

State of Vermont

Agency of Human Services
Office of Vermont Health Access

Transportation Procedure Manual

Transportation Procedures Manual

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Section 1 Policy and Information

Introduction

Medicaid is a benefit assistance program started in 1966 to help individuals who are low-income, aged, blind, and disabled and families with children with the cost of medical care. It is funded with federal and state monies and administered by the State. Medicaid Transportation is a statewide service for providing transports for eligible people to and from necessary medical services.

This manual describes the criteria for determining if a Medicaid beneficiary is eligible for transportation benefits and is used by brokers to determine both eligibility for and provision of the least costly, most appropriate transportation for eligible Medicaid beneficiaries. This manual does not replace or supercede the Vermont Medicaid Provider Manual found at www.vtmedicaid.com or the Vermont Medicaid CMS 1500 Supplement, NPI Billing Instructions also found at www.vtmedicaid.com.

1.1 General Program Information

The Agency of Human Services (AHS) is charged with the administration of all human service programs. The AHS delegates operational responsibility for individual programs to various departments, offices, boards and councils under its auspices. The responsibility for the administration of the Medicaid program has been assigned to the Office of Vermont Health Access (OVHA).

The Office of Vermont Health Access (OVHA) is responsible for providing coverage and reimbursement for covered services to eligible beneficiaries. The OVHA defines covered services, authorizes providers for participation in Medicaid, contracts with a fiscal agent for claims processing, and authorizes non-routine medical care, processes non-routine claims and reviews medical service utilization by Medicaid providers and beneficiaries.

Transportation is a covered service for beneficiaries enrolled in traditional and PC Plus Medicaid and the Dr. Dynasaur programs and is provided through a Personal Services Contract between the OVHA and the Vermont Public Transportation Association (VPTA). VPTA's local public transit operators ("brokers") secure appropriate transportation using locally available carriers such as volunteer drivers, taxis, vans, buses, etc. Brokers are subject to service approval, claims processing and utilization review like any other Medicaid provider. The OVHA oversees and monitors Medicaid transportation, issuing policies and procedures to coincide with changing circumstances

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and directives. Additionally the OVHA is responsible for approval of various trips and exceptions as set forth within this manual.

1.1.1 Program Administration

The OVHA contracts with VPTA to provide statewide access to transportation services for eligible beneficiaries. The VPTA subcontracts with local public transit operators (“brokers”) to ensure statewide access. The brokers screen for eligibility, schedule transports to medical appointments/services and submit claims to Electronic Data Systems (EDS) for processing and payment. EDS processes the claims and sends the payment and all remittance advices (RA) to VPTA for account reconciliation. VPTA reconciles accounts and reimburses brokers for their services, manages data, reports on statewide utilization of services and oversees the approval process, authorizes all trips over 30 miles, including all out of state trips and/or arranges for out of area and out of state transports for specialized medical services.

This manual does not address administrative costs or service reimbursement, as those are negotiated on an annual basis.

1.1.2 Definitions

Beneficiary: Medicaid enrollee (or beneficiary) eligible for Medicaid transportation services.

Cancellation: The termination, withdrawal or revocation of a trip request by a beneficiary that occurs within the prescribed acceptable time period for such action. Twenty four hours (24) hours notice of cancellation is generally accepted. Acceptable cancellation time frames vary from 4:00PM on the day prior to an early morning departure (before 8:00am) to a minimum of two (2) hours prior to passenger pickup time in an emergency.

Counting Trips: A trip is counted each time a beneficiary enters a vehicle. This is based upon the FTA definition of one-way, unlinked passenger trips. For example, a round trip from a beneficiary’s home to a medical appointment and return home counts as two trips. There is no limit on the number of trips submitted electronically, as long as trips are listed by procedure code and date of service.

Emergency medical condition: The sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in:

- 1) placing the member's physical or mental health in serious jeopardy; or
- 2) serious impairment to bodily functions; or

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3) serious dysfunction of any bodily organ or part.

Emergency services: Health care items and services furnished or required to evaluate and treat an emergency medical condition.

Estimated Time of Arrival (ETA): ETA is the projected time that the vehicle shall pick up the passenger. Due to the nature of coordinating numerous trips on the same vehicle, an absolute pick up and drop-off time is not always possible to strictly uphold due to traffic, weather and passenger needs.

Hospital: A medical institution that provides acute care.

Medically necessary: Health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

- 1) help restore or maintain the beneficiary's health; or
- 2) prevent deterioration or palliate the beneficiary's condition; or
- 3) prevent a likely onset of a health problem or detect an incipient problem.

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

Multiple Riders (billing for): When more than one beneficiary uses the same transport, separate charges should be billed. Pro-rated costs (total standard fare) divided by the number of users) apply in all cases.

No Show: Beneficiary failure to show for a service (trip) provided in good faith. A "No Show" has occurred when the vehicle has arrived within the pick up window of the ETA, a valid cancellation of a trip request has not been made, and the rider has not boarded the vehicle within the specified wait time.

Personal Choice Driver: An individual who meets the definition of a volunteer driver except they are not provided through a broker, but rather the individual has been recruited to provide transportation for the beneficiary by the beneficiary or the beneficiary's guardian. In no case may a parent, natural or adopted, be reimbursed as a personal choice driver for a child less than 18 years of age. Foster parents may serve as personal choice drivers if the child is in the custody of the Department for Children and Families.

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Prior Authorization (PA): All transports must be prior authorized in order to qualify for reimbursement by the Vermont Medicaid Program. For transports within the state but over 30 miles from the beneficiary's place of residence, prior authorization must be approved by the VPTA and retained in the broker's records. For transports out of state, the request must be submitted by the physician directly to OVHA for prior authorization. The only exceptions to this requirement are:

- 1) If a beneficiary was granted retroactive Medicaid eligibility and the beneficiary qualified for the Hardship Program.
- 2) If a beneficiary was granted retroactive Medicaid eligibility and had transportation expenses from the newly covered time period that had not been paid but met all of the criteria for Medicaid transportation eligibility in Section 2.

Reinstatement: Return of service privileges to the beneficiary after suspension.

Suspension: A period of time during which beneficiary does not have access to broker arranged transportation.

Unavailable Vehicle: A vehicle is considered unavailable, on the day needed, if:

- 1) the vehicle is not operating; or
- 2) the vehicle is not registered; or
- 3) the vehicle is not insured; or
- 4) there are no licensed drivers in household; or
- 5) there is no one in the household capable of driving the vehicle; or
- 6) the vehicle is being used for work purposes and
- 7) the wage earner is not able to take time off of work for the medical appointment,
- 8) the appointment cannot be scheduled around the wage earner's working hours; or
- 9) the wage earner works at such a distance that they are not able to be dropped off and picked up at work so that the vehicle may be used for the transport to a medical appointment.

If the beneficiary/family owns a vehicle that is unavailable according to the above criteria, they must complete and sign a form declaring the vehicle unavailable, which must be maintained on file with the broker and be updated by the beneficiary on a quarterly basis.

Volunteer driver: A driver provided through a broker who does not reside in the same physical household as the Medicaid beneficiary and who provides the vehicle for transport; or a driver provided through a broker who resides in the same physical household as the Medicaid beneficiary, is not related to the Medicaid beneficiary, and provides the vehicle for transport. In no case will a volunteer driver be reimbursed for driving a vehicle owned by the Medicaid beneficiary or a member of the Medicaid beneficiary's family, except in cases

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where reimbursement is provided under the Hardship Mileage Reimbursement Program. In no case may a parent, natural or adopted, be reimbursed as a volunteer driver for a child less than 18 years of age. Foster parents may serve as volunteer drivers if the child is in the custody of the Department for Children and Families. Court-appointed (non-parent) legal guardians for children under 18 years old are considered volunteer drivers. Court-appointed legal guardians for adults 18 and older are considered volunteer drivers.

Volunteer driver mileage:

A volunteer carrier/personal choice driver bills for mileage from the time the vehicle leaves its home base until it returns; mileage is not limited to miles driven while the beneficiary is in the vehicle/being transported.

If a volunteer/personal choice driver is asked to wait while a beneficiary keeps a medical appointment, he or she may bill for extra mileage as follows:

- 1) Drivers will be paid for wait-times in excess of one (1) hour calculated in half-hour increments after the first full hour. For example, when a volunteer driver must wait 1½ hours, he or she will be paid additional mileage for ½ hour.
- 2) Wait-time mileage is calculated at 17 miles per hour based on the current GSA rate reimbursement rate per mile.
- 3) Drivers are paid either mileage back to their home or wait-time mileage, whichever is lower. However, if the driver is called back by the broker to make another, separate transport during what otherwise would have been a wait-time period, the driver will under those circumstances, be paid at the higher rate for actual mileage.

Wait Time: The amount of time that a vehicle remains at the pick up site. The driver, in cooperation with the dispatcher, should provide adequate and reasonable wait time for the passenger. Reasonable accommodations such as additional wait time are provided for individuals with special circumstances. The driver should be made aware of persons with disabilities who need special notification and/or consideration.

The standard wait time is five (5) minutes for a public transit vehicles (van/bus) and ten (10) minutes for a volunteer car or taxi after scheduled or actual arrival time whichever is later.

Wait time during a beneficiary appointment is also covered under volunteer mileage above.

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1.1.3 Abbreviations

AAG	Assistant Attorney General
AHS	Agency of Human Services
CFC	Choices for Care (1115 Long Term Care Medicaid Waiver) Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare/Medicaid Services
DAIL	Department of Disabilities, Aging & Independent Living
DCF	Department for Children and Families
DHRS	Day Health Rehabilitation Services
DMH	Department of Mental Health
EDS	Electronic Data Systems, Inc.
HIPAA	Health Information Portability and Accountability Act of 1996
OADAP	Office of Alcohol & Drug Abuse Programs
OVHA	Office of Vermont Health Access
PC+	Primary Care Plus (State Managed Care Plan)
VHAP	Vermont Health Access Plan
VPTA	Vermont Public Transportation Association

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Section 2 Transportation Eligibility

2.1 Medicaid Transportation Eligibility

To be eligible for transportation services, beneficiaries must first be enrolled in one of the following programs:

- Traditional, fee-for-service Medicaid
- Primary Care Plus (PC Plus) managed care Medicaid
- Dr. Dynasaur

Beneficiaries of the following programs are not eligible for transportation benefit:

- VHAP-Limited
- VHAP PC Plus
- Pharmacy programs
- Catamount Health
- Employer-Sponsored Insurance (ESI)

In addition to the requirement that an individual must be enrolled in an eligible program, a request for beneficiary transport must meet all of the following conditions:

- Transportation is not otherwise available.
- The transport is to a necessary medical service.
- The appointment for the medical service can be verified.
- The health care practitioner is recognized by the Vermont Medicaid Program.
- The health care practitioner is the closest provider that is utilized by and generally available to members of the beneficiary's community. **Exceptions to this provision may be granted if the beneficiary has a proven existing relationship with a provider.**
- The mode/means of transportation is the least-costly and most appropriate to the beneficiary's medical condition.

There may exist situations where Medicaid will pay for transportation for a beneficiary to a service that is not a normal covered service under current Medicaid guidelines. These situations will be dealt with on a case-by-case basis.

2.1.1. Transportation Not Otherwise Available

Transportation is not otherwise available to a beneficiary if any of the following conditions is met:

- The beneficiary or beneficiary's family does not own an appropriate vehicle.
- The beneficiary or beneficiary's family owns an appropriate vehicle but the vehicle is unavailable as defined above.

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- The beneficiary cannot obtain the trip from any public transit system or broker or other organization using transportation programs funded by sources other than Medicaid. Examples of such programs are:
 - a) Long term Care providers supplying patient transportation (unless the patient receives Level 3 residential care)
 - b) substance abuse treatment programs that supply transportation to their participants
 - c) churches that provide transportation to members
 - d) hospital social service departments with lists of programs that provide free transportation
 - e) organizations that provide transportation to the general public for free

2.1.2 Medical Appointment/Medical Service

Medicaid transports eligible beneficiaries to and from necessary medical appointments/medical services. The medical appointment/service must be with or provided by a health care provider eligible to enroll in the Vermont Medicaid Program. In addition, the medical service must be recognized by the Vermont Medicaid Program as a covered medical service. As long as the medical service is recognized by the Vermont Medicaid Program for any category of Medicaid beneficiary, transportation may be provided to the service for any eligible beneficiary.

2.1.2.1 Recognized Health Care Providers

The following health care provider types are recognized by the Vermont Medicaid Program:

- Chiropractors
- Dentists
- Ophthalmologists
- Optometrists
- Physicians
- Podiatrists
- Licensed Master's and Doctorate-level Psychologists and Social Workers
- Certified Nurse Midwives
- Lay Midwives
- Physical Therapists
- Occupational Therapists
- Speech Language Pathologists
- Orthodontists
- Oral Surgeons
- Licensed Marriage and Family Therapists

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Generally, if the examination or treatment is covered by Medicaid and other necessary conditions have been met, such as referral from the Primary Care Provider (PCP) or psychiatrist then Medicaid covers transportation.

To find out which service entity is a Medicaid Provider, refer to the EDS "Provider List" given out periodically by OVHA. The list may also be found at the following web-site: www.vtmedicaid.com. Free clinics, such as WIC, are generally exempt from this rule if necessary medical services are provided. Usually, the local Health Department will refer beneficiaries for allowable trips. However, trips to fill out forms or pick up benefits apart from a medical service are not covered. When transporting to and from free clinics, brokers should try to ensure that such clinics are actually medical in nature. Examples of free or other exempt services for which Medicaid **will** provide transportation include:

- When the service would normally be covered by Medicaid but is free (such as flu shots).
- When beneficiaries have exceeded the dollar-cap for a covered service but have agreed to pay for additional medical/dental care themselves.

2.1.2.2 Examples of Services Eligible for Transports

Services that Medicaid will provide transportation for include, but are not limited to:

- Abortions – if out-of-area, a doctor's letter or Physician's Referral Form (Appendix B-1a) is required stating that the facility is the closest that will provide the service.
- Care Coordination visits – meetings with OVHA's Care Coordinators (nurse or social worker) at their office location.
- Childbirth Education Classes – if not a Lamaze class, prior authorization is required from VPTA or OVHA.
- Contraceptives – Medicaid will transport to pick up contraceptives.
- Fair Hearings – Medicaid covers beneficiary transport to and from fair hearings (see Section 3.3.6.3).
- Hearing Aids – Medicaid will cover transportation for beneficiaries to have their hearing tested or to have hearing aids repaired.
- Individuals accompanying the beneficiary to appointments – a spouse, a civil union partner or parent do not need a letter to accompany a beneficiary within his or her area.
- OBGYN, Greenfield, MA – is considered part of the Brattleboro area for obstetrical and gynecological care.
- Parents in Distress – a group therapy, family-counseling program in the White River Junction area.
- Sex Offenders' Group Therapy – if a licensed psychiatrist or psychologist leads or directly supervises the group.

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- Therapists – if licensed psychiatrists or directly supervised by a licensed psychiatrist.
- Well Child Clinics – only if no other means of transportation is available.
- WIC Clinics – restricted to trips where the beneficiary will receive a medical service.

Trips to fill out paperwork or pick up benefits are not covered.

2.1.2.2 Examples of Services Ineligible for Transports

The Medicaid transportation program will not provide transportation to self-directed activities or to any activity, program or service that cannot be directly billed to Vermont Medicaid or is not directly provided by an eligible health care provider.

Examples of transport situations which are not considered to be necessary medical services include, but are not limited to trips, to or from:

- Services required by a child's Individualized Educational Plan (IEP)
- Self-directed activities
- Smoking cessation workshops and programs, including hypnosis
- A pharmacy for non-medical items
- Horse-riding therapy
- Experimental treatments where a control-group is used or clinical trials
- Visiting sick friends or relatives
- DCF District Offices to report changes or for reviews
- Alcoholics Anonymous or other 12-step meetings
- Vermont Association for the Blind meetings
- Local Food Shelves
- WIC programs to obtain benefits
- Meetings with school counselors
- Daycare facilities (children)
- Summer Camps/Schools
- School tutoring/After school programs
- Gyms/exercise facilities
- Public or private pools for swimming
- Homeless shelters
- Civic organizations (American Legion, Lions, Elks, etc)
- Parenting classes (with the exception of child birth classes)
- Grocery/department stores (without pharmacies)
- Trip to a healthcare provider's office solely to obtain medical records
- Anger Management Classes
- Support Groups – battered women, cancer, Alcoholics Anonymous, etc.

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- University of Vermont (UVM) Substance Abuse Treatment Center in Burlington

2.1.3. Generally Available to and Used by Others

Medicaid transports eligible beneficiaries to the health care provider/medical service generally available to and used by other members of the community or locality in which the beneficiary is located. A beneficiary's freedom of access to health care **does not require** Medicaid to cover transportation at unusual or exceptional cost in order to meet a beneficiary's personal choice of provider.

Requests for transports more than 30 miles require a written referral completed by the beneficiary's primary care physician (PCP). If the beneficiary does not have a PCP, a psychiatrist may complete the referral for mental health transports or the referral may be completed by the physician treating the beneficiary for the condition requiring the referral.

Requests for transports to out-of-state non-border facilities require a completed, written referral from the PCP or the physician (as described above). Referrals should be received by the local transportation broker two weeks in advance of the medical appointment whenever possible. See Section 4.2 of this Manual for special procedures relating to requests for out of state transportation.

2.1.4. Least Costly Mode of Transportation

Transportation brokers arrange beneficiary transports based on the medical needs of the beneficiary and the least costly mode and manner for transport. Medicaid is not required to provide transportation at unusual or exceptional cost to meet a beneficiary's choice of providers or preference in transportation mode. In addition, if the beneficiary refuses to use the transportation provided by Medicaid or renders himself /herself unable to use it, Medicaid is not required to incur exceptional costs to transport the beneficiary.

The following modes/manners of transportation are commonly used:

- Free fixed-route public transportation
- Fixed and deviated route bus tokens or fares
- Monthly bus pass
- Volunteer driver trip (may have multiple riders)
- Taxi (may have multiple riders)
- Demand response public transport vehicle

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Section 3 Transportation Brokers

Brokers are responsible for arranging and securing transportation in their areas/towns for eligible Medicaid beneficiaries who do not have transportation of their own and know of no one else who can provide it.

Brokers must provide the least expensive means of transportation possible that will meet the beneficiary's medical needs. However, transportation must be assured to medically necessary services.

Since the least expensive means of transportation must be used when possible, brokers must establish and maintain a list of available carriers ranging from volunteer drivers to professional transportation carriers (buses, taxis, etc.). Social service and community organizations offering transportation for a variety of reasons may serve as sources of information for listings.

Transportation must be provided at no cost to the Medicaid beneficiary. Medicaid Policy M-154 states: "A provider must accept as payment in full the amounts paid in accordance with the fee schedule established by Medicaid". Accordingly, brokers are strictly prohibited from allowing transportation carriers to impose additional transportation charges on Medicaid beneficiaries for trips paid for by Medicaid.

Requests for Medicaid transportation must be submitted to the brokers with as much advance notice as possible, but with a minimum notice of 2 days (48 hours). Brokers will attempt to accommodate requests with as little notice as 24 hours whenever possible.

When brokers provide the driver, the broker must establish that the driver is appropriately licensed and insured and that the vehicle is inspected and insured. Whenever possible, trips should originate in the vicinity where the beneficiary resides. Beneficiaries will be returned to their residence or a drop off point at a shorter distance than their residence, but only at the beneficiary's request.

Brokers are contacted directly by Medicaid beneficiaries or by organizations acting on their behalf. These include the Department for Families and Children, the Vermont Department of Health, community mental health clinics, hospital social services, the Office of Alcohol and Drug Abuse, the Department of Disabilities, Aging, and Independent Living, Area Agencies/Councils on Aging, other state and public offices.

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3.1 Information Required for Transport

The broker must register calls received in an ongoing log. Initially, the broker lists available information, with the balance of information filled in as the request is processed. The log should provide space for the:

- 1) Date and time of the call
- 2) Beneficiary name, address, and Medicaid number
- 3) Beneficiary status as a Medicaid beneficiary
- 4) Name of the health care provider
- 5) Town in which medical appointment/service is located
- 6) Date and time medical appointment/service
- 7) Whether or not the request is ultimately granted
- 8) Whether or not the transport was made
- 9) If this was a last minute transport request, what resources/organizations were contacted to meet this need and how was this situation resolved (church transported beneficiary, public health nurse transported beneficiary, hired a taxi for the transport, etc)
- 10) Any unusual situations that may have occurred during the transport (driver was late, beneficiary was late, accident occurred during transport, beneficiary was not at home/medical facility to be picked up at appointed time, etc)
- 11) If out-of-state transportation for the service/stay was authorized by VPTA before the transport occurred.

3.1.2 Verification of Medicaid Eligibility

Brokers must verify a beneficiary's Medicaid eligibility by:

- 1) Checking the beneficiary eligibility via the Medicaid internet portal;
- 2) Entering the beneficiary's Medicaid number in the EDS swipe machine; or
- 3) Calling the EDS Voice Information Service at 1-800-925-1706 and entering the appropriate information, or
- 4) By using the PES software and entering the appropriate information. PES software is free and available for downloading at www.vtmedicaid.com

3.1.3 Verification of Transportation Program Eligibility

After verifying a beneficiary's Medicaid/Dr. Dynasaur eligibility a broker must:

- 1) Verify that transportation is not otherwise available to the beneficiary/family
- 2) Verify the trip is to a medical service/appointment
- 3) Verify the service/ appointment is provided by a health care practitioner recognized by the Medicaid program

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- 4) Verify this provider is the closest to provide the service – **although exceptions to this provision may be granted if the beneficiary has a proven existing relationship with a provider.**
- 5) Determine the least costly mode/means of transportation for the beneficiary's medical condition
- 6) Schedule and provide the transport

If the appointment is not an emergency, the broker may ask that it be rescheduled to assure transport or to provide the least expensive means.

If a broker opts to verify after transporting it must be indicated on their ongoing log that they verified requirements after transportation was provided.

If a broker transports a beneficiary and chooses not to verify eligibility, the validity of medical appointment/service; etc, the broker absorbs the costs of the transport.

3.2 Confidentiality, Disclosure of Information

When requesting transportation, the beneficiary must give the broker the name of the provider and the date and time of the medical appointment. This information is necessary to confirm the appointment date and time and for audit purposes. Refusal to provide the broker with information essential to the transport will result in a denial for the requested transport.

Federal and state law prohibits a broker from disclosing confidential beneficiary information to a third party, except when:

- 1) The beneficiary specifically asks a third party to intervene on his/her behalf and/or specifically consents to releasing information to a third party.
- 2) The information is directly related to the administration of transportation as a Medicaid covered service.
- 3) The information is requested by other departments within the Agency of Human Services for legitimate program purposes.
- 4) A law enforcement officer requests the current address of a beneficiary who is a fugitive felon.
- 5) The disclosure is pursuant to a court order or otherwise required by law.

If brokers have any questions about the disclosure of information, contact VPTA or the OVHA rather than risk a breach in confidentiality.

3.3 Community Resources for Transportation

Brokers must determine if transportation is needed and should be knowledgeable of and review services available in the community or available at no cost to Medicaid. Medicaid

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will reimburse transportation only when it is not otherwise available to the beneficiary, as described above in this Manual. Medicaid will not pay for transportation if the beneficiary could have been transported for free or if the transportation was unnecessary – reasonable efforts to locate other means of transportation should be exercised. Situations where transportation is either unnecessary or free include transports:

- 1) In the beneficiary's own vehicle (if not eligible for hardship mileage);
- 2) That could be provided by family members or friends;
- 3) That are unnecessary because the medical provider supplies services in the home (pharmacies that deliver, etc.);
- 4) Provided by brokers using programs funded by sources other than Medicaid;
- 5) Provided by other organizations, such as:
- 6) Long Term Care (LTC) providers supplying patient transportation (unless the patient receives Level 3 residential care);
- 7) Office of Alcohol and Drug Abuse Program (OADAP) providers that supply transportation to and from their programs (see Appendix C.4);
- 8) Churches that provide transportation to members;
- 9) Hospital social service departments with lists of programs that provide free transportation under certain conditions;

3.3.1 Service Available within the Beneficiary's Community

Medicaid transports eligible beneficiaries to the health care provider/medical service generally available to and used by other members of the community or locality in which the beneficiary is located. A beneficiary's freedom of access to health care **does not require** Medicaid to cover transportation at unusual or exceptional cost in order to meet a beneficiary's personal choice of provider.

Brokers must first distinguish between services for goods (for example, items provided by pharmacists and durable medical equipment suppliers), and treatment services such as physicians and other licensed practitioners provide.

For goods, transportation is limited to the nearest available pharmacy or durable medical equipment provider.

For treatment services, "services available within the beneficiary's community" consist of any medical service within 30 miles of the beneficiary's residence. If the closest available service is beyond 30 miles, then brokers may transport to the service nearest the beneficiary's residence (see Section 3.1.3).

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3.3.2 Distance Limitations

Medicaid transportation to and from medically necessary services is provided when no other transportation is available to the beneficiary and when the "medical service is generally available to and used by other members of the community or locality in which the beneficiary is located."

If the trip is for a medically necessary, non-hospital, non-specialized service, transportation is allowed to any site within 30 miles of the beneficiary's residence. Reasonable flexibility is allowed for broker discretion regarding the 30-mile limit. That is, if the trip is 31 or 33 miles (or whatever is reasonable considering the geographical location of services within the beneficiary area), then brokers may transport without OVHA approval. Most circumstances should be covered by obtaining or filling out a PCP referral letter or Physician's Referral, subject to the following exceptions:

If the closest medical office or facility is further than 30 miles from the beneficiary's home, then brokers may transport to the closest facility.

- 1) For family or primary physician care when a beneficiary moves to a new city or town and must travel beyond the 30-mile limit, brokers may transport to the beneficiary's still current doctor for not more than 60 days from the date of the first request to go beyond the limit. Brokers should inform beneficiaries that if they expect transportation assistance to continue, they must enroll with a doctor within the 30-mile limit or closest to the new residence.
- 2) Traditional Medicaid beneficiaries will still be transported to specialists beyond the 30-mile limit if the PCP, psychiatrist or treating physician confirms medical necessity in a letter or Physician's Referral Form. PC+ enrollees are transported to any service or facility authorized for the specific beneficiary and for which the beneficiary has a referral.
- 3) A beneficiary with Medicaid secondary is allowed to have the physician making the referral to the specialist complete the transportation referral form.
- 4) Other exceptions may be granted by OVHA for good cause shown, such as unique medical conditions. Brokers should contact VPTA at (802) 296-2143 or the OVHA (802) 879-5900 when VPTA staff cannot be reached.
- 5) Special procedures apply if a beneficiary requests transportation out of state. See Section 4.2.

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Section 4 Special Circumstances and Procedures

4.1 After-Hours Transportation

Sometimes, a beneficiary is in need of unscheduled transportation outside of normal office hours. Unscheduled transportation outside of normal business hours is limited to transports from a hospital to facilitate discharge. Brokers must develop and maintain mechanisms to accommodate such situations.

The transport is Medicaid-covered if the:

- a) broker verifies beneficiary Medicaid eligibility, and
- b) the trip originates from a health care facility utilized for treating emergency medical conditions (hospital emergency room), and
- c) the trip from the health care facility to the beneficiary's home is necessary to facilitate the beneficiary's discharge from the health care facility.
- d) A trip to/from a hospital emergency room is made by an individual using their own vehicle and the trip is reported to the broker within 48 hours of occurring. The trip is potentially eligible for hardship reimbursement, if all other conditions for eligibility are met.

At no time is a broker expected to provide a volunteer or employee to transport a beneficiary in an emergency situation to a health care facility, taking the place of an ambulance.

4.2 Out-of-State Trips Requiring Overnight Lodging and Meals

A. Longer-Distance Out-of-State Trips

To receive transportation benefits to longer-distance out-of-state facilities, the transports must meet the criteria outlined in Section 2 Medicaid Transportation Eligibility. In addition, these particular out-of-state trips must be prior authorized by the OVHA or they will be denied Medicaid payment.

Before a broker can arrange transport for this out-of-state treatment, an "Out-of-State Medicaid Transportation Physician Referral Form" must be sent from the primary care physician, psychiatrist or treating physician directly to OVHA. This form collects the following HIPAA-sensitive information:

If the transportation is requested in order to obtain a particular type of medical service:

- what is the precise medical service that will be delivered at the destination?
- is this service medically necessary? if so, why?

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- is this service obtainable in Vermont? if your answer is no, what efforts have been made to determine whether it is obtainable in Vermont?

If the transportation is requested in order to obtain a particular type of medical expertise:

- does the medical provider whom the patient will visit possess special expertise with regard to this patient or this patient's medical condition? if so, what is the precise nature of this expertise?
- is it medically necessary for the patient to be treated by a provider with this special expertise?
- is such expertise obtainable in Vermont? if your answer is no, what efforts have been made to determine whether it is obtainable in Vermont?

If the transportation is requested in order to maintain continuity of care:

- what is the patient's history with the provider - duration, condition(s) under treatment, nature of treatment(s)?
- is it medically necessary for the patient to be treated by this particular provider rather than another similarly qualified provider? if so, why?

Brokers/VPTA must obtain trip-approval for outpatient out-of-state appointments from the OVHA. The OVHA will review the referral form and decide whether to grant authorization, including any associated overnight lodging and/or meal reimbursement, or deny the request. OVHA will apply the same principles to requests for out of state overnight lodging and meal reimbursements as are described below for in-state travel.

When beneficiaries are authorized to stay out of state overnight in conjunction with approved travel, the broker or VPTA must arrange for the least expensive, appropriate lodging available. If a beneficiary declines broker-arranged lodging, then the beneficiary must pay for the lodging with no reimbursement from Medicaid.

If the broker or VPTA learns of any improprieties resulting from any of approved overnight lodging, such information should be relayed to the OVHA immediately.

B. In-State Out-of -Area Transports That May Require Overnight Lodging and Meal Reimbursement

VPTA will review all requests for transports beyond 30 miles that may require in-state overnight lodging and meal reimbursement. In such cases, VPTA will either authorize/deny the request or contact OVHA for assistance.

When beneficiaries are authorized to stay overnight in conjunction with approved travel, the broker must arrange for the least expensive, appropriate lodging available. If a beneficiary declines broker-arranged lodging, then the beneficiary must pay for the lodging with no reimbursement from Medicaid.

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When possible, VPTA should arrange and pay the lodging expenses directly to the facility providing lodging to the beneficiary. If this is not possible, arrangements should be made to have the bill sent directly to the broker or to reimburse the beneficiary, upon the submission of approved trip receipts.

Reimbursement of meal expenses are not authorized, unless VPTA authorizes an overnight stay. Enroute meals are also not a reimbursable expense. If overnight lodging is less expensive than multiple trips, beneficiaries may also be reimbursed for meals falling within the trip's timeframe. Meal claims must be accompanied by dated receipts and are reimbursed at cost up to \$5.00 per person per meal. Meals are only authorized for the beneficiary seeking medical treatment and for the individual(s) necessary for that treatment to occur. Lodging and meals for additional individuals, not necessary for the medical services to occur will not be authorized.

If there is more than one person seeking meal reimbursement, a letter or "Medicaid Transportation Physician Referral Form" must be obtained from the beneficiary's Primary Care Physician (PCP) or psychiatrist stating the medical need for additional people to accompany the beneficiary. For example, if a child is hospitalized and the provider states the medical need for both parents to accompany the child, then lodging and meal reimbursement is approved for both parents. The broker may determine the method for delivering the reimbursement to the beneficiary, according to the broker's policy.

4.3 Child Transports

Any biological or adoptive parent is responsible for transport when he or she has an appropriate vehicle. Some child transports may be eligible for "hardship" mileage reimbursement when personal vehicles are used.

Foster parents whose foster children are in DCF custody are considered volunteer drivers and will be reimbursed at the volunteer mileage rate, for all of the transports to medical services they provide to children placed in their care by the DCF.

Foster parents must request reimbursement for the following transports from their foster child's caseworker:

- 1) Transportation to and from hospitals for visits with their foster child(ren).
- 2) Transportation to and from special trainings on medical conditions, to help support the care of their foster child(ren).
- 3) Transportation to and from any facilities to support the foster child's family reunification plan.

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Court-appointed (non-parent) legal guardians for children under 18 years old are considered volunteer drivers.

If a transportation broker is not comfortable providing transportation to a minor who is to be transported alone, the broker may request that an adult accompany that minor for the transport to be provided.

4.4 Court-Ordered Services

If a beneficiary is mandated by a court to attend a service such as counseling or other form of therapy:

- If the service meets Medicaid guidelines, Medicaid covers the transport.
- If the service is outside the normal distance limit but is offered by an OADAP provider, Medicaid covers the transport.
- If the service is outside the normal distance limit and is not offered by an OADAP provider, the broker must obtain approval from OVHA before transporting.

4.5 Adult Day Services

Persons receiving adult day services are eligible for Medicaid Transportation to and from the adult day center – as long as all other Medicaid Transportation requirements are met. To verify eligibility for transportation for this service, brokers must obtain documentation from the requesting Adult Day Service provider which includes the Department of Disabilities, Aging, and Independent Living's Choices for Care Waiver Service Plan approved and signed by DAIL personnel. The plan will indicate the Adult Day Service provider approved to provide services and the number of hours every two weeks the Medicaid beneficiary is approved to receive this service.

4.6 Day Health Rehabilitation Services (DHRS)

Persons receiving day health rehabilitation services are eligible for Medicaid transportation to and from the adult day/day health rehabilitation center – as long as all other Medicaid Transportation requirements are met. To verify eligibility for transportation for this service, brokers must obtain a copy of the Vermont Day Health Rehabilitation Services Prior Authorization Form from the requesting Day Health Rehabilitation Services provider. This notice will specify the approved number of hours per week and the period of eligibility during which the Medicaid beneficiary may attend.

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Note: There may be occasions when an Adult Day or Day Health Rehabilitation provider refers a person whose eligibility for services is pending final approval. If the provider requests transports for this person prior to receipt of final approval, brokers should require the request in writing to include a payment guarantee, with a specified start and end date, in the event Medicaid eligibility is denied. Upon receipt of the written request and coverage guarantee, the broker should begin providing transporting but hold all billing until verification of final approval is received.

4.7 Residential Care Facilities

. A licensed Residential Care Home (Levels III & IV) or Assisted Living Residence shall provide transportation to medical services and local community functions up to twenty (20) miles round-trip without charge, not to exceed four (4) round-trips per month. Group trips count toward this quota. After the four round trips per month, Medicaid shall cover the cost of additional miles and transportation for medically necessary service only – as long as such trips are found to be eligible under Medicaid guidelines.

For example, if the Residential Care Home provides four round trips for a Medicaid beneficiary during the first part of the month but the mileage only totals 10 miles for all four trips, ensuing trips for medical services would be billed to Medicaid as the beneficiary has used up the quota of monthly trips. If the home transports a beneficiary to a medically necessary service and the round trip totals 40 miles, 20 miles are Medicaid reimbursable.

Brokers may require the Residential Care Facility to verify that they have met their obligations for the transportation of the beneficiary. The facility may verify this verbally.

Skilled nursing facilities are required to transport or pay for transporting residents with Medicaid for all medical services except for admission, discharge or dialysis treatments.

4.8 Substance Abuse Trips

Transportation to regular alcohol or drug counseling is allowed if the service is recognized by Medicaid as a medical service and the provider is enrolled as a Medicaid provider. This automatically includes all OADAP providers.

Methadone Treatment Centers:

Beneficiaries will be transported to the facility closest to the beneficiary's residence. If there is not a treatment slot available in the facility closest to the beneficiary's

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residence, the beneficiary may enroll to receive services at the next closest facility, until a slot for treatment becomes available at the facility closest to their residence. In order for a beneficiary to receive transportation benefits at a facility that is not the closest facility to their residence, the beneficiary must provide documentation from the closest facility documenting that no treatment slots are available there and that the beneficiary has been placed on a waiting list to receive treatment at that facility. The beneficiary must provide the broker with written notification that the beneficiary is on a waiting list for the facility closest to his/her residence, every six months.

Accordingly, beneficiaries within the following brokerage areas will be transported to the clinic so designated:

To Burlington:

Addison County Transit Resources (ACTR)
Special Services Transportation Service, Inc. (SSTA)
Northwest Vermont Public Transit Network (NTWRK)

To West Lebanon:

Marble Valley Regional Transit District (MVRTD)
Stagecoach Transportation Services, Inc. (STSI)

Mobile Methadone Units within the community:

Rural Community Transportation, Inc.(RCTI)
Green Mountain Transit Agency (GMTA)

To Brattleboro, VT or Greenfield MA (whichever is closest):*

Green Mountain Community Network (GMCN)
Connecticut River Transit, Inc. (CRTI)

Section 5 Transportation Programs

5.1 Hardship Mileage Reimbursement Program

A mileage reimbursement program for Medicaid beneficiaries who have a vehicle and who are transported over 50 miles per week or over 215 miles per month for medical appointments/services. The following individuals may be eligible to receive Hardship Mileage:

- 1) Any natural or adoptive parent of a child less than 18 years of age. Such an individual may receive Medicaid transportation reimbursement only through the Hardship Program.
- 2) An individual living in the Medicaid household providing transportation to a Medicaid beneficiary using a vehicle owned/provided by the Medicaid household.

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The beneficiary may be reimbursed for mileage if the beneficiary uses his or her own automobile for medically necessary transports under the following conditions:

- The beneficiary has a condition that requires repeated treatment on at least a weekly basis (such as dialysis, chemotherapy, physical therapy, psychotherapy etc.) and beneficiary mileage for these trips totals more than 50 miles per week.

- OR -

- The beneficiary has a condition that requires multiple trips and/or treatments each month and beneficiary mileage for these trips totals more than 215 miles per month.

Hardship mileage reimbursement is currently at the rate of \$.18 per mile. **It is necessary for trips to be pre-authorized by the broker under the hardship provision.** To obtain reimbursement for hardship mileage, the beneficiary must submit to the broker: the time and place of each medical appointment, the name of the medical provider, and actual miles traveled. The broker must verify the mileage using maps or online GoogleMaps information, dates and time of the appointments.

Beneficiaries **will not be reimbursed** for trips which do not meet the criteria outlined in Section 2 Transportation Eligibility. Trips to or from an emergency room will be reimbursed if they are reported to the broker within 48 hours of occurring.

5.2 Reach Up Program

“Reach-Up” is a training and work program primarily for parents receiving Reach Up grants and support services through the Department for Children and Families, Economic Services Division. The Reach-Up case manager will establish eligibility for related transportation. The case manager will fill out a transportation authorization form with two copies to the appropriate broker. Once eligible, the beneficiary is responsible for contacting the transportation broker. Services requested may include DCF office visits, support services, education and training and transportation for child care while the beneficiary attends Reach-Up activities.

Once a broker receives a transportation authorization form and has been contacted by the Reach-Up participant, transportation may be arranged. Additional trips can only be approved with another authorization form.

If transportation cannot be arranged, the broker should notify the Reach-Up case manager cited on the authorization form. If a broker is contacted by an individual for Reach-Up transportation but has no authorization form, the beneficiary should be referred to the local DCF District Office.

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If a trip is cancelled, beneficiaries should contact the broker 24 hours prior to the arranged trip. If "no shows" occur, carrier costs will be reimbursed, but the broker must notify the Reach-Up case manager by phone. The case manager will then decide if action needs to be taken up to and including denial of further transportation for beneficiaries who abuse the benefit.

Brokers bill for Reach-Up transports by using the "VPTA Reach-Up Transportation Billing Form".

Brokers will not provide transportation to Reach-Up beneficiaries without receipt of the completed transportation authorization form from the beneficiary's case manager.

5.3 Providing Transportation to a NON-Medicaid Beneficiary

When considering requests for transportation for someone other than the Medicaid beneficiary, brokers must establish that it is medically necessary for the Medicaid beneficiary for the other person to be transported. Such situations include:

- a) An adult accompanying a minor child
- b) A companion accompanying a disabled person
- c) A parent visiting a sick minor child in a hospital

In some cases, medical necessity is apparent; for example, a parent accompanying a minor child to ensure the provision of medical treatment. In other cases, medical necessity may not be apparent; for example, a parent visiting a minor child in a hospital. If the reason is obvious, brokers document the circumstances in their records. If not, brokers obtain a statement in writing from or call the beneficiary's attending physician.

Brokers may request written or verbal verification of any information they consider questionable.

5.4 Visitation Limitation

Medicaid will cover one round trip transport for the parent(s) (natural or adoptive) to visit a minor child in medically stable condition, admitted to a sub acute facility (nursing home or long term care facility) with approval by the OVHA, when the duration of minor child's stay is expected to exceed 30 days . If the visit is scheduled for the weekend, overnight lodging may be covered.

Visitation will not be covered in cases where a parent has chosen for their child to receive treatment from a facility other than the closest available facility.

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Section 6 Beneficiary Notification

6.1 Notification of Beneficiary “No Shows”

At the time of the first “no show” by a beneficiary, the broker shall send out a letter outlining the OVHA’s “no show” policy. The first “no show” shall not count against the beneficiary. A copy of this letter may be found as Manual Addendum #1.

On subsequent “no shows”, however, the broker should document the “no show” in their computer system and must send written notification of the “no show” to the beneficiary.

If the beneficiary has subsequent “no shows” each event must be documented by the broker and written notification of each occurrence must be sent to the beneficiary, noting they may lose access to their transportation benefit if they continue to “no show.”

After the third “no show” in a three-month period the broker must send written notification that the beneficiary has “no showed” for the third time in that three-month period and, therefore, may only access their transportation benefit through a personal choice driver. A copy of the benefit suspension letter may be found as Manual Addendum #2.

NOTE: Late or last-minute appointment cancellations by providers shall not be counted as “no shows” for beneficiaries. Also, good cause for missing appointments and/or rides may be taken into consideration by the broker and/or OVHA when addressing specific “no show” incidents.

The “no show” notice to the beneficiary must include the following elements:

- 1) How long the beneficiary will be suspended from using broker arranged transportation.
- 2) When the suspension begins.
- 3) The reason for the suspension.
- 4) A reference to this policy.
- 5) An explanation of the beneficiary’s right to appeal this decision to the Human Services Board by calling the Health Access Member Services Unit (Maximus) at 1-800-250-8427 or by writing to the director of the local DCF District Office within 90 days of the date of the suspension notice. (See below in this Manual for how to handle an appeal.)
- 6) A statement that all trips provided by their personal choice driver need to be prior authorized by the broker.
- 7) A statement that the beneficiary may return to using the broker arranged transportation after the suspension period ends.

Suspension Time

The following is the suspension time for the transportation benefit:

1st suspension 30 days

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- 2nd suspension 60 days
- 3rd suspension 90 days
- 4th suspension 120 days
- 5th suspension 180 days
- 6th suspension the beneficiary may only access the transportation benefit by a personal choice driver.

If a Reach Up beneficiary is a “no show,” copies of all “no show” notification letters will be sent to the beneficiary’s Reach Up Case Manager at the local DCF office.

The broker must send written notification to the beneficiary when the suspension period has ended informing the beneficiary how they may access their broker arranged transport again.

NOTE: If a broker does not follow this policy per direction (if notices are not sent out, etc), then the beneficiary’s “no shows” cannot be counted against them until the policy is followed correctly.

6.2 Notification of Transportation Denial

When a request for transportation is denied, a Medicaid beneficiary must be given a written notice explaining the reason for the denial and informing the beneficiary of the right to appeal. Brokers must use OVHA-220MT, a standard form letter provided by OVHA for this purpose.

Brokers complete OVHA-220MT by listing the Identification (ID) number, name and address of the head of household, the address of the local DCF District Office, the name and address of the transportation broker (see Appendix A.2 and A.4) and by checking the reason for denial. If the reason is not stated on the form, check “Other” and fill in the blank. All reasons must coincide with Medicaid policy. If in doubt, brokers should contact VPTA or the OVHA for guidance.

Distribute copies of the notice as follows:

- White - Medicaid beneficiary
- Yellow - DCF District Office
- Pink - Broker's file
- Gold - OVHA

6.2.1 Beneficiary Unruly, Dangerous or Illegal Behavior

Brokers must assure that transportation to and from necessary medical services is available for eligible beneficiaries. Therefore, brokers may not deny transportation

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services because the beneficiary is “unpleasant” (disagreeable, displeasing or generally obnoxious).

In some circumstances, brokers should report a beneficiary's behavior to the police - for example, if a beneficiary's behavior is dangerous, threatening, or threatens to become physically abusive to employees or the public. Also, if a broker believes the beneficiary is engaging in behavior that is against the law, such as using illegal drugs (for example, smoking marijuana while being transported), such behavior should also be reported. Beneficiaries exhibiting such behavior will be warned in writing that threats, physical abuse, dangerous or illegal behavior has been reported to the appropriate agencies/authorities and may result in suspension or denial of broker arranged transportation services.

In cases where beneficiary behavior is obnoxious or offensive but not dangerous or illegal, the broker should inform the beneficiary in writing that the behavior is unacceptable. The broker may also inform the beneficiary, in writing, that if the behavior continues, the broker is willing to reimburse a personal choice driver that the beneficiary obtains to provide the transports to medical services/appointments (but at no greater cost than otherwise would have been incurred). All of the transports provided by a personal choice driver must be prior authorized by the local broker.

In cases where a beneficiary has a history of abusive, offensive, dangerous or threatening behavior and as a result no carrier can be found willing to transport the beneficiary, a written denial notice must be given the beneficiary with the reason stated as “No carrier or driver willing to transport”.

6.3 Beneficiary Appeal for Fair Hearing

A beneficiary may appeal **any denial of a request for transportation**. All beneficiaries denied transportation must receive a written denial from the brokers. OVHA 220-MT informs beneficiaries that they may request a hearing by calling the Health Access Member Services Unit (Maximus) at 1-800-250-8427 or writing the director of the local DCF District Office within 90 days of the date of the denial. Once the beneficiary appeals:

- a) The District Director receives and forwards the beneficiary's written request and any additional information to OVHA.
- b) OVHA contacts the broker to obtain any other available information and notifies the Human Services Board which will hear the appeal. The Human Services Board then notifies the beneficiary of the time and place for the hearing.

To request a copy of a Fair Hearing decision pertaining to your brokerage, contact the Human Services Division of the Attorney General's Office at (802) 241-2840.

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Beneficiaries who use private transportation to and from a fair hearing may be reimbursed for mileage. A request for such reimbursement is handled by the applicable DCF District Office. Most persons are reimbursed for travel to a Fair Hearing outside of their town of residence by submitting an AAF-6A State of Vermont Personal Expense Claim.

Beneficiaries with special transportation needs, such as a ramp or lift equipped vehicle, with no car or those who live in remote locations, may be provided transportation by the designated broker serving the beneficiary's town of residence. Such transportation will be provided for those with special needs regardless of whether the hearing is held inside or outside of the applicant's town of residence.

Section 7 Suspected Fraud or Abuse

If brokers become suspicious of fraud against the Medicaid or Reach-Up transportation programs by a beneficiary, please discuss the matter with VPTA who will, as warranted, contact the Program Integrity Unit at the OVHA at 802-879-5900.

Suspected fraud by carriers, for example, padding of mileage or time reports by volunteer or personal choice drivers or others, and suspected abuse of beneficiaries by carriers should be reported for investigation to the Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office at 802-241-4440.

Suspected abuse of vulnerable adults also should be reported to Adult Protective Services at 1-800-564-1612. Please let it be noted that since brokers are technically subcontractors of the Agency of Human Services, they are mandated by state law to report such suspected abuse, whether such can be verified or not.

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Transportation Manual Addendum #1

“NO-SHOW” POLICY ADVISORY LETTER

The Office of Vermont Health Access provides travel assistance to eligible Medicaid recipients to access necessary medical services. This letter is to advise you, however, that you recently scheduled transportation but you were not present for the pick up by our driver on [DATE] for an appointment at [PRACTICE, LOCATION].

Per Vermont Medicaid/Reach Up policy, your transportation benefit may be suspended after excessive “no show” incidents. After three of these incidents in a three-month period, this transportation benefit will be suspended. The following explains the suspension time for this benefit:

- 1st suspension 30 days
- 2nd suspension 60 days
- 3rd suspension 90 days
- 4th suspension 120 days
- 5th suspension 180 days
- 6th suspension the beneficiary may only access the transportation benefit by a personal choice driver.

Should your transportation benefits come under suspension, you will only be eligible to have a personal choice driver transport you during the time that those benefits are suspended. Your personal choice driver will be reimbursed through Medicaid/Reach Up – but all of those trips will need to be prior-authorized through your local broker’s office and reimbursement and all other paperwork must be completed in advance.

In the future, you must call our office ahead of time to let us know that you are unable to attend a scheduled appointment so that a “no show” is not recorded. If you have any further questions, please feel free to contact our office at [BROKER PHONE].

Thank you.

Local Transportation Broker Name: _____

Address: _____

Phone #: _____

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Transportation Manual Addendum #2

**OUT-OF-STATE MEDICAID TRANSPORTATION
PHYSICIAN REFERRAL FORM**

OVHA provides travel assistance to eligible Medicaid recipients to access necessary medical services.
Please provide the following information to help us render that assistance. Thank you.

Physician's Office: Please mail or fax this completed form directly to Peter McNichol, Office of Vermont
Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495. Fax: 879-5919

Client Name _____

Medicaid Number _____ DOB _____

Appointment Date and Time _____

Name of Primary Physician _____

Name of physician to whom
the patient is being referred _____

Address _____

Phone # _____

Is overnight lodging necessary? Yes _____ No _____

Medically, how many people should accompany the patient? _____

Local Transportation Broker Name: _____

Address: _____

Phone #: _____

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Please answer whichever of the following questions are applicable, depending upon the purpose for the travel request. If necessary, use an additional sheet of paper:

If the transportation is requested in order to obtain a particular type of medical service:

- What is the precise medical service that will be delivered at the destination?
- Is this service medically necessary? If so, why?
- Is this service obtainable in Vermont? If your answer is no, what efforts have been made to determine whether it is obtainable in Vermont?
- Is this the closest provider that can provide the service?

If the transportation is requested in order to obtain a particular type of medical expertise:

- does the medical provider whom the patient will visit possess special expertise with regard to this patient or this patient's medical condition? If so, what is the precise nature of this expertise?
- Is it medically necessary for the patient to be treated by a provider with this special expertise?
- Is such expertise obtainable in Vermont? If your answer is no, what efforts have been made to determine whether it is obtainable in Vermont?
- Is this the closest provider that can provide such expertise?

If the transportation is requested in order to maintain continuity of care:

- What is the patient's history with the provider - duration, condition(s) under treatment, nature of treatment(s)?
- Is it medically necessary for the patient to be treated by this particular provider rather than another similarly qualified provider? if so, why?

Print name of Doctor or Doctor's Staff providing information

Signature of Doctor or Doctor's Staff providing information
(if phone contact, broker staff filling out this form)

Date