Division of Medical Assistance Programs
Worker Guide

Section 12 – Medical Transportation
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Oregon Health Authority

Division of Medical Assistance Programs
Client and Provider Education

Oregon HEALTH PLAN

Medical Transportation

Introduction

OAR 410-136-0030 through 410-136-0860

Non-emergent medical transportation (NEMT) assists clients going to and from routine or scheduled Oregon Health Plan (OHP) medical services. It does not include emergency ambulance transportation to a hospital. Clients in an emergency situation should call 911 for immediate assistance or go directly to the nearest hospital emergency room.

NEMT is federally mandated by the Centers for Medicare and Medicaid Services (CMS) rule, 42 CFR 431.53. Medical transportation is available to clients who have no other means to access appropriate medical care.

The Division of Medical Assistance Programs (DMAP) Medical Transportation Services Program in Oregon Administrative Rules, (OAR) chapter 410, division 136, provides for NEMT services for clients with an OHP Plus benefit package **(BMD, BMH, BMM, or CWX).** NEMT resources are **not** available for clients with OHP Standard (KIT), CAWEM (CWM) or Medicare-only (MED), as these clients are not mandatory populations under Medicaid.

This guide outlines the relationship and responsibilities of transportation brokerages, DHS branch office staff and the OHP in providing NEMT services to OHP eligible clients. Please read carefully as there are details, "A-typical" situations, and exceptions to consider. **Eligible clients in need of NEMT should first be referred to their regional transportation brokerage for service.**

This guide also covers prior authorization (PA) requirements broken down within 6 steps for branch office staff to follow. There are exceptions mentioned throughout this guide and information may be repeated for clarity.

Transportation brokerages

- A transportation brokerage (brokerage) is a single point of contact for most, but not all, transportation services offered by the OHP for NEMT. **Eligible clients in need of NEMT should first be referred to their regional transportation brokerage for service.**
- Brokerages cover all areas of the state by regions. *Find a link for brokerage contact information and map in the 'Resources' section at the end of this guide.*

Verifying Client Eligibility

- Brokerages verify OHP client eligibility, assess the client's needs and resources, and arrange and provide NEMT as appropriate.
- Brokerages authorize transports that are the least expensive, medically-appropriate mode in advance of the service being provided.

Types of NEMT

- Brokerages can provide bus tickets and passes, taxi service, wheelchair vans, stretcher vans, secured transportation and common carrier.

- Brokerages **may** provide DHS Volunteer transportation. Brokers work with branch staff and volunteer coordinators (in counties that have volunteer transportation programs) to determine if a client can be served more cost-effectively using a volunteer. If so, the branch and volunteer coordinator will arrange transportation.
- Brokerages arrange commercial travel (airline, train, etc.) and transportation locally to and from departure location if DMAP has approved out-of-State travel for OHP-covered medical services.
- The branch office staff will need to work with the client to arrange for reimbursement of any prior-authorized meals, lodging, and transportation that occurs in the other state.
- Brokerages **may** provide ambulance or air ambulance services in DMAP-piloted areas only. On rare occasions when clients require NEMT by ambulance or air ambulance, the transportation brokerage will refer the client to the branch office for authorization, unless located in a pilot area where the brokerage will make the arrangements. See prior authorization, step 4, detailing more information on ambulance services arranged by the branch.

Client Reimbursement

- Brokerages **may** provide client reimbursement in approved DMAP-piloted areas only:
  - All client requests for reimbursement for NEMT services must be prior authorized.
  - If the brokerage does not provide client reimbursement, they will refer the client back to the branch office for assistance.
  - If the brokerage provides client reimbursement, the brokerage will provide reimbursement for prior-approved meals and lodging. Branch Office staff must not reimburse for these services provided by a brokerage.
  - The brokerage may be more likely to have cost effective alternatives to reimbursement when a client has recurring regularly scheduled appointments, such as dialysis.

Urgent Care After-Hours and Emergencies

- Occasionally, a client may require an urgent, but non-emergency, medical transport after hours when it is not possible to prior authorize. If the client normally uses the transportation brokerage, the client should follow the brokerage's instructions for urgent care on its after-hours telephone message. If the client normally uses reimbursement, the client can drive or be driven to urgent care, and then contact the branch staff for retroactive authorization the following business day.
- The branch should approve retroactive authorization when the client demonstrates medical urgency, such as intense pain, bleeding, fever, allergic reaction, etc., that occurred after branch hours. If the branch determines there was no medical urgency, or the client could have contacted the branch during business hours prior to travel, the request for retroactive authorization should be denied.
- NEMT does not include emergency ambulance transportation to a hospital. Clients in an emergency situation should call 911 for immediate assistance or go directly to the nearest hospital emergency room.
- The branch office may receive retroactive authorization requests from ambulance providers for after-hours service. See the ambulance or air ambulance information in this guide and OAR 410-136-0300, Authorization, for more information.

- If the client had a medical emergency and drove to a hospital emergency room, authorize mileage reimbursement. Emergency is defined in General Rule, OAR 410-120-0000, Acronyms and Definitions.
- Prior authorization is never required for emergency medical transportation. The client may only receive reimbursement for mileage to the nearest hospital emergency room if they did not use an ambulance.
- Do not authorize mileage to a more distant hospital. (See OAR 410-136-0200, Emergency Medical Transportation, *for more information.)*

Clients without a branch office or case worker

- Many clients do not have an accessible branch office or an assigned case worker. These clients have medical benefits but no other DHS program benefits and are assigned to Branch 5503 (Oregon Health Plan's Statewide Processing Center).
- These clients should contact Branch 5503 at 503-378-2666 or 1-800-699-9075, for NEMT prior authorization and reimbursement.

Children in subsidized adoptions

- For transportation authorization for children in subsidized adoptions with OHP Plus medical assistance only (County 0060), refer the appropriate person to the DMAP Co-60 Transportation Coordinator at (503) 945-5920. See contact information in the 'Resources' section at the end of this guide.

Prior Authorization Steps (Branch Office Staff)

This section is intended primarily as a "how to" guide for branch office staff (DHS and AAA) that authorize NEMT for OHP clients. Each branch office designates staff to provide NEMT services for clients and serve as a primary point of contact. Designated staff will perform the following 6 steps for every NEMT authorization:

(Note: These steps are only necessary for services that are <u>not</u> provided by transportation brokerages. Brokerages follow their operations manuals.)

1. **Verify client eligibility**
2. **Verify covered medical service**
3. **Verify provider is closest available and enrolled with DMAP**
4. **Determine mode of transportation and attendant needs**
5. **Calculate meal and lodging needs**
6. **Authorize or deny**

Step 1: Verify client eligibility

- Check MMIS to verify the client is eligible. Only clients with an OHP Plus (BMD, BMH, BMM or CWX) benefit package are eligible for NEMT. The client must be eligible on the date of service, not the date of request.
- Do not authorize NEMT for clients with OHP Standard (KIT), CAWEM-only (CWM) or Medicare-only (MED).
- Do not authorize NEMT for dates after a client's eligibility has ended.
- Check eligibility only for the client receiving medical care, not for the client's "care attendant" or other clients in the same household or on the same case. *(See "Guardian or attendant (Care Attendant) below.)*
  (Note: For more information about OHP benefit packages, refer to DMAP Worker Guide IV: Benefit Packages, available here: http://www.oregon.gov/OHA/healthplan/data_pubs/wguide/2010/iv_wg_0510.pdf)

Step 2: Verify covered medical service

- NEMT is only available for transportation to and from necessary medical (including physical/dental/mental health) appointments that are covered by OHP and performed by enrolled OHP providers.
- If necessary, contact the medical provider, managed care plan, or DMAP for more information to determine if a medical service is covered.

  Note: Covered and non-covered services are defined in General Rule: For covered services, see OAR 410-120-1160, Medical Assistance Benefits and Provider Rules. For non-covered services, see OAR 410-120-1200, Excluded Services and Limitations.
- A visit to a PCP, Urgent Care Clinic, or Hospital Emergency Room for the purpose of diagnosing an unknown condition is always considered a covered medical service for the purposes of NEMT, even if the subsequent diagnosis is for a non-covered condition.
- Medicare does not have an NEMT benefit. Some medical services are covered by Medicare only. For all clients that are Medicare-Medicaid dual eligible, confirm that the service is included as part of OHP covered services.
- Sometimes the medical provider will only bill Medicare for a dual-eligible client because Medicare will pay the entire claim. This is not a determining factor. If the client and service are OHP eligible, non-emergent transportation can be approved.
- NEMT is not available for any non-medical service purpose including, but not limited to visitation, jobs counseling, school or education programs. NEMT is not available for long term care clients viewing or moving into a new facility or to relocate out-of-state.
- Whether or not a service is court-ordered for a client does not affect the need for PA. If the service is a covered service, it is eligible regardless of court order. However, a service is not covered while a client is in the custody or care of a law enforcement agency or a corrections facility.

Administrative exams

- A client who does not have an eligible OHP Plus benefit package may use NEMT to attend an administrative examination for the purpose of determining eligibility for medical assistance.
- The exam must be requested by the DHS/AAA case manager.
- The case manager must open eligibility using the ADMIN benefit package code for the date of service and complete form DMAP 729.
- If the client uses the transportation brokerage, send a copy of the form to the brokerage.
- NEMT may only be used in this situation to attend the requested examination and may not be used to attend any other medical service.

Medical Equipment

- NEMT is not available for pick up or delivery of durable medical equipment (DME). All DME providers are required to provide appropriate pickup and delivery as part of their OHP provider terms. Contact the DMAP DME policy analyst. *(See contact information at the end of this guide.)*

Pharmacy

- NEMT generally is not allowed for visits to a pharmacy unless it is medically-necessary for a new prescription to be filled immediately, the eligible client is already traveling for an OHP-related medical appointment, and the pharmacy is located on the way or is the closest available pharmacy.
- For refills and recurring prescriptions, clients should use postal prescription services. All OHP clients have a postal prescription option available, either from their managed care plan or Wellpartner (http://www.oregon.gov/OHA/healthplan/clients/mailrx.shtml, or call 1-877-935-5797).
- In some situations, mail order prescription service may not be available or appropriate. This may include prescriptions for certain controlled narcotics that cannot be delivered by mail. Consult with the appropriate mail order prescription service and, if no service is available, you may authorize transportation to the closest appropriate pharmacy.
- Other situations, such as a transient client or a client without regular access to a mailbox, may be evaluated on a case-by-case basis.
- If the client uses postal prescription and receives the wrong prescription or has an unexpected problem from a prescription, there may be an urgent need to go directly to a pharmacy. Approve requests for NEMT under these circumstances.

Step 3: Verify provider is closest available & enrolled with DMAP

(Note: American Indian/Alaska Native clients with an "HNA" case descriptor are not restricted to the closest provider, but the closest Indian Health Care Provider (Indian Health Services, 638 Tribal facilities or Urban Indian Health Program Clinic).

- NEMT is typically only available to transport clients to and from enrolled OHP providers in their local area.
- The client may choose to go to an out-of-area provider, but may not be eligible for NEMT when going out-of-area is purely a client choice and not a medical necessity.

- If the client is in a managed care plan, the appointment should either be with the client's local PCP, or a specialist referred by the PCP and approved by the managed care plan. If the managed care plan assigns a PCP or refers to a specialist out of the local area, verify with the plan that this is the closest available appropriate provider. The managed care plan may authorize a referral to a non-OHP provider. Managed care plan contact information is available here: http://www.oregon.gov/OHA/healthplan/managed-care/main.shtm.
- Fee-for-service or open card clients choose any OHP enrolled provider, but are only eligible for NEMT in their local area or the closest available appropriate provider or specialist. Sometimes, clients are unable to access care in the local area because of client-caused situations with providers. **Do not authorize travel out of the local area when the client could access appropriate care locally by complying with reasonable provider requirements.** *(See OAR 410-136-0160 for more information.)*
- Clients may get prior authorization for NEMT to go to Veterans' Administration or charity organizations appointments (such as Doernbecher's or Shriner's), when the service meets the description of OHP covered service and is provided at no cost to DMAP or the client. You may give prior authorization even when the site of service is out-of-area because it is cost-effective for OHP.

Out-of-State travel

- Funding of medical services under the Oregon Health Plan is authorized for services provided in-State, or within the 75-mile contiguous zone. Funding of out-of-State services require prior authorization unless the service is provided for an emergent condition and billed accordingly. Non-emergent out-of-State services that are available in Oregon are not covered.
- If the client is in a managed care plan, the plan is responsible for prior authorization for the out-of-State service. If the client is fee-for-service (open card), the out-of-State RN Coordinator in the DMAP Medical Unit will make the final determination for prior authorization of the service.(See contact information at the end of this guide)
- The brokerage will arrange any necessary commercial (airline/train) travel. You will need to work with the brokerage to determine the cost-effectiveness of commercial travel or mileage reimbursement. If out-of-state travel is approved, it may be more cost-effective for the client to travel by commercial carrier than to receive mileage reimbursement.
- The branch office staff will need to work with the client and brokerage to arrange for reimbursement of any prior-authorized meals, lodging and transportation that occurs in another state, unless the brokerage is in a DMAP piloted-area for client reimbursements.
- DMAP cannot authorize NEMT to return a client to Oregon from out-of-State when the client's out-of-State medical care was not prior authorized. *(For more information, see OAR 410-136-0050, Out-of-State Transportation.)*

Step 4: Determine mode of transportation and attendant needs

- If the client is unable to drive or get a ride from a friend or relative and does not require medical monitoring or care during travel, refer the client to the transportation brokerage. The brokerage will perform all eligibility verifications and arrange transportation. The client may still require branch office staff assistance with meal or lodging reimbursement.

- Eligible clients may have other resources available to them for transportation to medical appointments. Other transportation resources may include schools, care facilities or medical providers; public transit; charitable services; relatives or friends; or any other resource. As such, staff that authorize NEMT must first verify the client does not have another transportation resource available to access necessary medical care.

Mileage Reimbursement

- All client reimbursement for NEMT services must be prior authorized. Reimbursement is generally provided **after** travel has occurred and attendance at the appointment has been verified.
- Clients who are able to drive themselves, or who have others willing to drive them to a medical service but who are unable to provide expenses associated with driving, may be eligible for mileage reimbursement if all other criteria is met.
- NEMT is only available for the actual client attending a medical service and if required, one guardian or attendant. In some circumstances when it is necessary to travel with a number of passengers (such as having to find day care for several children) it may be better for the client to ride in a personal vehicle and receive mileage reimbursement as long as other criteria is met (lowest cost mode of transportation). Note: Foster parents are an exception and may be eligible for mileage reimbursement even if a lower cost mode of transportation is available.
- Mileage reimbursement is generally issued to the client, or if the client is a minor, the head of the household on the case. If reimbursement is intended for someone other than the client, obtain written approval from the client before authorizing reimbursement:
    - You may accept a signed statement as simple as "I authorize [Name] to receive my travel reimbursement."
    - Document the consent in the case file and verify that the other person is not receiving any other form of reimbursement for this service.
- If more than one client may carpool to medical appointments, only one client is eligible for mileage reimbursement. Do not reimburse multiple clients for the same trip in the same vehicle.
- If the client requests mileage reimbursement, determine point-to-point miles and driving time for home to service and back using MapQuest (do not use other programs) for driving directions and mileage: (See http://www.mapquest.com/)
    - Do not authorize additional miles. However, in some situations, it may be appropriate for a client to drive an alternate route, such as bad weather or road repair. Branch staff should use their knowledge of the local area and best judgment.
    - Also, after a medical appointment, a client may need to make a pharmacy stop on the drive home. It is acceptable to retroactively authorize additional miles for the pharmacy stop provided the pharmacy is the closest available pharmacy and the client had an urgent need to fill the prescription (could not use postal delivery). Do not authorize mileage for other stops.
    - Only authorize mileage for actual client travel. For instance, if a client receives a ride from a relative, do not include miles driven by the relative to pick up the client.
- The reimbursement rate for mileage is $0.25 per mile and is all-inclusive. Do not authorize additional reimbursement for gasoline, oil, or other expenses related to mileage.

Guardian or Attendant (Care attendant)

- A client may travel with a medically-necessary care attendant at no additional cost from the transportation provider.
- A care attendant may be a relative, friend, caregiver, or any other person who assists the client during transportation or during a medical procedure. The care attendant is not required to be an adult if the client is an adult.
- For NEMT services, verify eligibility for the client only. If the client is eligible, then the necessary "care attendant" is also eligible. Care attendants may be approved only to travel with the client and are not eligible for compensation. DMAP cannot reimburse a transportation care attendant for providing care or services.
- When medically necessary, payment for meals or lodging may be made for one attendant to accompany the client. At least one of the following conditions or circumstances must be met:
    - The client is a minor child and unable to travel without an attendant; or
    - The client's attending physician has forwarded to the client's branch office a signed statement indicating the reason an attendant must travel with the client; or
    - The client is mentally or physically unable to reach his or her medical appointment without assistance; or
    - The client is or would be unable to return home without assistance after the treatment or service.

Travel with a minor

- A child under age 12 requires an adult guardian for NEMT from any transportation provider, with exceptions for ambulance and secured transportation.
- A parent or legal guardian of any minor, even if over age 12, may travel with the minor at no additional cost.
- A child may not travel with both a parent and an attendant at no extra cost. Only one additional passenger may travel with the client for free.
- A child over 12 but not yet able to drive may be eligible for mileage reimbursement when driven by a parent or legal guardian. Issue reimbursement to the head of household on the case. *(For more information, refer to OAR 410-136-0245, Child Transports.)*

Volunteer Program or other resources

- In some areas there are DHS volunteer programs not associated with a transportation brokerage that provide transportation for clients. Check with your district volunteer coordinator or the DHS Volunteer Program Manager for additional information. (See Volunteer Program Manager contact information at the end of this guide.)
- If the client has any other transportation resource available that can provide appropriate transportation at no cost to the client or DMAP, then do not authorize NEMT and issue a written denial. Cite OAR 410-136-0300, Authorization.

Ambulance or Air Ambulance

(Note: When a client is in a hospital and requires non-emergent ambulance transportation to another hospital, the hospitals will arrange transportation.)

- The branch office, being responsible to ensure transportation is appropriate and cost-effective, may authorize non-emergent ambulance or air ambulance when appropriate for an eligible client. **Ambulances are only appropriate for medically fragile clients requiring medical care or monitoring during transportation, such as use of a ventilator or constant IV.**
- To authorize ambulance transports, the branch should contact local ambulance providers to determine availability for service and to obtain bid quotes. Under normal circumstances, the ambulance provider must agree to bill according to the DMAP Fee Schedule. However, in unusual circumstances, an ambulance provider may require additional payment authorization due to costs that go above and beyond normal ambulance service. This may occur when a client is bariatric and requires additional staff to assist moving the client, or under other unique circumstances. Discuss all circumstances with the ambulance provider. If no provider is able to accommodate at DMAP Fee Schedule rates, make arrangement with the lowest bidder.
- Branch offices may receive retroactive reimbursement requests from ambulance providers when clients use an ambulance for an after-hours urgent care situation or a hospital discharge. The branch should closely examine these requests to ensure medical appropriateness for ambulance. Do not authorize when ambulance was not the medically appropriate mode of transportation. Clients and hospital discharge staff must follow after-hours procedures for the brokerages and use appropriate and cost-effective, after-hours NEMT providers. *(See also the urgent care after hours and emergency information in this guide.)*
- For air ambulance, contact multiple providers using the contact information at the end of this guide. Hospital or facility social workers may also provide additional provider options. Select the available provider that offers the lowest bid amount. Ensure the bid includes all necessary ground transportation on both ends of the trip – if not, ground ambulance must also be arranged, and the bids should be evaluated accordingly.
- To prior authorize NEMT by ambulance or air ambulance:
    - Complete a form DMAP 405T, Medical Transportation Order, for the provider.
    - The form must include the authorized payment amount.
    - Under the block "$ Authorized," if the provider will bill according to the DMAP Fee Schedule, write "Fee Schedule." Otherwise, write in the total dollar amount authorized for the lowest bidder.
    - Send the original form to the provider and retain a copy in the client case file.
    - Refer any subsequent provider inquiries for payment to the DMAP Provider Services Unit, 800-366-6016.

(Note: For a medical emergency, no prior authorization is required; the ambulance or air ambulance provider may bill DMAP directly without involving the branch.)

Step 5: Calculate meal and lodging needs

Meals

- Meal reimbursements must be requested by the client and prior authorized before travel. A client is eligible for a meal allowance when traveling out of the local area more than four hours. Count the total duration of the trip, including travel in both directions, and the time spent at the appointment. The travel must also occur during a recognized normal meal time and may be authorized during the following times:
    - Breakfast when travel begins before 6 a.m.
    - Lunch when travel spans the entire period between 11:30 a.m. and 1:30 p.m.
    - Dinner when travel ends after 6:30 p.m.
- When meals are authorized for a full day, reimburse the full amount of $12 per day. Otherwise, meal reimbursement is calculated using the following fee schedule:

Breakfast:	$3.00
Lunch:	$3.50
Dinner:	$5.50

- Meal reimbursement is considered per diem and does not require the client to submit receipts.
- If the client also receives lodging, you must evaluate the lodging's capacity for meals. For example, many hotels provide free breakfast. If the client receives a Supplemental Nutrition Assistance Program (SNAP) benefit and stays in lodging where it is possible to prepare meals, do not issue a meal reimbursement. The SNAP benefit is presumed to provide for meals in these circumstances.
- Meals may be authorized for both the client and one necessary guardian or attendant. Evaluate the client and the guardian or attendant separately. *(See more information under Guardian or Attendant section in this guide.)*
- Do not authorize meals when a meal is provided as part of the medical service or is otherwise available at no cost. For example, if the client receives meals as part of hospital stay but the attendant does not, only reimburse for the attendant's meals.
- Occasionally, a facility may provide clients with an optional meal card or service that is not included as part of the medical service. In these situations, the facility may request direct reimbursement from the branch rather than billing the client. This is allowed with prior authorization:
    - Ensure only the facility is reimbursed.
    - Do not reimburse both the facility and the client.
    - Document in the client's case file.

Lodging

- Reimbursement for lodging may be provided when the client's prior authorized travel requires overnight stay outside the local area. Usually lodging reimbursement is for a short stay in a hotel or motel. When a client requires multiple continuous nights, lodging reimbursement may be considered and authorized for apartment rentals or other cost effective solutions. The branch office will process reimbursement for lodging. All lodging requests must be made in advance of travel and prior authorized:
    - Lodging may be authorized when the client would have to begin travel before 5 a.m. or return home after 9 p.m.
    - Lodging may be authorized for services that require multiple days out of the area.
    - Lodging is not considered per diem and requires receipts.
    - Lodging is paid the lesser of the actual cost, or $40 per night. Do not reimburse for client lodging in excess of $40 per night.
    - Lodging is available for a necessary care attendant only when the client and the care attendant are not able to stay in the same room.
    - Lodging is only available for the number of nights that are necessary.
    - Do not approve lodging for trips that can be completed in one day.
    - Do not approve lodging for multiple appointments on different days when they could be scheduled on the same day.
- Exception to above: In some cases, a client may have a legitimate medical need for multiple out of town appointments on different consecutive days and could make multiple round trips rather than utilize lodging. If it is cost-effective, the client may make one round trip and utilize lodging rather than make multiple round trips.

  Note: state and federal regulations limit the amount of driving time to ten hours per day when commercial drivers carry passengers. On rare occasions, clients in remote areas of Oregon traveling to Portland and back will cause a commercial driver to exceed this limit if making a round trip in a single day. The transportation brokerage should notify the branch if this is an issue. For clients utilizing mileage reimbursement, clients should not be expected to drive in excess of ten total hours in one day. In these cases, it is acceptable to approve an overnight stay even if the client would otherwise be able to complete the trip during the 5 a.m. to 9 p.m. window.
- As with meals, in some situations, a facility may provide lodging that is not considered part of the medical service and may wish to be reimbursed directly by the branch rather than billing the client. Ronald McDonald House usually prefers this arrangement. This is allowable and can be done with prior authorization.
- Be sure to only reimburse the facility. Do not also reimburse the client.
- Document in the client's case file.
- Do not approve lodging reimbursement when lodging is provided as part of the medical service, such as hospital in-patient.

Extended duration stays

- Clients may sometimes require extended duration stays out of their local area or out of state due to extensive recovery time from surgeries such as transplants. Because the client may be eligible for up to $40 per night, this can add up to as much as $1,240 per month. Under these circumstances, there may be various lodging options that are more cost effective and better for clients than staying in a hotel. Consider:
    - Rented apartments, RV parking, or any other solution that may be available.
    - Hospital social workers may be able to provide numerous alternatives to hotels.
- If an alternate lodging solution is used, only reimburse up to the lesser of actual cost and aggregated $40 per night. For example:
    - If the client stays in a rented apartment for 30 days for $800, reimburse $800, not $1,200.
    - Reimbursement may be made directly to the lodging facility if appropriate. Do not duplicate reimbursement to the client. *(For more information about meals and lodging, see OAR 410-136-0820, Qualifying Criteria for Meals/Lodging/Attendant.)*
- If the client requests meals or lodging but does not qualify, then do not authorize and issue a written denial. Cite OAR 410-136-0820, Qualifying Criteria for Meals/Lodging/Attendant.

Step 6: Authorize or deny

- Authorize or deny NEMT for the client on the DMAP form 0409: Medical Transportation Screening/Input Document.
- If the request is not authorized, issue a written denial and include the notice of hearing rights. Reference all applicable administrative rules for the reason for denial.
- In some situations, a request may be partially denied. For instance, a client may request mileage and meal reimbursement, but only qualify for mileage. Be sure the denial specifies what is approved and what is denied.
- If authorized, inform the client:
    - The client will be able to complete the reimbursement request after travel.
    - Be sure the client understands that reimbursement is dependent on verification that the client attended the medical service.
    - The client must complete the reimbursement request within 30 days of travel or the request will be denied. Inform the client that requests under $10 may be held by the branch until subsequent requests accumulate to a total of $10 or more.

For more information, see OAR 410-136-0800, Prior Authorization of Client Reimbursed Mileage, Meals and Lodging.

Verify appointment

- Once the branch has received the completed request for reimbursement DMAP form 0882: Medical Transportation Reimbursement Notice from the client, verify the client attended the medical service. Verification can be by phone call to the provider, by fax or e-mail from the provider, or by provider's signature or stamp on an attendance sheet.

- If the client did not attend the medical service, do not authorize and issue a written denial.
- If the client did not complete the request for reimbursement within 30 days of completion of travel, do not authorize and issue a written denial. Cite OAR 410-136-0800, Prior Authorization of Client Reimbursed Mileage, Meals and Lodging.
- If the request meets all eligibility criteria and the total reimbursement amount is $10 or more, issue reimbursement. If the request is for less than $10, the branch may hold the request until subsequent requests accumulate a total reimbursement of $10 or more. Reimbursement is issued by check from the DHS mainframe using the SPL1, SPL2 screens with code 35. Refer to DHS mainframe manuals for further instructions. Checks are automatically mailed to the client from Salem.
- When there is no time to wait for the check to be issued from Salem, the branch manager may decide to write the check in the branch and then complete the information for DMAP to reimburse the branch for the revolving fund check. The form DMAP 409 has instructions on the backside of the form. Submit copies of the form DMAP 409 and the revolving fund check to:

Micro-Imaging Unit
PO Box 14006
Salem, OR 97309

The original form DMAP 409 remains in the branch record.

Travel advance

- In exceptional circumstances, a branch may advance a full or partial reimbursement before travel. For example, a client may not have available cash to pay for gasoline and hotel stays prior to receiving reimbursement.
- Only the branch manager may authorize an advance payment to the client considering the risk of overpayment or a "no show:"
    - When the client's travel is complete, be sure to deduct any advance from the final reimbursement.
    - If the client did not attend the medical service, or incurred costs below the advance amount, refer the case to OPAR's Overpayment Recovery Unit at 503-373-7772 (Salem area) or 800-273-0548 (toll free). In the event of multiple overpayments to the same client, aggregate the total in the referral.

Note: There are minimum recovery amounts for overpayments referred to OPAR. Most advances for NEMT would fall below the minimum threshold, and therefore are unrecoverable. As such, it is imperative that any advance be carefully evaluated in terms of cost and risk. For further information, consult with OPAR.

NEMT Policy Exceptions

Policy Exceptions for cost effectiveness

- NEMT that would ordinarily be unavailable according to program rules or established exception procedures may be authorized on rare occasions, if it is in the best interest of both the client and OHP. Such policy exceptions are evaluated on a case-by-case basis and are only authorized by DMAP Management.
- In order to evaluate a request for policy exception, DMAP requires cost-benefit analysis. DMAP will only approve a policy exception when there is a demonstrable saving to OHP, a significant benefit for the client, and no burden placed on the client or providers. The DHS/AAA case manager should prepare a written proposal that clearly expresses all costs and benefits for submission to the DMAP Medical Transportation Policy Analyst (Policy Analyst). The DMAP Policy Analyst will review the proposal, ask for additional information if necessary, and submit to DMAP Management for authorization.
- If authorized, the DMAP Policy Analyst will send the case manager confirmation by e-mail and, if appropriate, send a copy to the transportation brokerage. The case manager will make necessary arrangements and retain copies of the authorization and any supporting documents in the client case file. *(Note: See contact information at the end of this guide.)*

Resources

Questions		
Kristi Jacobo DMAP Medical Transportation Policy Analyst kristi.jacobo@state.or.us (503) 945-6492	Valerie Rux DMAP Medical Transportation Policy Analyst valerie.rux@state.or.us (503) 945-5796	Julie McGuire DMAP Branch 60 Transportation Coordinator julie.mcguire@state.or.us (503) 945-5920
Carol Camfield, RN DMAP Medical Unit Out-of-state Coordinator carol.l.camfield@state.or.us (503) 945-5802	Caroline Price, RN DMAP Medical Unit Transplant Coordinator caroline.price@state.or.us (503) 945-6488	Greg Russo DHS Volunteer Program Manager gregory.p.russo@state.or.us (503) 945-8994

Transportation brokerages and service area maps
http://www.dhs.state.or.us/policy/healthplan/guides/medtrans/broker-list-map.pdf

Oregon Administrative Rules (OAR) for Medical Transportation
http://www.dhs.state.or.us/policy/healthplan/guides/medtrans/main.html

Ronald McDonald House
http://www.rmhcoregon.org/contact

Air ambulance companies enrolled with DMAP

This list is not all-inclusive and subject to change. A receiving hospital's transportation planner or social worker may be able to provide additional air ambulance companies or revised contact information.

Air Ambulance Company	Telephone	Website
Air Ambulance Network	800-327-1966	http://www.airambulancenetwork.com
Air St. Lukes Boise RMC	877-785-8537	http://www.stlukesonline.org
Airlift Northwest	800-426-2430	http://www.airliftnw.org
AirLink Critical Care	800-353-0497	http://www.stcharleshealthcare.org
American Medflight	800-799-0400	http://www.americanmedflight.com
American Medical Response	503-736-3425	http://www.amr.net
Cal-Ore Life Flight	541-469-7911	http://www.cal-ore.com
Care Flight	800-648-4888	http://www.care-flight.info
Emergency Airlift	541-756-6802	http://www.emergencyairlift.com
Life Flight Network	503-678-0206	http://www.lifeflight.org
Mercy Flights	800-903-9000	http://www.mercyflights.com
Northwest Medstar	800-572-3210	http://www.nwmedstar.org
PHI Air Medical	800-421-6111	http://www.phiairmedical.com
Premier Jets	503-640-2927	http://www.premierjets.com
REACH Air Medical	541-257-2600	http://www.mediplane.com