[redacted]
[redacted], MI [redacted]

Date Mailed: September 4, 2020
MOAHR Docket No.: 20-004713
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on August 19, 2020. Petitioner appeared and testified on her own behalf. Allison Pool, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (MDHHS or Department). Carlene Krepps, Eligibility Specialist, testified as a witness for the Department.

During the hearing, the Department submitted one evidence packet that was admitted into the record as Exhibit A, pages 1-44. No other exhibits were submitted or admitted.

ISSUE

Did the Department properly deny Petitioner's requests for mileage reimbursement for non-emergency medical transportation (NEMT)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a Medicaid beneficiary generally eligible for NEMT through the Department. (Testimony of Eligibility Specialist).

2. On January 31, 2020, Petitioner requested reimbursement for her mileage to a medical appointment on January 23, 2020 in Norton Shores, Michigan. (Exhibit A, pages 25-26).

3. On February 4, 2020, the Department sent Petitioner written notice that

the request for medical transportation had been denied because Petitioner was requesting transportation to a provider located outside of her community when comparable care was available locally. (Exhibit A, page 22).

4. Petitioner also had similar requests denied for the same reasons around that time. (Testimony of Petitioner; Testimony of Eligibility Specialist).

5. On February 18, 2020, Petitioner requested a hearing with respect to the denials and her case was docketed by the Michigan Office of Administrative Hearings and Rules (MOAHR) as Docket No. 20-000991. (Exhibit A, pages 15-39; Testimony of Eligibility Specialist).

6. On May 13, 2020, Docket No. 20-000991 was dismissed after Petitioner failed to appear for a hearing scheduled on May 12, 2020. (Exhibit A, pages 15-16).

7. On July 1, 2020, Petitioner requested reimbursement for her mileage to two medical appointments, one on June 28, 2020 in [redacted], Michigan, and another on June 30, 2020 in [redacted], Michigan. (Exhibit A, pages 10-11, 13-14).

8. On July 2, 2020, the Eligibility Specialist sent Petitioner written notices that the requests for medical transportation had been denied in part because Petitioner was requesting transportation to providers located outside of the community when comparable care was available locally. (Exhibit A, page 9, 12).

9. On July 27, 2020, MOAHR received the request for hearing filed in this matter regarding the denials of Petitioner's requests for medical transportation reimbursement. (Exhibit A, pages 6-8).

CONCLUSIONS OF LAW

The Medicaid program (MA) was established pursuant to Title XIX of the Social Security Act (SSA) and is implemented by 42 USC 1396 *et seq*. and Title 42 of the Code of Federal Regulations, 42 CFR 430 *et seq*. The program is administered in accordance with state statute, the Social Welfare Act, MCL 400.1 *et seq*., various portions of Michigan's Administrative Code, 1979 AC, R 400.1101 *et seq*., and the State Plan promulgated pursuant to Title XIX of the SSA.

Policy addressing medical transportation coverage under the State Medicaid Plan is found in the Bridges Administrative Manual (BAM) 825 and the Medicaid Provider Manual (MPM).

In part, the MPM states:

SECTION 1 – INTRODUCTION

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

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

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

Forms referenced in this chapter are accessed via the beneficiary's case worker and are maintained on MI Bridges. The Medical Transportation Statement (MSA-4674) is also available on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

* * *

SECTION 3 – TRANSPORTATION AUTHORIZATION [CHANGES MADE 4/1/20]

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

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected

through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all services covered under the managed care contract. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

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

Reimbursement for special transportation requires a completed, original Medical Verification for Transportation (DHS-5330) to serve as documentation of medical need and must be retained in the beneficiary's file. Special transportation includes medically needing a wheelchair lift-equipped vehicle, Medi-Van vehicle, attendant, prior authorization, and other special circumstances supported by medical documentation. (For prior authorization requirements, refer to the Prior Authorization (PA) section of this chapter.) The DHS-5330 must be completed annually. A local MDHHS office can authorize NEMT without a DHS-5330 for beneficiaries who do not require special transportation. Additionally, verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services. **(text added per bulletin MSA 19-38)**

An initial verification of medical need for special transportation is required by the beneficiary's primary care physician (PCP). An original, completed DHS-5330 signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. In situations when a beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, is unavailable and unable to complete an original DHS-5330 in a timely manner, another licensed provider may complete the form. Example providers include, but are not limited to, a

physician specialist, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary. **(revised per bulletin MSA 19-38)**

In situations when a completed, original DHS-5330 cannot be secured prior to a beneficiary's scheduled Medicaid-covered appointment, authorizing parties may approve and reimburse all necessary NEMT services if the DHS-5330 is completed and returned to the authorizing party within 10 business days of the appointment. Allowable circumstances include, but are not limited to, the beneficiary's first trip to their PCP or medical appointment, or an inability by the beneficiary's physician's office to complete the form and secure the necessary signatures in a timely manner.

Authorizing parties must retain the completed, original DHS-5330 in the beneficiary's file and make it available upon request. Authorizing parties are responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.

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

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

* * *

SECTION 5 – COVERED SERVICES

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

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

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

* * *

5.1 MILEAGE

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

- Commercial and nonprofit transportation
- Fixed route, demand response and deviated route public transportation
- Volunteer drivers
- Individuals with a vested interest

- Beneficiaries providing their own NEMT in their personal vehicle

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

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

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

As applicable, NEMT mileage reimbursement will align with standard mileage rates maintained by the Internal Revenue Service (IRS). Individuals with a vested interest or Medicaid beneficiaries providing their own NEMT will be reimbursed at the IRS rate for "medical or moving purposes", while volunteer drivers and foster care parents will be reimbursed at the IRS rate for "business miles driven".

* * *

SECTION 10 – DENIALS AND BENEFICIARY APPEALS

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

- The DHS-301 and postage-paid return envelope must be mailed to the beneficiary within one business day of the service being denied;

- A copy of the DHS-301 must be kept in the beneficiary's file and made available upon request; and

- An employee with knowledge of the denial must be available to testify at an administrative hearing, if required.

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

SECTION 11 – NON-COVERED SERVICES

The following transportation services are not reimbursable:

- Waiting time;

- Trips that were provided prior to approval from the authorizing party;

- Multiple trips for a single Medicaid service;

- When a beneficiary failed to keep their appointment;

- Trips to and from services that are not covered (e.g., grocery store, non-Medicaid covered medical services);

- *Routine medical care outside a beneficiary's community when comparable care is available locally, unless prior authorized;*

- Transportation to and from services for individuals who have not met their spend-down;

- Expenses for services that have already occurred;

- Services for long-term care beneficiaries. Routine, non-emergency medical transportation provided for long-term care residents in a van or other non-emergency vehicle is included in the facility's per diem rate. This includes transportation for medical

appointments, dialysis, therapies, or other treatments not available in the facility. (Refer to the Nursing Facility Coverages chapter of this manual for additional information regarding NEMT for long-term care beneficiaries);

- Transportation for managed care program enrollees for services covered under the program contract (refer to the Managed Care Programs section of this chapter for additional information); and

- Transportation for services provided in FQHCs.

MPM, April 1, 2020 version
NEMT Chapter, pages 1-5, 9-10, 18-19
(italics added for emphasis)

Here, the Department denied Petitioner's requests for mileage reimbursement for NEMT pursuant to the above policies and on the basis that reimbursement is not covered for transportation for routine medical care outside of a beneficiary's community when comparable care is available locally, unless prior authorized; the routine medical care Petitioner received was available locally; and there was no prior authorization for going outside her community.

In appealing the denials, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying her requests. Moreover, the undersigned Administrative Law Judge is

Given the record and applicable policies in this matter, Petitioner has failed to meet that burden of proof and the Department's decisions must therefore be affirmed.

As a preliminary matter, the undersigned Administrative Law Judge would note that, while the Social Security Act and the federal regulations which implement the Social Security Act allow an opportunity for fair hearing to recipients like Petitioner who believe the Department may have taken a negative action erroneously, s*ee* 42 CFR 431.200 *et seq.*, that opportunity for fair hearing is limited by a requirement that the request be made within 90 days of the Department's negative action: "The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing." 42 CFR 431.221(d). Accordingly, any denials issued more than 90 days prior to the date of the filing of Petitioner's request for hearing, *i.e.* July 27, 2020, whether part of Petitioner's earlier appeal or not, are untimely and the undersigned Administrative Law Judge lacks jurisdiction over them.

Moreover, with respect to the more recent denials properly before the undersigned Administrative Law Judge, he finds that Petitioner has failed to show that she had to travel outside her community for the routine medical care she received because

comparable care was not available locally. Petitioner described her reasons for why she travels outside her community, including better service, doctors familiar with her medical history and an ability to be seen right away, but, while those reasons are understandable, they do not establish that Petitioner met the criteria for mileage reimbursement or that the Department erred.

Accordingly, for the reasons discussed above, the undersigned Administrative Law Judge finds that the Department's decisions should be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that, to the extent he has jurisdiction over Petitioner's appeal, the Department properly denied Petitioner's requests for mileage reimbursement.

IT IS, THEREFORE, ORDERED that:

- Petitioner's appeal of denials issued prior to April 28, 2020, is **DISMISSED** for a lack of jurisdiction

- The Department's decisions with respect to the remaining denials are **AFFIRMED**.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS Department Rep.

M. Carrier
Appeals Section
PO Box 30807
Lansing, MI
48933

Agency Representative

Allison Pool
222 N Washington Square
Suite 100
Lansing , MI
48933

Petitioner

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