRT.

When a client is pending Medicaid approval and has not been instructed by the Worker to apply for NEMT within the 60-day time limit, that client must be given a reasonable amount of time to submit NEMT applications for the time prior to Medicaid approval.

Recipients of CSHCN and others who qualify for reimbursement of transportation expenses are eligible as determined by the program which provides the medical services.

D. REDETERMINATION SCHEDULE

There is no redetermination process for NEMT other than that for Medicaid. Each request for reimbursement is treated as a separate application.

E. THE BENEFIT

Services provided under this program include reimbursement for transportation and certain related expenses necessary to secure medical services normally covered by Medicaid. Funding for this program is provided by three different sources:

- Title XIX funds for all Medicaid recipients, including foster children,
- Title V funds for non-Medicaid eligible recipients of the Children with Special Health Care Needs Program (CSHCN), and
- Agency administrative funds for applicants for cash assistance or Medicaid who need a physical examination in order to complete the eligibility process.

Reimbursement for transportation and related expenses is available to Medicaid recipients who:

- Require transportation to keep an appointment for medical services covered under the Medicaid group for which he was approved;
- Receive scheduled Medicaid-covered services at a clinic, hospital or doctor's office;
- Receive pre-authorization as necessary; and
- Comply with the 60-day application submittal deadline.

Reimbursement is also available for applicants for Medicaid who must travel to obtain necessary medical examinations and tests required to determine eligibility. See Section 27.13 for specific eligibility requirements.

F. EXPEDITED PROCESSING

Procedures for expedited processing do not apply to NEMT.

G. THE APPLICATION FORM

The required form for all Medicaid recipients, including Access to Rural Transportation (ART) clients, is the DFA-NEMT-1. It must be completed by the recipient or by a parent, guardian or other responsible person when the recipient is a child or an incapacitated adult. The form is mailed or brought to the recipient's local DHHR office.

The ART client completes the DFA-NEMT-1 and submits it to the Right from the Start Program Designated Care Coordinator (DCC) for verification and approval. In addition, the DCC may sign the application in lieu of the doctor or his designee when the DCC has verified the appointment was kept. The approved DFA-NEMT-1 is then forwarded to DHHR by the DCC for processing. The same 60-day deadline for submission applies to ART clients and other Medicaid recipients as well.

The medical service provider, his designee or the DCC is required to sign the section verifying that the individual had an appointment and was seen for Medicaid-covered treatment or services. Medical service providers include doctors, nurses, nurse practitioners, physicians' assistants, lab technicians, and others who perform a Medicaid-covered service. The DCC may sign in place of the physician or his designee routinely. There is no requirement that the client fail to obtain the signature of the physician or designee in order for the DCC to sign the form. Only when the form is signed by the DCC is it used to verify the reimbursement amount and that the appointment for a Medicaid-covered service was kept.

When prior approval is required for out-of-state travel, the applicant may apply in person at the local DHHR office so that the required documentation can be made and/or obtained. Coordination of the process may be facilitated by telephone and/or fax with BMS and the physician, as necessary.

The form may be used for verification of up to 4 trips. Each trip date must be entered in the space titled "Date of Appointment." Regardless of the number of trips included on the form, payment for any trips which occurred more than 60 days prior to the date the form is submitted to DHHR for payment must be denied. See Section 27.2,C for exceptions.

As noted above, the submission deadline for the completed DFA-NEMT-1 is 60 days from the date of the trip(s). Compliance is determined by comparing the date of the earliest trip entered on the form with the date the application is received by DHHR for processing.

Altered forms which include questionable entries will result in denial of the application, unless the Worker is able to resolve the discrepancies. Items which have been corrected must be initialed by the applicant or other person providing the information.

27.3 THE CASE MAINTENANCE PROCESS

A. CLOSURES

The AG is ineligible for NEMT when Medicaid is closed.

B. CHANGE IN INCOME

Changes in income that do not affect Medicaid eligibility have no effect on NEMT.

C. UPDATE OF CASE INFORMATION

Updates in case information are not required for NEMT, except when such changes affect Medicaid eligibility.

27.4 IEVS

IEVS is not used for NEMT.

27.5 VERIFICATION

Specific requirements for verification of travel expenses are included on the DFA-NEMT-1. Forms submitted by a DCC for the ART program are considered verified and approved for payment.

Additional verification is not required, unless the Worker has reason to suspect misuse or abuse of the program. When deemed necessary, policy in Section 27.14 applies.

27.6 RESOURCE DEVELOPMENT

NEMT recipients are assumed to have met requirements to develop resources under Medicaid eligibility guidelines, including application for Medicare, as appropriate.

27.7 CLIENT NOTIFICATION

Notification of the decision for NEMT applications must be received by the client no later than 30 days following the date the application is received by DHHR.

27.8 COMMON ELIGIBILITY REQUIREMENTS

A. RESIDENCE

All applicants for NEMT must be residents of West Virginia.

B. CITIZENSHIP AND ALIEN STATUS

Applicants must be citizens of the United States or be qualified aliens in accordance with Chapter 18.

C. COOPERATION WITH QUALITY CONTROL (QC)

NEMT is not reviewed by QC. However, Medicaid recipients who fail to cooperate with QC and lose their Medicaid no longer qualify for NEMT.

D. LIMITATIONS ON RECEIPT OF OTHER BENEFITS

Except for the requirement to be a Medicaid recipient or covered by the qualifying programs listed in Section 27.2. NEMT is not affected by the receipt of any other benefits.

E. NON-DUPLICATION OF BENEFITS

Applications submitted for trips or other expenses which have already received reimbursement from any other source are denied.

HCB, TBI and I/DD Waiver Medicaid recipients may have some transportation costs billed directly to BMS up to a set mileage limit. The Worker must verify if BMS has paid before issuing NEMT payment to any Waiver Medicaid recipients.

F. ENUMERATION

A valid SSN is required.

27.9 ELIGIBILITY DETERMINATION GROUPS

A. THE ASSISTANCE GROUP (AG)

The AG is the individual(s) for whom transportation is required.

B. THE INCOME GROUP (IG)

The IG is the same as for Medicaid in each coverage group.

C. THE NEEDS GROUP (NG)

The NG is the same as for Medicaid in each coverage group.

27.10 INCOME

There are no specific income guidelines for NEMT. Medicaid recipients and those who meet guidelines for reimbursements under other programs are considered income-eligible for NEMT.

27.11 ASSETS

There are no specific asset limits for NEMT as applicants with valid Medicaid coverage are considered to meet applicable asset tests.

27.12 WORK REQUIREMENTS

There are no work requirements for NEMT.

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 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 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 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 Benefit Repayment Section 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 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.

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.

27.14 BENEFIT REPAYMENT

There is currently no repayment procedure for NEMT. However, recipients must be informed that fraudulent claims will result in denial of subsequent requests up to the amount of the claim and could result in permanent ineligibility for NEMT.

Workers who become aware that a client may be obtaining NEMT reimbursements to which he is not entitled must monitor all applications from the client to determine if misuse or abuse of the program is actually taking place. Any information deemed questionable must be verified, even if not routinely required.

If the Worker has reason to suspect that reimbursement is being requested for trips that were not taken, he must contact the medical provider(s) listed and verify appointment dates and whether or not the appointments were kept.

Unless the Worker has sufficient reason to suspect misuse or abuse, and/or finds reasonable proof that misuse or abuse has occurred, properly completed and signed applications will be assumed to be correct.

27.15 BENEFIT REPLACEMENT

See Chapter 21 for the replacement of a WV WORKS Supportive Service payments and Medicaid NEMT checks. The DF-36 must reflect that the check is for NEMT.