MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

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Distribution: Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders, MI Choice Waiver Agents, Maternal Infant Health Program Providers, Medicaid Health Plans

Issued: February 1, 2017

Subject: Medicaid Provider Manual Chapter for Non-Emergency Medical Transportation (NEMT)

Effective: June 1, 2017

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild, MI Choice, Maternity Outpatient Medical Services

The purpose of this bulletin is to inform Michigan Department of Health and Human Services (MDHHS) local offices, NEMT contractor staff, NEMT providers, and all other NEMT authorizing parties of changes to Medicaid Fee-for-Service (FFS) transportation policy. Effective for dates of service on and after June 1, 2017, NEMT policy will be maintained in the Non-Emergency Medical Transportation chapter of the Medicaid Provider Manual. BAM 825 will no longer include up-to-date policy information for Medicaid FFS NEMT services.

The proposed policy applies to Medicaid FFS only. Medicaid Health Plans may develop their own requirements, which may differ from Medicaid FFS requirements. Providers, authorizing parties, and beneficiaries should contact the specific health plan for questions related to NEMT for managed care enrollees.

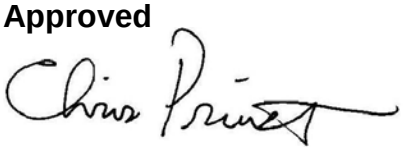
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Chris Priest, Director
Medical Services Administration

NON-EMERGENCY MEDICAL TRANSPORTATION

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SECTION 1 – INTRODUCTION

This chapter applies to non-emergency medical transportation (NEMT) providers and authorizing parties. The Medicaid NEMT benefit is covered for Medicaid, MIChild, and Healthy Michigan Plan (HMP) beneficiaries, and for Children's Special Health Care Services (CSHCS) beneficiaries who also have Medicaid coverage.

Federal law at 42 CFR 431.53 requires Medicaid to ensure necessary transportation for beneficiaries to and from services that Medicaid covers. The NEMT benefit must be administered to beneficiaries in an equitable and consistent manner.

Beneficiaries are assured free choice in selecting a Medicaid medical provider to render services. A beneficiary's free choice of medical provider selection does not require the Medicaid program to cover transportation beyond the standards of coverage described in this policy in order to meet a beneficiary's personal choice of medical provider.

Forms referenced in this chapter are accessible on MI Bridges or on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

SECTION 2 – COMMON TERMS

Authorizing Party	An affiliated entity of the Medicaid program (e.g., local MDHHS office or Medicaid-contracted transportation broker) responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.
Commercial Provider	A transportation provider who uses a motor vehicle that belongs to a company or corporation to provide transportation services to a beneficiary.
Daily Long Distance Trip	A daily trip that exceeds 50 miles one-way from the beneficiary's home.
Demand Response (Dial A Ride) Public Transportation	Public transportation characterized by the following: ▪ The vehicles do not operate over a fixed route or on a fixed schedule except, perhaps on a temporary basis to satisfy a special need, and ▪ Typically, the vehicle may be dispatched to pick up several passengers at different pick-up points before taking them to their respective destinations and may even be interrupted en route to these destinations to pick up other passengers.
Fixed Route Public Transportation	Services provided on a repetitive, fixed schedule basis along a specific route with vehicles stopping to pick up and deliver passengers to specific locations.
Individual With a Vested Interest	A transportation provider who is a relative or friend of a beneficiary and who has a personal stake or interest in the livelihood of a beneficiary.
Long-Term Care Resident	A beneficiary who resides in a Medicaid-certified nursing facility, county medical care facility, or hospital long-term care unit.
Medi-Van	A vehicle used to transport a beneficiary who is able to ambulate and transfer into and out of the vehicle, but requires door-to-door or curb-to-curb service due to their medical condition. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.
Medically Necessary Attendant	An individual, other than the driver of the vehicle or an individual with a vested interest, who assists a beneficiary, due to their physical, mental, or developmental status, on trips to and from a service or appointment that Medicaid covers.
Nonprofit Provider	A transportation provider who utilizes a motor vehicle that belongs to an entity that has been organized to carry out a charitable, educational, religious, or scientific purpose, and meets specific tax-exempt purposes to provide transportation services to a beneficiary.
Paratransit Transportation	Wheelchair-accessible, demand response services provided by public transportation agencies.
Prolonged Treatment	Medical treatment that is required to treat a medical condition which lasts more than 12 weeks.
Public Transportation Provider	An individual employed by a public entity that provides regular or special continuing transportation available for use by the general public. This does not include school bus, charter, or intercity bus or passenger rail transportation.
Transportation Provider	An individual (e.g., an employee of a public, commercial, or nonprofit transportation entity, volunteer driver, individual with a vested interest, or medically necessary attendant) who provides transportation services to beneficiaries.
Unloaded Mileage	Mileage traveled when the beneficiary is not in the vehicle.

Volunteer Driver	A transportation provider who utilizes their personal motor vehicle to provide NEMT services to a beneficiary. Volunteer drivers do not have a personal stake or interest in the livelihood of the beneficiary.
Waiting Time	The time that a vehicle is waiting at a Medicaid-enrolled provider's facility in order to transport the beneficiary to another location during the same trip.
Wheelchair Lift Equipped Vehicle	A vehicle that is equipped for a beneficiary who requires a wheelchair and that provides door-to-door service due to their inability to ambulate. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.

SECTION 3 – TRANSPORTATION AUTHORIZATION

Medicaid authorizes fee-for-service (FFS) NEMT services via local MDHHS offices, except in Wayne, Oakland, and Macomb counties. FFS transportation services in Wayne, Oakland, and Macomb counties are administered through a contracted transportation broker. (Refer to the Directory Appendix for transportation broker information.)

The Medicaid program contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs are responsible for providing NEMT services to their enrollees for all services covered under the managed care contract. (For additional information, refer to the Medicaid Health Plans chapter of this manual.)

MHPs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific health plan for further information regarding NEMT. Transportation services for managed care enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual

Reimbursement for medical transportation requires an initial verification of medical need by the beneficiary's primary care physician (PCP). An original, completed DHS-5330 (Medical Verification for Transportation) signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. The DHS-5330 must be completed annually. Verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services.

The authorizing party is responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.

The beneficiary's need for NEMT must be evaluated before services are authorized. This includes assessing all of the following:

- The beneficiary's eligibility;
- The transportation requested is for a service Medicaid covers; and
- The beneficiary has no other means of transportation available. Availability is not dependent on whether the beneficiary previously provided their own transportation.

SECTION 4 – TRANSPORTATION PROVIDER QUALIFICATIONS

Procedures must be in place to document and verify that vehicles used by providers meet the safety needs of the beneficiary including, but not limited to:

- Seatbelts and child safety seat requirements, if appropriate; and
- Functional heating and air conditioning.

4.1 VOLUNTEER DRIVERS

The minimum volunteer driver requirements are:

- 18 years of age and older;
- Cannot physically reside in the same household as the beneficiary;
- Must be able to read and communicate effectively in English;
- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Motor vehicle insurance;
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program.

4.2 INDIVIDUALS WITH A VESTED INTEREST

The minimum requirements for individuals with a vested interest are:

- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Motor vehicle insurance;
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program.

4.3 Commercial and Nonprofit Providers

The minimum requirements for commercial and nonprofit providers are:

- 18 years of age and older;
- Must be able to read and communicate effectively in English;
- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted drivers licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Maintenance of all necessary licensure and certification required by all transportation public laws, ordinances, and regulations applicable to the transportation provider, including any that may require liability insurance;
- Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended;
- Operation of vehicles that meet the safety and medical needs of the beneficiary;
- Compliant with any state or federal statutes applicable to commercial and nonprofit transportation providers;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

4.4 Public Transportation Providers

The minimum requirements for public transportation providers are:

- 18 years of age and older;
- Must be able to read and communicate effectively in English;
- Commercial Driver's License (CDL) if operating a vehicle having a gross vehicle weight of 26,001 pounds or more, or designed to transport 16 or more people (including driver);
- Compliant with Michigan state statutes: Michigan Motor Bus Transportation Act of 1990, as amended; Michigan Motor Carrier Safety Act of 1963, as amended; and Michigan Vehicle Code, as amended;
- Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended;
- Operation of vehicles that meet the safety and medical needs of the beneficiary;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

SECTION 5 – COVERED SERVICES

NEMT expenses, regardless of whether there is a corresponding medical claim on the date of service, may be covered for trips to and from:

- Treatment Medicaid covers (one-time or ongoing);
- Ancillary service providers (e.g., pharmacies, durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] providers) to obtain a service or item Medicaid covers;
- Medical care, treatment or services that have been prior authorized;
- Appointments to obtain medical evidence (for eligibility verification purposes only); and
- Facilities providing services Medicaid covers that do not charge for care.

Transportation from a service Medicaid covers is only covered when it is from the provider's location to the beneficiary's residence or to another service Medicaid covers. The least costly mode of transportation appropriate for the beneficiary's medical needs must be used.

Medicaid authorizes and reimburses transportation providers directly for the following NEMT services:

- Long-term lodging for approved transplant hospitals.
- Transportation to and from pregnancy-related services for Medicaid beneficiaries enrolled in the Maternity Outpatient Medical Services (MOMS) program.
- Transportation to and from day treatment provided by a Community Mental Health Services Program (CMHSP) (as part of its treatment package) for children enrolled in the Children's Waiver Program (CWP).

Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete, original MSA-4674 (Medical Transportation Statement) for all trip-associated costs to the authorizing party to receive reimbursement. NEMT reimbursement must reflect the total incurred cost to the transportation provider(s) and to the beneficiary, and must be verified with original, itemized, unaltered receipts. All receipts must be legible and attached to the MSA-4674.

In order to assure appropriate reimbursement for NEMT, MDHHS maintains a database of provider rates which is available on the MDHHS website. The database is reviewed and updated as applicable. (Refer to the Directory Appendix for website information.) NEMT providers must bill MDHHS the usual and customary fee charged to the public. If the public receives a service without charge, an NEMT provider cannot bill MDHHS for the same service.

5.1 MILEAGE

The Medicaid program covers the least-costly available mode of transportation suitable to the beneficiary's medical condition. The following modes of transportation are commonly utilized:

- Commercial and nonprofit transportation

- Fixed route, demand response and deviated route public transportation
- Volunteer drivers
- Individuals with a vested interest
- Beneficiaries providing their own NEMT in their personal vehicle

Volunteer drivers will not be reimbursed for driving a vehicle owned by the beneficiary or a member of the beneficiary's family.

When available, medical providers or entities that offer transportation or medical delivery services at no charge (e.g., prescription delivery services offered by the beneficiary's pharmacy) should be utilized.

Mileage is reimbursed according to transportation provider type at the appropriate rate as indicated on the MDHHS NEMT Database. Total round-trip mileage must be rounded up to the nearest mile and must be verifiable using an online mapping service or a Global Positioning System device.

5.2 MEALS

Authorized meals for beneficiaries, volunteer drivers, or individuals with a vested interest are reimbursed at cost or at the maximum allowable amount, whichever is less. To be entitled to meal reimbursement, one of the following must be met:

- For breakfast: The vehicle with the beneficiary must depart at, or before, 6:00 AM and must return at, or after, 8:30 AM
- For lunch: The vehicle with the beneficiary must depart at, or before, 11:30 AM and must return at, or after, 2:00 PM
- For dinner: The vehicle with the beneficiary must depart at, or before, 6:30 PM and must return at, or after, 8:00 PM

Meal reimbursement requires original, itemized, unaltered receipts which must include the business name, address, date, time, itemized list of items purchased with cost of each item. Bulk purchases of groceries and shared meals are not reimbursable. Meals must be purchased and consumed on the day and within the time of travel. Reimbursement for alcoholic beverages is not permitted. If a lodging reservation or other travel includes a complimentary breakfast or other meals, Medicaid does not provide any additional reimbursement for that meal.

5.3 FEES AND TOLLS

Travel-related fees and tolls (e.g., parking, toll road, and bridge fare) are reimbursed at actual cost and require original, unaltered receipts.

5.4 LODGING

Medically necessary overnight stays which include meals and lodging may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or individual with a vested interest) for no more than five consecutive nights. Medically necessary overnight stays beyond five nights require prior authorization (PA) from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.)

Medically necessary overnight stays which include meals and lodging at a Level IV Neonatal Intensive Care Unit (NICU) may be authorized for a beneficiary, and a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or individual with a vested interest) for no more than 14 nights. Necessary overnight stays at a Level IV NICU beyond 14 nights require PA from PRD.

Overnight stays which include meals and lodging ordered by a physician or required due to travel distance may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or individual with a vested interest). The least expensive, sufficiently maintained lodging available must be utilized. The availability of nonprofit accommodations (i.e., Ronald McDonald House or accommodations available through the visiting medical facility) must be explored before commercial lodging is considered. Lodging expenses are reimbursed at cost or the maximum allowable amount, whichever is less. Original, itemized, unaltered receipts are required. Reimbursement beyond an accommodation's suggested donation amount or per night rate, as charged to the public will not be made.

5.5 Special Allowances

Special allowances (i.e., wheelchair lift-equipped or Medi-Van vehicles, or medically necessary attendants) are reimbursed at the rate listed on the MDHHS NEMT Database. The beneficiary's physician must document the medical necessity of all special allowances on the DHS-5330.

5.5.A. Wheelchair Lift-Equipped Vehicles

Beneficiaries may be eligible for specialized NEMT provided by wheelchair lift equipped vehicles when at least one of the following conditions is met:

- Beneficiary is wheelchair dependent; or
- Beneficiary is medically dependent on life sustaining equipment which cannot be accommodated by standard transportation

Drivers of wheelchair lift equipped vehicles are expected to assist and escort the beneficiary.

5.5.B. Medi-Van Vehicles

Beneficiaries may be eligible for specialized NEMT provided by Medi-Van vehicles when they require door-to-door or curb-to-curb assistance. Drivers of Medi-Van vehicles are expected to assist and escort the beneficiary.

5.5.C. Medically Necessary Attendants

Beneficiaries may be eligible to receive assistance from one attendant in addition to the driver of a wheelchair lift equipped or Medi-Van vehicle. The attendant must be medically necessary due to the beneficiary's physical, mental, or developmental status. If more than one attendant is needed, prior authorization is required. For additional information, refer to the Prior Authorization (PA) section of this chapter.

SECTION 6 – MANAGED CARE PROGRAMS

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to beneficiaries. These entities are responsible for providing NEMT services to their enrollees for all services covered under their contract. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP or ICO for further information regarding NEMT for their beneficiary. Transportation services for these enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

If a beneficiary was admitted into an inpatient hospital setting prior to the date of enrollment into an MHP or ICO, that entity will not be responsible for the inpatient stay or any travel-related expenses (e.g., miles, meals, or lodging) incurred by the beneficiary or transportation provider until the beneficiary's date of discharge. This includes transportation expenses incurred as a result of the beneficiary's return trip from the hospital to their residence or other outpatient setting. The MHP or ICO will be responsible for all care, including travel expenses, from the date of discharge forward (excluding expenses incurred as result of the beneficiary's return trip to their residence).

For beneficiaries whose ICO or MHP enrollment status has changed, transportation may be authorized and reimbursed retroactively in the following situations:

- The beneficiary's Medicaid eligibility was made retroactive, and the beneficiary received NEMT during the retroactive eligibility time period; or
- Transportation was authorized while enrolled in an ICO or MHP, and then the beneficiary was disenrolled retroactively by the program, and enrolled into FFS.

SECTION 7 – PRIOR AUTHORIZATION (PA)

Transportation may require PA in certain situations. The PA request must be submitted in writing before the service is provided unless an urgent situation exists and the circumstances are documented. Payment authorization will not be given for PA requests submitted more than 30 days after the service is provided. The PA request, along with the DHS-5330, must be submitted to the PRD for review. (Refer to the Directory Appendix for contact information.)

Reimbursement for travel expenses related to the following situations requires PA:

- All travel to and from out-of-state/beyond borderland medical providers. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter of this manual for additional information);
- Transportation reimbursement requests for medical care outside a beneficiary's community when comparable care is available locally;
- Meals and lodging for overnight stays if the medical facility is within 50 miles of the beneficiary's residence;
- Meals and lodging for overnight stays beyond five nights unless the beneficiary is admitted to an approved children's hospital. (Refer to the MDHHS NEMT Database for additional information.);
- Necessary meals and lodging for overnight stays beyond 14 nights for a beneficiary who is admitted to an approved children's hospital;
- Prolonged treatment requiring multiple transports (PA may be requested for up to six months);
- Requests for advance payment of travel costs; and
- Travel expenses for two or more individuals with a vested interest or medically necessary attendants.

The PA request must include:

- Beneficiary name and Medicaid identification number
- Case number
- Beneficiary address
- Explanation of medical necessity of the services requiring PA
- Travel origin and destination
- Effective travel date(s)
- Diagnosis
- Name and telephone number of the individual requesting PA
- Documentation supporting the request

Based on the documentation submitted, the PA request is either approved, denied, or returned for more information. Authorizing parties are informed of the decision in writing, and a copy of the decision must be retained in the beneficiary's file. The authorizing party must then immediately inform the transportation provider and beneficiary of the approval or denial of the PA request. Approval of a PA does not guarantee beneficiary eligibility or payment. It is the authorizing party's responsibility to verify beneficiary eligibility for the date a service prior to NEMT services being rendered.

SECTION 8 – SPECIAL SITUATIONS

8.1 UNLOADED MILEAGE

Unloaded mileage incurred by commercial and nonprofit providers is not reimbursable by the Medicaid program.

8.2 MINORS TRAVELING ALONE

The following travel circumstances apply for minor (under 18 years of age) beneficiaries:

- Children under 12 years of age must be escorted to medically necessary appointments by a parent, foster parent, caregiver or legal guardian.
- For children between the ages of 12 and 18 years, a consent letter signed by a parent, foster parent, caregiver or legal guardian is required for a child to be transported without accompaniment unless access to the service does not require parental consent by the Medicaid program.

The above policy is waived for beneficiaries who have been emancipated or are seeking transportation for health care services for which a minor is legally able to consent (i.e., pregnancy-related, sexually transmitted/venereal disease, HIV/AIDS, substance use disorder, or outpatient CMHSP care).

8.3 MEDICAL REVIEW TEAM APPOINTMENTS

Transportation is a Medicaid-covered benefit and may be authorized for beneficiaries seeking financial or medical assistance due to a disability or blindness. Transportation is limited to one trip for examination and one trip per Disability Determination Services recommendation. A completed DHS-49-F (Medical – Social Questionnaire) serves as documentation and must be retained in the beneficiary's file.

SECTION 9 – REFERRALS

An NEMT referral is not considered a denial of transportation and, as such, a DHS-301 (Medical Transportation Notice) must not be issued when an NEMT referral is made.

The following circumstances are considered referrals:

- Referring a beneficiary to their MHP (for additional information, refer to the Managed Care Programs subsection of this chapter);
- Referring a beneficiary to the CMHSP; and
- Referring a beneficiary to medical providers who bill Medicaid directly for services (for additional information, refer to the Covered Services section of this chapter).

SECTION 10 – DENIALS AND BENEFICIARY APPEALS

Beneficiaries who have Medicaid coverage have a right to an administrative hearing when services have been denied, reduced, changed or terminated. When a request for NEMT is denied, a beneficiary will be notified with a written denial notice (DHS-301), provided by the authorizing party, which explains the reason for the negative action and informs the beneficiary of their right to appeal. The following requirements must also be met when a beneficiary is denied transportation services:

- The DHS-301 and postage-paid return envelope must be mailed to the beneficiary within one business day of the service being denied;
- A copy of the DHS-301 must be kept in the beneficiary's file and made available upon request; and
- An employee with knowledge of the denial must be available to testify at an administrative hearing, if required.

The beneficiary or beneficiary's authorized representative may request an administrative hearing. The Michigan Administrative Hearing System (MAHS) arranges and conducts the appeals process. Any questions regarding the appeal process should be directed to MAHS. (Refer to the Directory Appendix for contact information.)

SECTION 11 – NON-COVERED SERVICES

The following transportation services are not reimbursable:

- Waiting time;
- Trips that were provided prior to approval from the authorizing party;
- Multiple trips for a single Medicaid service;
- When a beneficiary failed to keep their appointment;
- Trips to and from services that are not covered (e.g., grocery store, non-Medicaid covered medical services);
- Routine medical care outside a beneficiary's community when comparable care is available locally, unless prior authorized;
- Transportation to and from services for individuals who have not met their spend-down;
- Expenses for services that have already occurred;
- Services for long-term care beneficiaries (refer to the Nursing Facility Coverages chapter of this manual for additional information regarding NEMT for long-term care beneficiaries); and
- Transportation for managed care program enrollees for services covered under the program contract (refer to the Managed Care Programs section of this chapter for additional information).