Covered Services and Limitations (Transport)

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Covered Services and Limitations (Transport)

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Transportation services are provided to Virginia Medicaid Members to ensure necessary access to and from providers of all medical services covered by the *State Plan for Medical Assistance*. Both emergency and non-emergency services are covered, with certain limitations.

This chapter describes the details of the transportation coverage available, the limitations, the method for requesting Non-Emergency Medical Transportation (NEMT) through the fee-for-service (FFS) broker and Managed Care Organization (MCO) plan(s).

All NEMT Reservation and Ride Assist telephone numbers for FFS, MCO plans can be found at: http://dmas.virginia.gov/#/nemtservices click on "Transportation Contacts."

Covered Transportation Services

In the Virginia Medicaid Program, covered transportation services are categorized into two major categories: Emergency Ambulance and NEMT.

Emergency Ambulance Services

Emergency ambulance transportation is a covered service for Medicaid Members with emergency conditions such as heart attacks and other life-threatening injuries. Emergency ambulance transportation coverage is not available for Medicaid Members with conditions such as minor abrasions, lacerations, bruises, fever, normal labor pains, headaches, intoxication, and other similar non-life-threatening conditions. Ambulance providers seeking payment for emergency transportation will have Medicaid payment denied if an emergency condition is not documented.

Non-Emergency Medical Transportation (NEMT) Services

NEMT is provided to eligible Medicaid members through a transportation broker or internal transportation service, who must pre-authorize the trip and assign it to a transportation provider who transports the Members to or from the Medicaid-covered service (see Chapter I). The FFS broker or MCO plan is responsible for all non- emergency transportation services provided to Medicaid Members. The FFS broker is not responsible for Members enrolled in a MCO plan. Medicaid Members

enrolled in a MCO receive their transportation services through their MCO broker or internal transportation service. The only exception to this is for MCO Members who are also enrolled in the Community Living (CL), Building Independence (BI), Family and Individual Support (FIS), and FFS Elderly or Disabled with Consumer Directed (EDCD), federal waiver programs Medicaid coverage. While the majority of these individuals receive their acute and primary medical coverage from the MCO, they receive transportation to their Medicaid covered waivered services through the FFS broker. Medicaid Members with a CCC Plus Waiver will receive transportation services through their MCO plan.

- Virginia Title XXI program Members enrolled in a DMAS-contracted MCO do not receive non-emergency transportation services. All Medicaid Members, including FFS, must contact their broker or internal transportation service in advance to have their trip pre-authorized. All NEMT providers must have a contract or be enrolled with the FFS or MCO transportation broker/internal transportation service in order to be assigned the trip and receive Medicaid payment. If you have questions on whether you have transportation benefits please contact your FFS or MCO plan for information: The contact numbers can be found at: http://www.dmas.virginia.gov/#/nemtservices Look under the heading “Information,” and click on “Transportation Contacts.”
- Additional information on the FFS NEMT program can be found at: http://transportation.dmas.virginia.gov. This web site will give you information such as the FFS Member Handbook and various links to assist with transportation services.

The FFS and MCO brokers and MCO internal transportation program performs the following functions:

- Inform and educate Members and facility providers about the NEMT program and process.
- Verify Member eligibility for FFS or MCO Medicaid or the Virginia Title XXI program.
- Verify that the purpose of the trip is to receive a service covered by FFS,

MCO Medicaid or the Virginia Title XXI program.

- Determine the appropriate mode of transport and delivery (e.g. curb-to-curb, door-to-door, or hand to hand delivery).

- Authorize transportation services on a Demand Response or recurring (Standing Order) basis.

- Schedule and assign trips on a Demand Response or recurring (Standing Order) basis.

- Operate a toll-free call center for trip requests and ride assist. A list of these telephone numbers can be found at: http://www.dmas.virginia.gov/#/nemtservices Look under heading Information and click on "Transportation Contacts"

- Recruit and maintain an adequate transportation provider network.

- Assure compliance with provider, driver, attendant, and vehicle requirements. The list of FFS NEMT Provider, Driver, Attendant, and Vehicle requirements can be found at: http://www.dmas.virginia.gov/#/nemtservices Look under NEMT Requirements and click on "DMAS FFS Driver, Attendant, and Vehicle Requirements."

- Provide reimbursement for transportation services.

- Develop and implement a monitoring system and quality assurance plan.

- Develop and implement a system that tracks complaints and their resolutions.

- Provide administrative oversight as directed from FFS or MCO Transportation contracts.
- Submit management reports to Department of Medical Assistance Services (DMAS) as directed by FFS or MCO Transportation contracts.
- Protect Member confidentiality.
- Maintain adequate staff and facilities as directed from FFS or MCO Transportation contracts.
- Operates a Transportation Information Management System (TIMS) as directed by FFS or MCO contact

The broker(s) contracts with a number of transportation providers in order to provide the Member with the most appropriate mode of transportation for each trip, including:

- Non-emergency ambulance
- Stretcher van
- Wheelchair van
- Common carrier bus services
- NEMT Providers with NEMT tags or for Hire License plates
- Commercial taxicab services
- Public transit services (Bus Tickets)
- Volunteer Driver
- Transportation Network Company (TNC) with DMAS permission
- Mileage reimbursement - The broker or internal transportation service is

encouraged to use mileage reimbursement to provide the most cost-efficient transportation service to the Member if such transportation is appropriate to meet the needs of the Member. The broker must have procedures in place to verify and document that vehicles and drivers used in mileage reimbursement comply with appropriate state operating requirements, driver's licensure, vehicle registration, and insurance coverage.

Guidelines to Determine Transportation Necessity

Brokers must use the following guidelines to determine the need for transportation service:

1. Mobility: Transportation is provided and covered if the Member does not own an operable automobile or cannot operate it safely. Transportation is covered if the recipient has no other transportation available from a spouse or, in the case of minors, from a custodial parent. The driver must have a valid operator's license and the vehicle must be properly registered and inspected. The vehicle must be in operable condition and available for use at the time of the appointment. Exceptions to "no other transportation available" shall be made for Members who are going to dialysis treatment, chemotherapy, or radiation treatment; who are receiving foster care; who are enrolled in a Medicaid home- or community-based waiver; and when the length or frequency of the trip(s) would impose a financial burden on the Member or the Member's family.

2. Eligible Purpose: Transportation is provided and covered so services that are covered by Medicaid can be received (see Chapter I). If the covered service requires pre-authorization by DMAS or its agent, the Member must have the required pre-authorization before requesting transportation for the service and any follow-up visits. However, transportation for a service consultation or evaluation does not require pre-authorization.

3. Transportation is provided and covered for the nearest available source of care capable of providing the patient's medical needs. For transportation purposes, the nearest provider of care is defined as:

    - The nearest enrolled service provider, who provides the Medicaid-covered services needed by the Member, will accept the Medicaid

Member as a patient, and can provide the service when it is needed.

OR

- The nearest enrolled service provider of specialized care required to tend to the Member's specific medical needs.

OR

- The service provider has a client/patient relationship of at least one year with the Member. Transportation to the medical provider's office is covered when it is within a reasonable distance from the Member's home or as approved by DMAS.

OR

- The nearest enrolled service provider who has agreed to serve as a primary care physician for a Member enrolled in Client Medical Management.

4. Hospital transport to an upper level of care may be provided between hospitals for the purpose of specialized procedures not available at the original hospital. Members are not returned to the original hospital once transported to another hospital for upper level of care unless approved by DMAS or MCO. However, Medicaid payment is limited to the nearest facility offering the specialized or upper level of care. Medicare may also cover this transportation when an ambulance is necessary.

Guidelines for Determining Curb-to-Curb, Door-to-Door, or Hand-to-Hand Service

Curb-to-curb service is provided to Medicaid Members who need little (if any) assistance from the vehicle to the door of the pick-up point or destination. The assistance provided by the driver includes opening and closing the vehicle doors, helping the passenger enter or exit the vehicle, folding and storing the Member's wheelchair or other mobility device as necessary, and securing the wheelchair or other wheeled mobility device in the vehicle. It does not include lifting any Member. Drivers are to remain in or nearby their vehicles and are not to enter any buildings nor stay with members for appointments.

Door-to-door service is provided to Medicaid Members who need assistance to

safely move from the door of the vehicle to the door of the pick-up point or destination. For this service, the driver exits the vehicle and assists the passenger from the door of the pick-up point (e.g. residence) to the door of the vehicle and assists the passenger in entering the vehicle. The driver is responsible for assisting the Members throughout the trip. Drivers, except for ambulance personnel, are not allowed to enter a residence. In order to receive door-to-door service, the Member must request the FFS or MCO broker or internal transportation service. Some examples of disabilities that may require door-to-door service are:

- Blindness
- Deafness
- Cognitive Disabilities Mental illness
- Dementia
- Physical disability of a degree that personal assistance is necessary
- Members in a wheel chair

Hand-to-Hand service means transporting the Member from a person at the pick-up point into the hands of a facility staff member, family member, or other responsible party at the destination. Some Member with dementia or developmental disabilities, for example, may need to be transported hand-to-hand.

Non-Covered Transportation Services

Virginia Medicaid does not cover the following transportation services:

- Transportation of Member is not covered from nursing facilities to a physician's office or a hospital outpatient department when the needed medical care can be performed in the nursing facility. If a patient can be treated by a general practitioner, the patient must not be transported out of the facility. Members must not be transported to emergency rooms from nursing facilities for routine medical services covered under nursing facility care.
- Transportation of Members is not covered from nursing facilities to hospital outpatient departments or to clinics to obtain routine physical therapy. These services must be provided through other arrangements by the nursing facility.
- Lateral transfers are not covered, except as follows:

  - When a person becomes eligible for Medicaid while in a non-enrolled hospital or nursing facility, transportation is covered to the nearest enrolled provider with an available bed.
  - When a hospital or nursing facility closes or ceases to be an enrolled provider, transportation is covered to the nearest enrolled provider with an available bed.
  - Transportation to another hospital is covered when more specialized care is required and cannot be obtained at the original hospital. However, if the patient is admitted to the second hospital, transportation back to the original hospital is not covered unless approved by DMAS or MCO plan.
  - Transportation is covered from one nursing facility to another when a change in the level of care is required.
- Transportation to a mental institution is not covered when the admission is court-ordered.
- Transportation for routine physicals and immunizations is not covered except to receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services or as specified by DMAS
- Transportation is not covered for long-term speech therapy or as specified by DMAS.
- Transportation is not covered for picking up prescriptions and refills at a pharmacy when the drugs can be delivered or mailed. Transportation is covered if the pharmacy has no delivery service, will not mail the prescription, or the prescription can't be filled at the medical facility. Normally, the prescription should be filled initially on the return trip from the medical appointment.
- Transportation for picking up Women, Infants, and Children (WIC) Supplemental Food Program vouchers or certification/recertification for the WIC Program is not covered.
- Transportation is covered by the FFS broker to medical services in areas bordering other states or the District of Columbia. In these instances, transportation is covered and provided by the broker to bordering the city or county of residence, such as Scott County to Kingsport, Tennessee, Tazewell County to Bluefield, West Virginia, or northern Virginia to the District of Columbia. Additional FFS Out of State Transportation information can be found later in this chapter. Members enrolled in a

MCO plan must contact the plan they are enrolled with for Out of State Transportation arrangements and/or reimbursement.

- Transportation is not covered for any non-covered services (see Chapter I).

NEMT Driver, Attendant, and Vehicle Requirements (Transport)

The FFS, MCO broker(s) or MCO internal transportation service shall assure that all providers, drivers' attendants, stretcher van and vehicles transporting in these programs meet the requirements of their contracts. The FFS Provider, Driver, Attendant, and Vehicle requirements can be found at: http://www.dmas.virginia.gov/#/nemtservices Look under NEMT Requirements and click on "DMAS FFS Driver, Attendant, and Vehicle Requirements."

Non-Compliance of Driver, Attendant, Stretcher Van, and Vehicle Requirements

Any vehicle or driver found out of compliance with these requirements, or any state or federal regulations, may be removed from service immediately by authorized employees of DMAS, MCO or the broker(s) until the MCO or broker(s) verifies that the deficiencies have been corrected. Any deficiencies and actions taken shall be documented and become a part of the vehicle's and the driver's permanent records.

Medical Coverage for Non-Resident Aliens (Transport)

As amended, paragraph 3 of Section 1903V of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for nonresident aliens when these services are provided in a hospital emergency room or inpatient hospital setting. Virginia Medicaid will cover transportation for nonresident aliens for emergency conditions only.

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Deliveries
- Acute coronary difficulties
- Emergency surgeries (i.e. appendectomies)
- Episodes of acute pain (etiology unknown)

- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed the limits established for other Medicaid Members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Local social services departments determine the eligibility of the nonresident alien to receive emergency Medicaid coverage based on normal eligibility criteria and the documentation from the service provider that the emergency services have been provided. Referrals to the local social services agency may come from the provider or from the nonresident alien (see Chapter III for additional information).

The documentation of the emergency treatment will be verified by the local social services agency through the patient's medical records obtained from the provider. This documentation must include all required Medicaid forms and a copy of the Member's complete medical record. (For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those age 21 and older.) The local social services agency will submit this documentation to Medicaid for approval of the treatment coverage and to establish the time for which this coverage will be valid.

If the Members is found eligible and the emergency room coverage is approved by Medicaid, each provider rendering the emergency care will be notified via the Emergency Medical Certification Form of the Member's temporary eligibility number, the conditions for which treatment or services will be covered, and the dates for which the eligibility number is valid. Coverage for nonresident aliens is valid only for the conditions and time stated on this form. This form will also be used to notify providers that a nonresident alien is not eligible for emergency care.

To submit a claim for these emergency services for a nonresident alien:

1. Complete the appropriate Medicaid billing form (and other required

forms) in the usual manner.

2. Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and, therefore, does not need to be attached with this claim (check *Transportation* Provider Manual for a sample of the form).

3. Submit the claim using the pre-printed envelopes supplied by Medicaid or by mailing the claim directly to the appropriate post office box.

NOTE: The same procedures apply for adjusted or voided claims.

All claims for nonresident aliens will pend for certification to verify they were related to the approved emergency situation. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeals process for those services which are not approved.

Payment for Emergency Air and Ground Ambulance Services

Payment for FFS emergency ambulance transportation services shall be in accordance with the billing instructions and rates established by DMAS. Payment for MCO emergency ambulances shall be in accordance of the MCO plans billing instructions. Contact the MCO plan for Emergency Services Billing instructions.

The DMAS FFS Service Transportation Billing Instruction Manual can be found on link below by finding Transportation on the pull down menu and clicking on Chapter V: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual. DMAS FFS Emergency Air and FFS Emergency Ground Ambulance rates can be found at: http://www.dmas.virginia.gov/#/ambulance. Look under heading "On and After 07-01-2012" and click on DMAS FFS Ambulance Rate Table with DOS on or after 07-01-2012.

In order for a provider to receive payment for FFS Non-Emergency Medical Transportation (NEMT) services, the trip must be preauthorized, assigned to provider, and paid for by the FFS broker. Please contact the FFS transportation broker at 1-866- 386-8331 for prior approval and provider requirements.

Neonatal Ground Ambulance Services

The use of this service is restricted to neonatal patients who require ambulance transportation by licensed Class D-neonatal ambulances. Payment rates for this mode of transportation can be found at: http://www.dmas.virginia.gov/#/ambulance. Look under heading "On and After 07-01-2012" and click on DMAS FFS Neonatal Ambulance (A0225 with A0425 U1 modifier) on or after 07-01-2012.

Neonatal Ambulance mileage is determined from the dispatch point to the drop-off point. Waiting time is covered by DMAS when the provider remains for more than 30 minutes at the location where the Members is picked up or taken. Waiting time is covered for all trips without regard to the number of transport miles.

Charges shall not exceed $1,320.00 total for all reimbursement categories (round trips, base rate, mileage, and wait time).

In-State and Out-of-State Medicaid Member Travel

Medicaid members enrolled in a MCO must contact the Managed Care Organization (MCO) for in state and out of state travel prior authorization and travel reimbursement instructions. MCO contacts can be found at: http://www.dmas.virginia.gov/#/nemtservices Look under heading Information and click on “Transportation Contacts”

FFS Medicaid covered services may require in state or out of state long distance travel. Medical necessity for in state and out of state services must be established prior to travel. **Medicaid members must obtain prior authorization before travel begins.**

FFS In-state long distance travel or travel to surrounding cities out of state must have prior authorization from the Non-Emergency Transportation Broker before travel begins. Please contact the transportation broker at 1-866-386-8331 for prior approval. The non- emergency transportation broker is responsible for travel arrangements and reimbursement for in state and surrounding areas to the State of Virginia.

FFS out-of-state travel not covered by the broker must have prior authorization before travel begins. Please contact DMAS Medical Support Unit at (804) 786-8056 thirty (30) days prior to travel. Out-of-State travel days will be approved by Medical support. Travel Reimbursement will be reimbursed at the state employee travel, hotel, per diem, mileage reimbursement rate. Once approved the FFS DMAS Transportation unit can answer travel questions. Please send questions to Transportation@DMAS.Virginia.gov

Medicare Catastrophic Coverage Act of 1988 (Transport)

[Effective Date: January 1989]

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid programs to expand the coverage of services to certain low-income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

Qualified Medicare Beneficiaries (QMBs)- Coverage Limitations (CMHRS)

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the individual's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers may contact Magellan of Virginia directly for more information.

Qualified Medicare Beneficiaries (QMBs)- Extended Coverage Limitations (MHS)

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These individuals are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.