North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
1985 Umstead Drive – 2512 Mail Service Center - Raleigh, N.C. 27699-2512
Courier Number 56-20-06

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April 16, 2003

Re: Medicaid Transportation Questions

Dear County Director of Social Services and
Director of Local Transit System:

Following is a series of questions and answers regarding Medicaid transportation. The questions were provided by transportation staff at county departments of social services and local transit staff, in preparation for a series of Medicaid/Transit Forums to be held in May.

A. Medicaid Covered Services

Medicaid will only pay for transportation to and from Medicaid covered services.

1. We have Medicaid customers that we often take to the Veteran's Administration. It is a 240-mile round trip. These men are not service connected so they do not receive travel reimbursement. Since they are eligible for Medicaid transportation and are receiving medical treatment at the VA, can I bill the trip to Medicaid when they are not paying for the medical care?

   No. Services at VA hospitals are not covered by Medicaid. Therefore, Medicaid transportation may only be used for transport to Medicaid covered services.

2. Are any Vocational Rehabilitation appointments covered under Medicaid transportation? We have been informed that some of these appointments can be billed to Medicaid. If so, what are the qualifying factors in this case?

   Medicaid is primary payer over Vocational Rehabilitation if the service is covered by Medicaid. If the individual is eligible for Medicaid and is being transported to a Medicaid covered service, the transportation costs may be reimbursed by Medicaid. Check with the VR counselor and the doctor to determine if the service will be billed to Medicaid or to VR. If it will be billed to Medicaid, transportation to and from the service may be paid by Medicaid.

3. A recipient has equipment that will be provided to him free from the School for the Deaf in Morganton and is requesting transportation to pick it up. Can we provide this transportation under Medicaid?

   No, if the equipment is being provided to the individual at no cost, it is not a Medicaid covered service and Medicaid transportation may not be used.

4. A Medicaid-eligible recipient has an appointment with cardiac rehab for a pulmonary function test. If the recipient fails the test then she will be admitted to the cardiac rehabilitation program and subsequent visits will be billed to Medicaid. If she passes the test (her heart and lungs are functioning well), would the first trip be covered under Medicaid?

   Transportation is available for transport to Medicaid covered services. Pulmonary function tests are covered under Medicaid. If the test is billed under the hospital's out patient number, and all eligibility requirements are met, the claim will process. However, Medicaid currently only covers inpatient cardiac "instruction"(rehab) billed through the DRG. If the recipient is admitted to the cardiac rehab program on an out patient basis the services are non-covered and transportation to them will not be covered.

5. We sometimes find it difficult to know if certain services received through the local mental health agency are Medicaid covered services or not. Especially when the client is CAP because the social worker will often say it is Medicaid covered because it is a CAP waivered service. However, not all CAP waivered services are medical services, such as mentors. We have also found that the services may be Medicaid covered but the client is not eligible for Medicaid transportation assistance. For example, they live in a group home, host home, or with an Alternative Family Living (AFL) Provider that is already contracted and paid by the mental health agency to provide transportation for the client.

   If a service is paid for by the Medicaid program, even though it would not usually be considered a medical service, it is considered a medical service for purposes of Medicaid transportation. If you have a question as to whether or not a particular service will be paid for by Medicaid under CAP/MR (or any other CAP program), contact the case manager. Ask him or her specifically, Will this service be paid for by Medicaid? If yes, Medicaid transportation may be available. Similarly, ask the case manager whether or not the entity where the person lives is contracted to provide medically related transportation.

6. An eligible Medicaid recipient is requesting transportation to the blood donor clinic to give blood for surgery she will be having. She wants to bring several adults with her. They are not Medicaid recipients but state they want to give blood in case there is a need for extra during surgery. If these adults do not give blood and if more is needed Medicaid will be billed for the blood, which is not as cost effective. Can these adults go with her and the transportation cost be given to the eligible recipient?

   Blood donations, even for oneself, are not a covered service. Therefore, Medicaid transportation may not be used to pay for the transportation. Additionally, there is no cost savings for Medicaid in this situation. The blood necessary for the surgery is already included under the hospital's DRG based payment for the admission. No money is saved because the recipient or others donated blood.

7. Please respond to transportation services provided to Medicaid-eligible children attending developmental disability centers.

   Determine if this is a Medicaid enrolled provider, providing Medicaid covered services to the recipient, for which it will bill Medicaid. If the answer is yes, Medicaid transportation may be used. Generally, speaking the answer is no, Medicaid transportation may not be used to transport children to developmental disability centers.

8. Please explain DMA policies regarding transportation for psychiatric inpatient hospitalizations.

   Medicaid pays for psychiatric inpatient hospitalizations for individuals under age 21 and for individuals age 65 and over. Medicaid transportation can be used to transport these individuals to inpatient psychiatric hospitals if the hospital is an enrolled provider and accepts the patient as a Medicaid patient. If the recipient is between the ages of 21 and 65 and is being transported to an inpatient psychiatric facility for treatment of a psychiatric problem, Medicaid transportation is not available, because this is a non-covered service. If the recipient is admitted to or being treated at the facility for medical reasons only, it is a Medicaid covered service and the cost of transportation would be eligible for Medicaid reimbursement.

B. Reimbursement for DSS Workers Providing Transportation

Medicaid transportation may be used to pay for the non-county share of the salary of DSS workers providing transportation. The reimbursement rate is at the FMAP rate (federal/state/county) for covered services.

1. Why are medical trips provided by DSS transportation aides ineligible for Medicaid reimbursement?

   They are eligible for reimbursement. Refer to questions 2., 3, & 4., below.

2. If a social worker provides medically related transportation for a Medicaid recipient, can the county be reimbursed for the time that transportation is actually provided at the same reimbursement rate as it would if the trip had been provided by a transportation aide (e.g., federal/state/county match rate for services)?

   Yes. Please refer to the answer to Question 3. The county is reimbursed at the same rate (FMAP) regardless of the DSS staff member's position (E.g. transportation aide, social worker, income maintenance caseworker, etc.).

3. If a DSS worker (aide, social worker, income maintenance worker, whoever gets a payroll check from DSS) transports a Medicaid recipient to the doctor, what do they code and do they get the Medicaid enhanced rate or 50/50? Then explain your answer so the Fiscal people can understand.

   DSS costs associated with staff time spent providing Medicaid transportation services (actual drive time) should be reported on the DSS-1571, Part IA, as Function Code 06, under Column 15. These costs are reimbursed at the enhanced (FMAP) rate. Staff time spent providing the trip should be reported on the DSS-4263 as SIS Code 250, Program Code T. If the DSS worker uses his/her own vehicle to provide the trip, the worker's mileage reimbursement is cost allocated to all programs, as is all service travel. The mileage reimbursement costs should be reported on the DSS-1571, Part II as Code 349.

   If an agency vehicle is used to provide the trip, the cost should be reported on the DMA-2055, Reimbursement Request Form. These costs are also reimbursed at the enhanced (FMAP) rate. All Medicaid transportation services should be documented on the DMA-2056, Title XIX Transportation Log. Use the information collected from the DMA-2056 to complete the DMA-2055. (DMA Adm. Letter 01-95, page 22 V.D.1.a. & b.) This interpretation has been given to the LBLs.

4. When a county DSS has custody of a child and provides Medicaid transportation, either by an aide, social worker, or income maintenance worker, can the county be reimbursed at the federal/state/county (FMAP) match rate or because the DSS is "financially responsible" for the child, would reimbursement be at the 50% administrative rate? DMA Administrative Letter No. 01-95, V.B.2.a.(1) indicates that a direct payment to a financially responsible parent is to be reimbursed at the 50% administrative rate. Also, how does this apply when transporting adults for whom the county DSS is named guardian?

   Yes, the county may be reimbursed at the FMAP rate. While the county may have custody of the child or be guardian of the adult, it is not a financially responsible relative. The same is true for transporting adults for whom the county DSS is the guardian.

C. Transportation of Residents of Adult Care Homes and Nursing Facilities

Adult care homes and nursing facilities are responsible for assuring medically related transportation of Medicaid recipients,

1. There is great confusion over "Assisted Living Centers" transportation. We understand that these facilities come under the same regulation as Adult Care Homes. However, in reality these recipients are much more mobile and independent and often call for transportation service directly, instead of coordinating through a facility staff member. Who is responsible for their medical transportation?

   "Assisted Living Center (or Facility)" is a very broad term. However, there is no licensed entity called an "Assisted Living Center/Facility." Such a facility generally encompasses a variety of levels of living arrangements and levels of care, beginning at stand alone residences or apartments and progressing in level of care to apartments where the person receives some services such as meals and staff checking in on them periodically, to adult care homes, and to nursing facilities. Of these living arrangements, adult care homes and nursing facilities may be responsible for providing medically related transportation.

   If a Medicaid recipient is in an adult care home or a nursing facility, the facility is responsible for assuring the medically related transportation for that individual.

2. This transit system is experiencing significant issues with the transportation of recipients who reside in Nursing Facilities and Adult Care Homes. The issue is who is responsible for the recipient's transportation. Is it the facility or the recipient? We understand that there have been changes at DMA regarding Medicaid reimbursement for medical transportation and we need to fully understand the impacts. According to

our local EMS department, EMS can no longer be reimbursed for the transportation of these recipients unless it is a true emergency. At the same time the facility says it is no longer their responsibility. If this is the case, the transit system anticipates a great increase in calls for service to the facilities for wheelchair transportation. Will this be an allowable cost under Medicaid? And who do we bill, the facility, Medicaid or other? Do the facilities receive any per diems/etc. for this type of transportation? Do we need to be "on-guard" for double–dipping?

Nursing facilities and adult care homes are responsible for assuring medically related non-ambulance transportation for Medicaid recipients in the facility. (See question 1., above.)

Non-emergency medically necessary ambulance transportation when the recipient can be transported by no other means remains a covered service for all Medicaid recipients. It is not the responsibility of the facility or the county DSS. The ambulance service must file a claim for the service.

Generally, it is not considered medically necessary for persons who are confined to a wheelchair to be transported by ambulance. They can be safely transported by wheelchair-equipped vans. As stated above the facility is responsible for assuring (including paying for it) medically necessary non-ambulance transportation for Medicaid recipients in the facility. The facility is responsible for assuring transportation for individuals who are confined to a wheelchair.

3. For Medicaid dialysis recipients in nursing homes, what can a nursing home do to get more transportation assistance since the recipient goes to dialysis approximately 12 times a month?

Nursing facilities report the costs they incur for transporting Medicaid recipients in their annual cost reports. If a facility experiences unduly high costs as a result of Medicaid transportation of dialysis (or other) patients, it will be reflected in the rate they are paid by Medicaid.

4. Clarification is needed regarding facilities' responsibility to pay for transportation costs over the transportation amount included in Medicaid reimbursements (fully allocated cost of transportation charged by community transportation programs versus amount provided to the home through state allotment).

It is up to the facility to assure medically related transportation for its Medicaid patients. The State has not established a maximum amount that may be spent by the facility for medically related transportation of Medicaid patients. It would seem good business on the facility's part to negotiate the best price it can

get for the service. However, a transit system is not required by Medicaid policy to accept less than the fully allocated cost that it normally charges for a trip.

D. Transportation of Individuals Who Are Not the Recipients of Medical Care – Spouses, Parents, Attendants, etc.

Medicaid transportation may be used to transport a recipient's caregiver, attendant, child, etc. when it is necessary that they accompany the recipient to the medical care.

1. A Dear County Director of Social Services from the Division of Medical Assistance, dated April 17, 1995, provides a list of questions and answers regarding Medicaid transportation. Question number 8 pertains to attendants and caregivers. The answer given includes, "however, if he cannot find a person to assist him, the county must find someone to accompany the recipient." Per DMA Administrative Letter No. 01-95, page 13, if suitable transportation is not available, and the appointment cannot be rescheduled, the DSS is not obligated to arrange transportation. On pages 20 and 21 of the DMA Administrative Letter No. 01-95, it is not written that the county is responsible for providing an attendant. Please explain how it becomes the county's responsibility to provide an attendant. As an example: we have a client that is receiving surgery. The surgery can be done inpatient or outpatient. As outpatient, an attendant is required. The client chooses to have outpatient surgery but is not able to get his own attendant. The surgery could be inpatient, but the client chooses not to be an inpatient and the doctor allows with the attendant stipulation. Is the county responsible for soliciting and contracting someone to be an attendant, out of county and overnight, for this client?

   It is the responsibility of the county DSS to assure medically related transportation for its Medicaid recipients. If it is necessary that the recipient have an attendant in order to be transported to a medical service, that is part of the requirement to assure transportation.

   It is unclear from the question why an overnight stay is required. However, it is likely that an outpatient surgery with an attendant is more cost effective than inpatient surgery.

2. When CAP in-home aides take patients to the doctor they have to go "off the clock" for CAP and the transportation at that point is the responsibility of DSS. The in-home aide agency continues to bill DSS at the $13.92 in-home aide rate even though Medicaid will only reimburse DSS for $5.15. The county has to pay the difference. The in-home aide agency bills not only for the transit time but also for the wait time. Our assumption is that CAP clients, by virtue of their physical/mental impairments, generally need an attendant while waiting and while talking to the doctor. Do we have to verify the need for an attendant for each client? If the wait time is not

Medicaid billable does the in-home aide agency have to separate out the wait time from the transit time? We would point out that to do so increases case management time as well as county expense.

Contact the CAP case manager to determine if an attendant is medically necessary. This is required for each client.

The Medicaid transportation policy does not prohibit paying for an attendant's waiting time for an outpatient visit. DMA Administrative Letter No. 01-95, V.C.2.c.(2) states that reimbursement may not be claimed for an attendant's salary to wait with a recipient who is a patient in a medical facility. By "medical facility" the policy is referring to some type of inpatient setting, e.g. an inpatient hospitalization.

The county DSS is not required to pay the in-home aide from the agency. It is free to find another attendant at a lower price. It must seek out the most cost-effective attendant that is appropriate to the recipient's needs. It then is reimbursed by Medicaid transportation for the non-county share that it had to pay for the attendant. Medicaid has not set a maximum price for this transportation service.

3. A Medicaid-eligible mother has three children and she claims that there is no one available to take care of them while she attends her doctor's visit. Would Medicaid pay the transportation costs for the three children?

   If no one can be found to care for the children, yes, Medicaid can pay for this transportation.

4. A two-year old Medicaid-eligible child needs to be seen by a doctor and his mother must go with him. His mother is wheelchair bound and is unable to perform certain tasks required to safely transport the child (e.g., securing the child in a car seat). An attendant is needed to help the mother. Would Medicaid pay the transportation costs for the child, mother and attendant?

   Yes.

5. A seriously ill child, who is a Medicaid recipient, is in the hospital. The child's doctor needs to consult with the child's parents on a course of care. It is not feasible to do this over the telephone, as the mother is deaf. Will Medicaid transportation cover transporting the parents to the hospital for this consultation?

   Yes.

6. What do we do when the parent wants to take all 5 or 6 of her children with her when there is another adult in the home who could keep them? Drivers are limited by the number of children they can accommodate in car seats simply by the size of the seats and the size of the vehicle.

   The DSS is responsible for assuring the most cost-effective transportation appropriate to the recipient's needs. In this situation, it is appropriate for the DSS to include in its evaluation whether or not the other adult in the home is capable and willing to care for the children. If the DSS determines that this other adult is capable and willing then it is under no obligation to transport the children. However, it cannot force an adult who is not capable or who is not willing to care for the children. Of course such a decision (as any other) can be appealed. If the other adult is not capable and willing to care for the children, you will have to arrange transportation that can accommodate the children. Remember, the cost of their transportation is reimbursable by Medicaid.

7. An unmarried couple, both in wheelchairs, request transportation to a regional medical facility for the Medicaid-eligible woman to have outpatient surgery. The man is considered as the woman's "companion" and can assist in listening to the doctor's instructions. Would Medicaid cover the cost of the man's transportation?

   Yes.

8. How do we determine medical necessity of an attendant? What is Medicaid reimbursable, time wise?

   To determine the medical necessity of an attendant, obtain the statement of the recipient's doctor. In the case of a CAP recipient, DSS may also accept the statement of the recipient's case manager. DSS can claim reimbursement for the time the attendant spends in the transport process, from the point the recipient is picked up until he is dropped off. If this is an outpatient visit reimbursement may also be claimed for the time the attendant spends at the outpatient provider with the recipient. If the recipient is admitted to an inpatient facility, reimbursement may not be claimed from the time he is admitted until he is discharged.

E. Recipient Cooperation Issues

1. When a recipient demands and/or uses an ugly tongue to the coordinator, what are DSS's options?

   The DSS should establish a county policy that includes warnings and counseling prior to refusing service.

2. Medicaid transportation assistance requires the use of the least expensive, most appropriate means of transportation assistance. If the transportation provider refuses to transport due to behavior, do we have to make other transportation arrangements? For example, there have been situations where the recipient refused to wear the seat belt that is a requirement of the transporter, or the recipient has been verbally abusive to the driver and/or other passengers. There has been a situation where a recipient owed the transporter money and the transporter refused to transport even though the recipient was not paying for the current trip. Assuming that this is the least expensive mode of transportation and it has been determined that it is suitable and appropriate for the recipient, does a more expensive mode of transportation have to be provided?

   In situations where the recipient has been abusive to the provider and/or passengers, if after warnings and counseling the recipient has persisted in the behavior and the transportation provider will not provide service, there is no obligation to provide transportation that is more expensive. It is recommended that the DSS and local transit system work together to develop compatible policies regarding abusive clients.

3. We need a State policy on "No-Shows!"

   It is the responsibility of the county DSS to develop its own transportation policies within the State guidelines set forth in DMA Administrative Letter No. 01-95 and addenda. Item IV.D.5.d. of the administrative letter provides guidelines for establishing a no-show policy. Basically, it calls for counseling the recipient, involving family members if available, restricting the recipient to a single mode or provider and after warnings and a series of failures to keep appointments, denying transportation. As with abusive clients, it is recommended that the DSS and the local transportation system work together to develop compatible policies regarding "No-Shows."

4. We have some clients who always have an "emergency" and they are driving the doctors and us crazy. Sometimes transportation is involved but not always. We need more detailed State policies and training on how to deal with these situations.

   We suggest that you work with the recipients' doctors, to determine if the requests are truly emergencies or if they are situations that can wait. If DSS documents that the recipient is consistently abusing the request for emergency transportation, attempt to counsel the recipient about this. Explain the problems it creates for the ability to effectively provide transportation for him and for all recipients. Carefully question the recipient about the nature of his condition to help him or her ascertain whether he in fact has an emergency. Additionally, check with the recipient's doctor to determine if he or she intends to see the recipient.

5. If all medical providers accepting Medicaid patients refuse to see the recipient due to non-compliance or outstanding debt, and the recipient then has to go out of county for medical services, is that person eligible for Medicaid transportation assistance? For example: dialysis patient discharged due to behavior. No other dialysis unit in the area will take the patient (same owner). Is Medicaid transportation required to transport to a facility at a significant distance when the recipient chooses not to follow the rules of the dialysis unit? This particular recipient is capable of understanding and following the rules and has received multiple verbal and written warnings prior to discharge.

   We reviewed this situation with the Centers for Medicare and Medicaid Services (CMS). Medicaid must continue to provide transportation in this instance, even if it means transporting out of the county. The requirement is to assure transportation to necessary medical care. The medical care is still necessary. Additionally, if the dialysis is not obtained, Medicaid costs will increase due to lack of treatment.

6. A Medicaid-eligible child with multiple health problems requires frequent visits to medical facilities, which are located 100 miles away. The mother has been told repeatedly (verbally and by written notice) that she must be pre-approved for trip cost reimbursement, prior to the appointments. Mother comes to the DSS in January and requests reimbursement for (documented) medical trips that were taken in September, October, November and December but were <u>not</u> pre-approved. She claims that a "friend" provided the transportation for each trip and is expecting to be paid. Is the DSS obligated to provide reimbursement?

   If the recipient's mother has been notified in writing that the trips require prior approval, the county does not have to pay for the transportation. We suggest that you meet with the mother to once again explain the policy and obtain her signature acknowledging that she understands she must request approval for the transportation in advance.

F. Driver Wait Time

Medicaid will only reimburse for the time a driver actually spends driving the recipient to and from medical care.

1. Who pays for driver wait time when transporting Medicaid recipients to medical facilities?

   If the driver's time is billed by the amount of time spent in transporting the recipient, Medicaid will not pay for the waiting time. It will be the responsibility of the driver or the entity for which he works. However, the transportation

provider may bill by the trip. In determining the per trip cost, it may figure in the cost of wait time. Medicaid can pay the amount billed for the trip.

2. A transportation provider transports a Medicaid-eligible recipient to a regional hospital 150 miles away for an outpatient surgery. Complications occur, which require the Medicaid recipient to be admitted as an inpatient overnight. It is late in the day when the decision is made to hospitalize the Medicaid recipient. Rather than drive 150 miles back to the county of origin and then drive back again the following morning to pick up the passenger, it would be more cost-efficient for the driver to spend the night in a local hotel. Would Medicaid pay the meals and lodging costs for the driver?

   We question how this would be cost effective for Medicaid. Medicaid only pays for the trip from pick up until drop off of the recipient. It does not pay for the return to headquarters and then the trip back to pick up the recipient. However, it is possible that meals could be paid for. See DMA Administrative Letter No. 1-95, V.C.4.a. for the State's rules for when meals may be paid. If the County has more liberal rules they may be used.

   Also refer to question M.8., which discusses paying for a recipient's overnight food and lodging

G. Ambulance Transportation

Medically necessary non-emergency transportation when there is no other suitable transportation is a covered service under Medicaid. The ambulance company files the claim through normal claims processing procedures. Neither the county DSS, adult care home, nor nursing facility is required to provide for ambulance transportation.

Also, see question C.2., above.

1. Our agency continues to have problems regarding Medicaid paying an ambulance bill when the trip is non-emergency but medically necessary and there is no other transportation. Example: A quadriplegic with skin grafts is not allowed to sit and has a letter from his doctor stating that he cannot sit up but must lie on side until skin grafts are healed. He needs ambulance transportation in order to go to the doctor yet there are problems in getting the bill paid, often denied. What must be done on the ambulance and DSS part to get the bill paid?

   The problem likely has to do with problems in the claim filed by the ambulance provider. If the claim is denied, the ambulance provider should contact EDS-Federal, Provider Services, to review the claim to see why it did not pay and

what they need to do for the claim to process properly. Additionally, the provider and the recipient both have the right to request a reconsideration of the claim denial.

2. Why can't ambulances be reimbursed when transporting individuals who are non-ambulatory due to amputations?

Non-emergency ambulance transportation is only covered if it is medically necessary that the person be transported by ambulance and that there is no other suitable means of transportation. Generally, this means they require stretcher transport. Many non-ambulatory individuals can be transported by wheelchair. In which case, ambulance transport is not the only suitable means of transportation. The person could also be transported by a van that accommodates wheelchairs. However, there are some non-ambulatory persons who cannot use a wheelchair and must be transported by stretcher. Medicaid would likely cover ambulance transportation for such persons. The provider may contact EDS-Federal, Provider Services, for assistance in documenting on the claim the requirement for ambulance transportation.

H. Other Issues Related to Transportation Appropriate to the Recipient's Needs

There are concerns regarding recipient's rights according to Americans with Disabilities Act and liability issues regarding the transportation system. Example: A Medicaid recipient weighing over 400-500 pounds presents an issue of getting the recipient on the lift safely. A recipient who is in a reclining wheelchair goes to dialysis and recipients who use the three wheel scooters are in a position that their chairs cannot be secured as safely as should be. Can they be denied transportation based on this unless they agree to provide and ride in an appropriate wheelchair that can be tied down securely?

There are several different issues here. The Federal Transit Administration (FTA), has issued a letter of interpretation stating that if a transit operator has a mandatory securement policy, or upon the request of a rider, the operator is required to use the securement system. Transit systems have the discretion to make wheelchair securement on buses/vans either mandatory or optional. If the transit operator has a policy that mandates the use of wheelchair securements, the transit operator may deny transportation to a wheelchair user who declines to permit his or her mobility device to be secured.

In this particular situation, the individual's wheelchair/scooter cannot be secured by the transit vehicle's existing restraint system. According to the DHHS Office of Civil Rights, the transportation system has an obligation to purchase an appropriate restraint system to meet the needs of the particular wheelchair/scooter. The transit provider cannot require the rider to use an alternative "mobility device." However, if

the purchase of the restraint system is cost-prohibitive and would cause major financial adjustments for the transit system to procure the apparatus, the system could claim <u>Undue Hardship</u> and, therefore, deny the trip.

All Community Transportation Program funded (lift-equipped) vehicles currently have the capacity of 800 pounds. According to ADA guidelines, the transit operator is allowed to refuse service, regardless of other qualifying functional limitations that the user may have if the combined weight of the mobility device and the user exceeds the weight limit set forth in the guidelines.

I. Use of Client Vehicle for Medically Related Transportation

1. The recipient has a vehicle that he uses for local appointments, but doesn't feel safe driving to out-of- town medical appointments. He is requesting transportation for out-of-town trips. Can we do this or does he have to drive his own vehicle?

   The county can use Medicaid transportation for this.

2. The recipient has a vehicle but states that it is not in working order. Do we accept her statement and for how long would we provide transportation using social service car service while waiting on the repair?

   It is your choice on whether or not to accept the recipient's statement. It is suggested that you accept it unless there is reason to doubt.

   If it is determined that the recipient's vehicle is in good working order and is being used for other similar trip purposes, the DSS should evaluate if it is more cost effective for the recipient to use his own vehicle for medical transportation than to use other methods for transportation, such as a county vehicle or other purchased service.

3. When is it appropriate to provide a gas voucher or mileage reimbursement to a recipient who has his or her own car?

   It is appropriate when the recipient has a working vehicle and it is the most cost effective means that safely meets the recipient's needs.

J. Transportation to Dialysis Centers

Dialysis continues to be a large issue without any way to really plan for a sudden increase in number of Medicaid dialysis recipients needing transportation. Is there any way that the dialysis centers could get transportation assistance like the nursing homes do to provide transportation?

Nursing facilities have a regulatory requirement to provide Medical transportation for their patients. No such requirement exists for dialysis centers. A dialysis center is enrolled in Medicaid to provide a very specialized service, dialysis. A nursing facility provides a much broader scope of services, caring for the day-to-day needs of the recipient.

Also, refer to question C.3. above.

K. Transportation to Dental Care

It is difficult for Medicaid recipients to find dental care. Often it requires transportation more than one county away. Wouldn't it make sense to have a dental fund that could pay a local dentist to do the work with the difference you spend in transportation costs having to go out of county for routine dental work?

The Division of Medical Assistance is working on the issue of access to dental care. Please refer to the Dear County Director of Social Services letter dated March 27, 2003. Dear County Director of Social Services letters may be found online at www.dhhs.state.nc.us/dma/dcdss.html.

L. Safety

During recent ice storms road conditions have been extremely treacherous. The DMA policy states that Medicaid recipients are entitled to transportation to the doctor. At some point the health and safety of the drivers and passengers must be considered. Is there some point when we can say that the weather is too bad to provide transportation?

It is our opinion that this is a call that you must make. It makes no sense to attempt to transport the recipient to medical care when it places his health and safety at risk as well as that of the driver. We have reviewed this with the Centers for Medicaid and Medicare Services (CMS) and they agree.

M. Administrative Issues

1. Does DSS need to approve each Medicaid trip? Can we give blanket approval during a given time period?

   DSS does not need to approve each individual trip for medical care. Policy allows for blanket approval for a period of time.

2. Is there a maximum of what a county pays out for Medicaid transportation? If Medicaid has to pay for transportation to doctors, then why do regular insurance companies not have to?

   There is no maximum of what may be paid for Medicaid transportation, except in the area of reimbursement to recipients for mileage, meals, and lodging. (Reimbursement to the recipient for mileage, meal, and lodging is limited to the higher of the state rates for state employees or the rates for county DSS employees.)

   Medicaid is not a private insurance company. It is a program to assist certain low-income individuals with medical expenses. One of the requirements in federal regulations is that Medicaid recipients be assured transportation. To our knowledge there is no such legal or regulatory requirement for private insurance companies.

3. A Medicaid recipient requires after-hours "emergency" transportation to a Medicaid covered service. Must the recipient sign an application for transportation and be assessed prior to the transportation being provided?

   A signed application for transportation is <u>not</u> required. DMA Administrative Letter No. 01-95, VI.C.1. states that transportation may be requested by phone. In emergency situations, an assessment may be completed after the fact. Item II.A.2. of the Administrative Letter allows for transportation when a need arises suddenly. Item IV.C. says that in an emergency medical situation, an assessment can be completed at a later date. This would include the request of transportation services after the fact.

4. Is it necessary to require a transportation driver to provide DSS with written documentation from the medical provider/facility stating that the Medicaid recipient actually received medical services for each Medicaid billed trip?

   Medicaid quality control reviews of medically related transportation have revealed that in many instances, recipients are being provided transportation paid by Medicaid, but not receiving a medical service. Medicaid may pay only for medically related transportation. To ensure that transportation was to provide a Medicaid covered service, the counties may require this.

5. Please explain why local transportation systems are not allowed to bill Medicaid directly.

   Only enrolled providers may file claims with Medicaid for covered medical services. Except for ambulance services, medical transportation is primarily an administrative function, and providers are not enrolled. As an administrative function transportation is the responsibility of the county DSS, which is the local administrator of the Medicaid program.

6. Could Title XIX (Medicaid) funds be used to support a "Mobility Manager" position at a local transportation system if the person is responsible for coordinating/arranging Medicaid transportation trips?

   If the county department of social services has contracted with the local transportation system to coordinate/arrange Medicaid trips, the staff time doing this could be reimbursed by Medicaid at 50%.

7. Can annual Medicaid transportation assessments via telephone be done for SSI recipients that do not have regular contact with DSS?

   Yes.

8. A transportation provider transports a Medicaid-eligible recipient to a regional hospital 150 miles away for an inpatient hospitalization. The driver drops the passenger off at the hospital and returns to the county of origin only to find out later in the evening that the passenger was not admitted. Rather than drive 150 miles back to the hospital (after hours – overtime pay) to pick up the passenger, it would be more cost-efficient for the passenger to spend the night in a local hotel. Would Medicaid pay the meals and lodging costs for the Medicaid-eligible recipient?

   If it is in fact cost-effective and the recipient is able to get to lodging and to meals, then Medicaid could pay meals and lodging. However, remember that Medicaid only pays from the time and point of pick-up to the time and point of drop-off. If the trip is billed by mileage and time for the driver, the mileage and time prior to pick-up and after drop-off is not Medicaid reimbursable.
   Also refer to question F.2., regarding paying for lodging and meals for a driver.

9. What is the plan to effectively communicate this information to the facilities, recipients, their families, local DSS, EMS, county and state officials and transit systems?

   It is DMA's intent to reissue transportation policy as soon as resources are available to work on it. The policy will be issued to the county DSS's and will be available online. In the interim these question and answers have been presented in the form of a "Dear County Director of Social Services Letter." It has been published on-line and the county DSS's notified of its publication.

   The county DSS's will be responsible for advising recipients of the policy. Additionally, we will share the material with other interested state agencies that can share with their local counterparts.

   Dear County Director of Social Services letters may be viewed online at www.dhhs.state.nc.us/dma/dcdss.html.

If you have any questions, please contact your Medicaid Program Representative.

/s/
Nina Yeager
Director

[This material was researched and written by Andy Wilson, Project Coordinator, Medicaid Eligibility Unit, DMA.)