MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 14, 2010

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1900 – TRANSPORTATION

BACKGROUND AND EXPLANATION

This chapter has been modified to clarify the starting point of mileage reimbursement for voluntary drivers.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity.

These policy changes are effective December 15, 2010.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 46/10 CHAPTER 1900 – TRANSPORTATION	MTL 23/10, 40/10 CHAPTER 1900 – TRANSPORTATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1904.2	**Coverage and Limitations**	Added "from the point of where a recipient has been picked up"

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SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1900 - TRANSPORTATION

BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 1900 has been updated to add the definition of Assessment and to add a 45 day time limit for Paratransit Assessment.

These policy changes are effective December 15, 2010.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 47/10 Chapter 1900 - Transportation	MTL 23/10 Chapter 1900 - Transportation

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1902	**Definitions**	Added definition of Assessment
1904	**NET Services**	Added 45 day time limit for Paratransit Assessment

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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TRANSPORTATION SERVICES

1900 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP/Nevada Medicaid) and its contractors assure the availability of emergency and Non-Emergency Transportation (NET) services for Medicaid and Nevada Check Up (NCU) recipients, to provide access to covered medically necessary services by all eligible, Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP/NCU), recipients. Transportation services are provided to and from Medicaid and NCU medical providers pursuant to 42 CFR Part 431 and the respective State of Nevada Title XIX and Title XXI State Plans.

The DHCFP has comprehensive risk-based contracts with Managed Care Organizations (MCOs), which are contractually required to cover all the emergency transportation needs of their enrollees and are prohibited from requiring prior or post authorization for emergency services, including emergency transportation services originating through "911". Emergency transportation services provided for Fee-for Service (FFS) recipients do not require prior or post authorization and are covered under the FFS reimbursement program option. NET services are provided to all Medicaid and NCU recipients through the contracted NET broker and must be authorized by the broker. This chapter provides details about covered services, how to access services, and the entities responsible for reimbursing providers and, in some instances, recipients.

All transportation providers, including the DHCFP's contracted NET broker, must comply with all applicable Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC), the Code of Federal Regulations (CFR), the United States Code, and the Social Security Act, which assure program and operational compliance. Additionally, pursuant to Medicaid Services Manual (MSM) Chapter 100 transportation providers, the DHCFP's NET broker and members of the NET broker's provider network may not discriminate unlawfully against recipients on the basis of race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions). Nondiscrimination and Civil Rights regulations extend to job applicants and employees of service providers as well.

1901 AUTHORITY

The rules set forth below are intended to supplement, and not duplicate, supersede, supplant or replace other requirements that are otherwise generally applicable to Medicaid programs as a matter of federal statute, laws and regulations. Nevada's Non-Emergency Transportation (NET) broker is not a Prepaid Ambulatory Health Plan (PAHP). In the event that any rule set forth herein is in conflict with any applicable federal law or regulation, such federal law or regulation shall control. Such other applicable requirements include, but are not limited to:

a. 42 Code of Federal Regulations (CFR) Part 431.53 for assurance of medically necessary transportation to providers;

b. 42 CFR 434.6 of the general requirements for contracts; and Part 2 of the State Medicaid Manual, Centers for Medicare and Medicaid Services (CMS) Publication 45-2;

c. 45 CFR 92.36 (b)-(f) for procurement standards for grantees and sub grantees;

d. The Deficit Reduction Act of 2006 (Pub. L. No. 109-171) for provision that the states may use state plan authority to operate a transportation brokerage system;

e. The requirement that certain entities be excluded from participation, as set forth in §1128 and §1902 (p) of the Social Security Act and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

f. Section 1932 (b)(2)(D) of the Social Security Act for limits on amount paid to non-contracting providers of emergency services;

g. Confidentiality and privacy requirements as set forth in 45 CFR Parts 160 and 164;

h. The requirement of freedom of choice for family planning services and supplies, as set forth in 42 CFR 431.51 and as defined in Section 1905 (a)(4)(C) and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

i. The respective State of Nevada Title XIX and Title XXI State Plans;

j. Nevada Revised Statutes (NRS) Chapter 422 and Chapter 706; and

k. DHCFP NET Services Brokerage Contract.

These rules are issued pursuant to the provisions of NRS Chapter 422. The Nevada State Department of Health and Human Services (DHHS), acting through the DHCFP, has been designated as the single state agency responsible for administering the Nevada Medicaid program under delegated federal authority pursuant to 42 CFR 431. Accordingly, to the

extent that any other state agency rules are in conflict with these rules, the rules set forth herein shall control.

1902 DEFINITIONS

ABLE CAREGIVER

An able caregiver is a legally responsible relative who has the option to be present in the home during the time necessary maintenance, health/medical care, education, supervision, support services, and/or provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are needed.

ACCESS

Access refers to a recipient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their reasonable acceptability to the recipient and provider, the location of health care facilities, availability of transportation, hours of operation and cost of care.

ADVANCED LIFE SUPPORT (ALS) ASSESSMENT

ALS Assessment is performed by an ALS crew as part of an emergency response that was necessary due to the recipient’s reported condition at the time of dispatch and was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the recipient requires an ALS level of service.

ADVANCED LIFE SUPPORT INTERVENTION

ALS Intervention is a procedure that is, in accordance with State and local laws, beyond the scope of practice of an Emergency Medical Technician-Basic (EMT-Basic).

ADVANCED LIFE SUPPORT LEVEL 1 (ALS-1)

ALS-1 is transportation by ground or air ambulance and the provision of medically necessary supplies and services, including the provision of an ALS assessment or at least one ALS intervention, which must be performed by personnel trained to the level of an Emergency Medical Technician-Intermediate (EMT-Intermediate) or paramedic, in accordance with State and local laws.

ADVANCED LIFE SUPPORT LEVEL 2 (ALS-2)

ALS-2 is transportation by ground or air ambulance and the provision of medically necessary supplies and services, including:

a. at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or

b. the provision of at least one of the ALS-2 procedures defined by the Centers for Medicare and Medicaid Services (CMS).

These procedures must be performed by personnel trained to the level of an EMT-Intermediate or paramedic, in accordance with State and local laws, and may include: manual defibrillation/cardioversion; endotracheal intubation; central venous lines; cardiac pacing; chest decompression; surgical airway, and intraosseous line.

AIR AMBULANCE

Air ambulance means an aircraft (fixed or rotary wing) specially designed, constructed, modified, or equipped to be used for the transportation of injured or sick persons. “Air Ambulance” does not include any commercial aircraft carrying passengers on regularly scheduled flights.

AMBULANCE

Ambulance is defined as a medical vehicle that is specially designed, constructed, staffed, and equipped to provide basic, intermediate, or advanced services for one or more sick or injured person or persons whose medical condition may require special observation during transportation or transfer.

BASIC LIFE SUPPORT (BLS)

BLS is transportation by air or ground ambulance to facilitate the provision of medically necessary supplies and services. The ambulance must be staffed by an individual qualified, at least as an EMT-Basic, in accordance with State and local laws.

BUS

Bus is defined as public or private fixed-route, fixed-schedule, intra-city or inter-city congregate transportation.

CAPABLE CAREGIVER

A capable caregiver is a responsible adult who is physically capable of carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

CAPITATION PAYMENT

A payment the Division of Health Care Financing and Policy (DHCFP) makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical

and/or transportation services under the State Plan. The DHCFP makes the payment without regard to individual utilization of services during the period covered by the payment.

COMMERCIAL TRANSPORTATION VENDOR

A transportation provider who subcontracts with the NET broker to supply transportation services for compensation.

CONFIDENTIALITY

Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid and Nevada Check Up (NCU) applicants and recipients, Medicaid providers, and any other information which may not be disclosed by any party pursuant to federal and State law, and Medicaid Regulations, including but not limited to, Nevada Revised Statute (NRS) Chapter 422, 42 Code of Federal Regulations (CFR) 431, 45 CFR 160 and 164, and The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191).

DISTRICT OFFICE (DO) ASSESSMENT (NET)

Assessment means that a Health Care Coordinator (HCC) completes the assessment during an interview with the recipient at the District Office (DO) in order to establish information for appropriate levels of service for Non-Emergency Transportation (NET). An interview may be completed in person, via telephone with the recipient/legal guardian or done by historical case data.

DIVISION or DHCFP

Division of Health Care Financing and Policy

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation is ground or air ambulance, as medically necessary, to transport a recipient with an emergency medical condition. A ground or air ambulance resulting from a “911” communication is included as emergency medical transportation.

ENROLLEE

An enrollee is either a Medicaid or NCU recipient who is enrolled in an MCO.

ESCORT/ATTENDANT

An escort is defined as an individual whose presence is required to assist a recipient during transit and while at location for Medicaid-reimbursable services. Escorts will be transported at no additional expense and are allowed for members who have been approved through an assessment process to receive ambulatory assistance (e.g., blind, mentally retarded, deaf, physically disabled, or under 21 years of age) during transit.

GRIEVANCE

Any oral or written communications made by a recipient, or a provider acting on behalf of a recipient with the recipient's written consent, to any of the Contractor's employees or its providers expressing dissatisfaction with any aspect of the Contractor's operations, activities or behavior, regardless of whether the communication requests any remedial actions.

HEARING

A hearing is an orderly, readily available proceeding before a hearing officer, which provides for an impartial process to determine the correctness of an agency action (See MSM Chapter 3100-Hearings). Recipients and Medicaid providers are afforded an opportunity for hearing in certain circumstances and when requested in a timely manner. An agency, MCO, or transportation broker action or adverse determination made against a recipient's request for service or payment as well as a determination against a provider that terminates, suspends or denies a provider application must provide opportunity for hearing.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians, and parents of minor recipients, including stepparents, foster parents, and adoptive parents.

MANAGED CARE ORGANIZATION (MCO)

Managed Care is a system of health care delivery that influences utilization, cost of services and measures performance. The delivery system is generally administered by an MCO, which may also be known as a Health Maintenance Organization (HMO). An MCO or HMO is an entity that must provide its Medicaid or NCU enrollees inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, home health services, emergency services, and additional

contracted State Plan benefits. The MCO provides these services for a premium or capitation fee, regardless of whether the individual enrollee receives services.

MARKETING

Any communication from the NET broker (including its employees, affiliated providers, agents or contractors) to a Medicaid or NCU recipient that can reasonably be interpreted as intended to influence the recipient to use specific transportation services or to purchase other services that may be offered by the above listed entities.

MEDICOACH, MEDIVAN, MEDICAR

These interchangeable terms refer to a motor vehicle staffed and equipped to transport one or two persons in wheelchairs or on gurneys or stretchers, door-to-door.

MILEAGE REIMBURSEMENT

Car mileage is reimbursement at a per mile rate, paid when appropriate and approved by the NET broker for the transport of an eligible recipient to a covered service. Reimbursement will be at the Internal Revenue Service rate for medical/moving mileage reimbursement unless otherwise agreed to in writing by DHCFP.

NON-EMERGENCY TRANSPORTATION (NET)

NET is any conveyance service that can be scheduled ahead of time which is necessary to convey an eligible program recipient to and from covered medical services. The recipient has the duty to use the least expensive alternative conveyance and the nearest appropriate Medicaid health care provider or medical facility.

Conditions exist for non-emergency medical transportation when a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would not place the health of the individual in serious jeopardy or cause serious impairment to a bodily organ or part.

NON-EMERGENCY TRANSPORTATION (NET) BROKER

The NET broker contracts with individual transportation companies and volunteer drivers who provide transportation for Nevada Medicaid and NCU recipients. The NET broker manages, authorizes, and coordinates NET services for Medicaid recipients. The NET broker also provides various utilization management reports to the DHCFP for quality assurance purposes. The NET broker does not perform the transportation services. The NET Broker may not have an ownership interest in a subcontractor for whom the broker is setting reimbursement rates.

PARATRANSIT

Paratransit is a shared-ride program providing transportation for eligible people with disabilities of all ages who are unable to use fixed-route, fixed-schedule conventional public transportation. Paratransit services may be designated “curb to curb,” or “door-to-door.”

PAYMENT AUTHORIZATION REQUEST (PAR)

A PAR also referred to as a request for Prior or Post Authorization, is a request a provider or recipient submits to the NET broker for payment of transportation to a Medicaid-reimbursable service. The NET broker may require verification that the DHCFP’s QIO-like vendor or contracted MCO has authorized the medical service.

PERSONAL CARE SERVICES (PCS)

Refer to MSM Chapter 3500 – Personal Care Services.

PRIOR AUTHORIZATION

See definition of Payment Authorization Request (PAR).

PRIVATE DRIVERS

Individual(s) who provide transportation of an eligible recipient to a covered service and without compensation. A private driver may be a relative, friend, neighbor or other individual willing and qualified to provide the transportation. Since there is no compensation and no contract with the NET broker, no authorization is needed for a private driver to provide the transportation. Private drivers differ from “Volunteer Drivers” in that volunteer drivers are not contracted with the NET broker but may be compensated.

PROVIDER DISPUTE

A request to the NET broker by any provider who provides services to Medicaid or NCU recipients for the NET broker to review and make a decision to change or uphold a Contractor’s decision regarding, but not limited to, quality of plan service, policy and procedure issues, denied claims, claim processing time, or other disputes.

PRUDENT LAYPERSON

A person who possesses an average knowledge of health and medicine, who could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

REASONABLE PROMPTNESS/TIMELINESS

All requests for NET service determinations will be issued with reasonable promptness by Nevada Medicaid and its contractors. Reasonable promptness means Nevada Medicaid and its contractors will take action to approve, deny, terminate, reduce or suspend service(s) no more than 14 calendar days from the date the service request is received or within any more restrictive policies and procedures that address specific circumstances.

SCHEDULED EMERGENCY TRANSPORTATION

Scheduled emergency transportation is transportation to covered medically necessary, provider directed services scheduled on behalf of the recipient, usually with less than 48 hours notice. An example of a scheduled emergency is transportation for a medically stable recipient on an organ transplant list who receives notification an organ available from a donor and the recipient must be present at the transplant facility within the timeframe determined by the surgeon or the transplant coordinator. (See also Urgent Services.)

SIGNIFICANT CHANGE OF CONDITION OR CIRCUMSTANCE

A significant change in condition may be demonstrated by, for example, a recent hospitalization (within past 14 days), a physician's visit (within past seven days) resulting in an exacerbation of previous disabling condition, or a new diagnosis not expected to resolve within 30 days.

A significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI.

A significant change in condition or circumstances expects imminent hospitalization or other institutional placement.

SPECIALTY CARE TRANSPORTATION (SCT)

SCT is hospital-to-hospital transportation of a critically injured or ill recipient by a ground or air ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Intermediate or paramedic. SCT is necessary when a recipient's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training). SCT's are not covered under NET, nor do they require prior authorization. An example of SCT is the transfer of a newborn from a critical care neonatal unit to a hospital where immediate heart surgery may be performed.

STRETCHER

A type of transportation where the recipient must be transported in a prone position on a gurney or a stretcher. Stretcher transport is not a covered NET broker service.

SUBCONTRACTOR

Third party, not directly employed by the NET broker, that provides services identified in the NET contract not including third parties who provide support or incidental services to the NET broker.

URGENT SERVICES

With respect to NET services, an urgent service consists of transportation to a covered medically necessary, provider directed service which is scheduled on behalf of the recipient with less than 5 business days notice. A recipient must have a medical need to see the provider in less than 5 business days in order to schedule an urgent transport.

UTILIZATION MANAGEMENT AGENCY

The state's fiscal agent or Quality Improvement Organization (QIO)-like vendor. The utilization review/control requirements of 42 CFR 456, are deemed met if a State Medicaid agency contracts with a Medicare certified QIO-like vendor, designated under Part 475, to perform review/control services.

VOLUNTEER DRIVER

Volunteer drivers (private citizens who do not contract with the NET broker) who are not LRIs, nonprofit organizations, or Indian Health Services (IHS), may receive mileage reimbursement for driving a recipient to medical services, where this is the least expensive mode of transportation.

WHEELCHAIR LIFTS AND TIE DOWNS

Wheelchair lifts are mechanical devices that raise a person seated in a wheelchair, or a person who cannot traverse steps, from ground level to a vehicle's floor level. Tie downs lock a wheelchair in place so it does not move during transit.

1903 POLICY

The Division of Health Care Financing and Policy (DHCFP) and its contractors assures the availability of medically necessary emergency and Non-Emergency Transportation (NET) services for eligible Title XIX Medicaid recipients and Title XXI (Children's Health Insurance Program (CHIP)/Nevada Check Up (NCU)) program recipients. These transportation services are provided to and from DHCFP Fee-for-Service (FFS) medical providers and Managed Care Organization (MCO) network and non-network providers pursuant to 42 CFR Part 431, § Part 438, and the respective State of Nevada Title XIX and Title XXI State Plans.

1903.1 EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation does not require prior authorization. Claims must be submitted to the DHCFP FFS Fiscal Agent or the recipient's Medicaid MCO, if applicable, for processing. According to the Centers for Medicare and Medicaid Services (CMS), emergency response to "911" calls normally result in a Basic Life Support (BLS) or Advanced Life Support Level 1 (ALS-1) service level. Note that emergency medical transportation providers who submit claims coded as Advanced Life Support Level 2 (ALS-2) must present supporting documentation to verify that the transport included the type of care described in the ALS-2 definition in Section 1902.

1903.1A COVERAGE AND LIMITATIONS, EMERGENCY MEDICAL TRANSPORTATION

1. Emergency transportation is provided for eligible recipients, whether FFS or MCO.

2. The DHCFP has contracts with MCO's that are contractually obligated to cover emergency medical transportation services for their enrollees by applying the prudent layperson standard. For MCO enrolled recipients, claims for emergency transportation are to be submitted to the MCO in which the recipient is enrolled.

3. Providers are to submit claims for reimbursement of emergency medical transportation to the Fiscal Agent for all FFS recipients. Neither the DHCFP nor its contractors will reimburse the following individual services in connection with emergency medical transportation:

    a. Response with "Non-transport";

    b. Routine or special supplies, including oxygen, defibrillation, IV's, intubation, ECG monitoring, extra attendant, or air transport excise taxes;

    c. Ambulance charges for waiting time, stairs, plane loading;

    d. Deadheading (an empty trip to or from a destination); or

e. Transportation of deceased persons.

1903.1B AUTHORIZATION PROCESS

No prior or post authorization is required for emergency medical transportation that originates with a "911" call. Other transportation treated as an emergency does not require prior or post authorization if the recipient is enrolled in FFS Medicaid, but prior or post authorization may be required if the recipient is enrolled in a contracted Medicaid or NCU MCO. Providers must submit claims for service to the DHCFP's Fiscal Agent using the appropriate nationally devised billing codes for all FFS recipients or to the responsible contracted MCO for managed care enrollees.

1903.1C SPECIALTY CARE TRANSPORT

Specialty Care Transport is hospital-to-hospital transportation of a critically injured or ill recipient by a ground or air ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Intermediate or paramedic. Specialty Care Transport (SCT) is considered an emergency service and does not require prior authorization when the recipient is covered under FFS Medicaid. SCT is defined as a type of emergency transportation due to the necessary Level of Care (LOC) and is not covered under the NET program.

If the recipient is a member of a Medicaid or NCU MCO, prior authorization may be required for out-of-state travel. The transportation provider must contact the MCO for direction before providing the service. In-state Specialty Care Transportation is considered an emergency service and does not require prior authorization when the recipient is covered under an MCO.

Provider and recipient responsibilities in situations involving SCT are the same as for emergency medical transportation and are referenced in Sections 1903.1E and 1903.1F.

1903.1D SCHEDULED EMERGENCIES

Scheduled Emergency Transportation may be arranged by a hospital, physician or an emergency transportation provider or it may be scheduled by the DHCFP's NET~~)~~ broker.

In determining whether scheduled emergency transportation should be the responsibility of the DHCFP's NET broker, distance or cost is not the deciding factor. In-transit care needs and time-critical factors take precedence. The following guidelines provide general direction.

1. When the recipient's care needs during transit exceed the capabilities of a NET provider, scheduled emergencies will be treated as emergencies.

   Examples of exceeding the capabilities of a NET provider include:

a. Transportation of a critically ill recipient to a location where an organ transplant will occur;

b. Hospital-to-hospital transfer of a seriously injured or ill recipient when medically necessary tests or treatment are not available at the dispatching hospital and the recipient's care needs during transit exceed the scope of service of an Emergency Medical Technician-Basic (EMT-Basic); and

c. Facility-to-facility transfer of a seriously mentally ill adult or severely emotionally disturbed child who qualified health care professionals deem is an imminent danger to self or others and who requires significant chemical or physical restraints and/or the attendance of security personnel during transit.

Scheduled emergency transportation provided under the above circumstances does not require prior authorization when the recipient is covered under FFS Medicaid. However, if the recipient is a member of a Medicaid or NCU MCO, prior authorization may be required. The provider responsible for arranging the transportation must contact the MCO for direction before providing the service.

Sections 1903.1E and 1903.1F set forth provider and recipient responsibilities when scheduled emergency transportation is treated as an emergency.

2. When the recipient's care needs during transit are within the scope of services provided by the DHCFP's NET broker, the NET broker will make every effort to fulfill the transportation request within the required timeframe. Prior authorization by the NET broker will be required. If the request for scheduled emergency transportation exceeds the level of NET services that the NET broker is capable of providing, the service will be treated as an emergency. Questions of the levels of NET will be decided by the DHCFP.

Examples of scheduled emergencies that, time permitting, may be handled by the NET broker include:

a. Transportation of a medically stable recipient to a location where an organ transplant will occur;

b. Hospital-to-hospital transfer of a medically stable recipient; and

c. Hospital to mental health facility transfer with a qualified escort of a seriously mentally ill adult, an individual with dementia, or a severely emotionally disturbed child who is not a danger to self or others but whom, during transit, may need minimal chemical or physical restraints that are within the scope of service of an escort who is qualified as an EMT-Basic. This is in accordance with NRS 433.

Provider and recipient responsibilities when scheduled emergency transportation is handled by the DHCFP's NET broker are found in Sections 1903.2B and 1903.2C, and the authorization process is described in Section 1903.2D.

3. Due to the nature of some scheduled emergencies (e.g., time-critical air transportation to another city for organ transplant), it is occasionally necessary for a recipient, or an individual on behalf of a recipient, to pay for transportation costs from personal funds. When this occurs, a reimbursement request may be submitted to the DHCFP. The person who submits the request must provide a letter that explains why expenses were handled in this manner. Documentation that the transportation was medically necessary (e.g., a hospital admitting form) and original receipts for out-of-pocket costs must be attached.

   a. Reimbursable expenses include ground and/or air transportation, lodging and meals for the recipient and one attendant, if necessary. Reimbursement for lodging, meals and mileage, and other necessary items are reimbursed in accordance with the current DHCFP travel policy. Recipients and escorts must present receipts for reimbursement. Recipients and escorts must use low cost accommodations such as the Ronald McDonald House whenever available and reimbursement will not be authorized or reimbursed for higher costs unless the recipient can demonstrate to the NET broker that the low-cost accommodations in the area were unavailable at the time the recipient required them.

1903.1E PROVIDER RESPONSIBILITY

The transportation provider is solely responsible for verifying program eligibility and enrollment and assessed levels of NET service for each recipient. Whenever possible, this should be done prior to rendering emergency transportation services. Information concerning eligibility and enrollment verification is located in Section 103.5, Chapter 100, of the Nevada Medicaid Services Manual (MSM).

The provider must ensure the confidentiality of recipient medical records and other information, such as the health, social, domestic and financial circumstances learned or obtained in providing services to recipients.

The provider shall not release information related to a recipient without first obtaining the written consent of the recipient or the recipient's legally authorized representative, except as required by law. Providers meeting the definition of a "covered entity" as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

The DHCFP expects that providers will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable.

1903.1F RECIPIENT RESPONSIBILITY

The recipient or legally authorized representative shall:

1. Provide the emergency transportation provider with a valid Medicaid/NCU Identification card at the time the service is rendered, if possible, or as soon as possible thereafter.

    a. Recipients shall provide the emergency transportation provider with accurate and current medical information, including diagnosis, attending physician, medication regime, etc., at the time of request, if possible;

    b. Recipients shall notify the emergency transportation provider of all third party insurance information, including the name of other third party insurance, such as Medicare, Champus, Workman's Compensation, or any changes in insurance coverage at the time of service, if possible, or as soon as possible thereafter;

    c. Recipients shall not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability, and/or national origin.

    d. Participate in and cooperate fully with the NET eligibility and level of service assessment.

1904 NON-EMERGENCY TRANSPORTATION (NET) SERVICES

The DHCFP has contracted with a NET broker to provide transportation to medically necessary covered services statewide. Although ride scheduling will only be accommodated during customary business hours, transportation may be scheduled for confirmed after hours medical appointments. After hours, weekend and holiday rides that are not prior authorized may be reimbursed only when the recipient requires urgent medical care. The transportation must be to an emergency care facility, such as an emergency room or after hour's clinic.

All NET services require prior authorization by DHCFP's NET broker with the exception of NET services provided by Indian Health Services (IHS) clinics. The NET broker is required to authorize the least expensive alternative conveyance available consistent with the recipient's medical condition and needs. Examples of NET services may include the following:

a. Charter air flight;

b. Commercial air;

c. Rotary wing;

d. Fixed wing;

e. Ground ambulance;

f. Bus, local city;

g. Bus, out of town;

h. Paratransit – Public;

i. Paratransit – Private;

j. Private vehicle; and

k. Taxi.

NET never originates from a "911" call. NET seldom requires the recipient's care needs during transit to exceed the scope of service of an EMT-Basic.

1904.1 ASSESSMENT AND AUTHORIZATION PROCESS

A. With the exception of services provided by IHS (see 1903.2A (14)), the need for NET services must be assessed as specified in this section, and authorized by the NET broker.

B. The goal of the combined assessment and authorization processes is to determine the appropriate level of non emergency medical transportation service.

C. Assessment and prior authorization to use NET:

1. Recipients wishing to use NET services will be assessed for the proper level of transportation prior to being authorized access to NET.

a. Otherwise appropriate request for lower levels of ground transportation, i.e. mileage reimbursement, public bus or public paratransit, will be assessed and authorized by the NET broker without intervention from the Medicaid District Office (DO).

b. If the request is for a greater level of ground transportation than mileage reimbursement, public bus or public paratransit, the NET broker should use due diligence in questioning the recipient to see if a lower level transport is acceptable and sufficient for their medical condition. If the recipient agrees to the lower level, then that transport will be authorized by the NET broker without intervention from the Medicaid DO.

c. If the recipient does not believe the lower level transport is appropriate or acceptable, then they will be referred to the Medicaid DO for a needs evaluation.

d. If the recipient has not been authorized for NET, the broker will, within 48 hours, mail the recipient an application form for NET assessment by the Medicaid DO and refer the recipient to the Medicaid agency NET contact, who will schedule an assessment.

e. Until the higher level of transportation is either approved or denied by the Medicaid DO, the NET broker will provide rides at the requested level.

f. The NET broker will maintain a list of all assessment referrals and will provide a copy of new listings to the Medicaid DO's daily.

g. The Medicaid DO will maintain a list of all assessments and the level of transportation that has been authorized. The Medicaid DO will provide the NET broker with written documentation regarding the recipient's authorization status and level of service.

h. The reports of member requests/assessments that are exchanged between the Medicaid DO and the NET broker must include enough information for the recipient to be easily identified, and it should clearly indicate which

Medicaid DO is responsible for the assessment. This may be as simple as "Las Vegas District Office" and "Other District Office".

i. If the NET broker believes that a recipient is receiving unnecessarily expensive transportation, and that it is unlikely their Medicaid DO assessment will qualify them for this method of transportation, then the broker is expected to contact the appropriate Medicaid DO and ask for that assessment to be given a high priority.

j. When recipients contact the NET broker requesting a ride, they will be screened for prior authorization and will only be permitted to ride within the level of service authorized.

k. If the recipient requires NET prior to the time of the assessment including a ride to the Medicaid DO assessment or to a paratransit assessment, the NET broker will authorize the rides. Rides to medical services require documentation that there is a medical necessity to receive services prior to the time the assessment is scheduled.

l. Recipients within the service areas of Clark County, Washoe County, and Carson City public transit systems and who require transportation above the level of fixed route, must receive an assessment disqualifying them from public paratransit prior to being authorized for a higher level of service.

1. Once a recipient has been referred to Paratransit for an assessment, the recipient has 5 days in which to contact Paratransit to schedule an assessment. Paratransit has up to 45 days to complete an assessment. The level of service requested by the recipient will be provided until an assessment has been completed. Failure to complete the Paratransit assessment within 45 days will result in the recipient being placed on fixed route bus service for all NET transportation, unless the recipient can show in writing, that Paratransit was unable to complete an assessment within the 45 days.

m. Recipients may be authorized for mileage reimbursement or private commercial transportation in addition to use of public transit if, during the assessment, they demonstrate a medical necessity to travel outside the public transit system service area.

n. For authorization other than the public transit, the NET Broker will explicitly state the name of the provider, the providers location, the medical

condition, the treatment, and the frequency of the transit that the recipient is permitted.

o. When the Medicaid DO has completed the NET assessment, the assessor will determine the level of service for qualified recipients to access NET.

p. Recipients who submit evidence from an assessment showing they do not qualify for public paratransit may be qualified for a higher level of service.

q. The Medicaid DO will provide the NET broker with written documentation regarding the recipient's authorization status and level of service.

2. If the recipient states that they are unable to ride at the level of service assigned due to a significant change in condition or circumstance, the recipient will be referred to the Medicaid DO for re-evaluation. This referral will include a verbal explanation of the process accompanied by the mailing of an application form for a NET assignment.

a. Recipients contesting their assessed level of service will not be provided with NET at a higher service level prior to reassessment unless they can provide medical evidence that inability to access medical care during the re-evaluation period will result in serious exacerbation of their medical condition or unacceptable risk to their general health. Recipients will not be provided the higher level of NET for routine medical appointments.

b. Recipients are required to ride the least expensive transport within a level of service and will not be placed on a higher cost transport because of personal preference or convenience.

c. Recipients may be reassessed for a greater level of service if they can document a significant change in their condition or circumstance or demonstrate that they no longer have access to the assigned transportation level of service.

D. A Legally Responsible Individual (LRI) may request assistance with transportation to a covered medical service on behalf of an eligible recipient in the event the recipient is unable to submit a request to the NET broker for his or her own travel.

E. The NET broker must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider and/or the Medicaid DO when appropriate.

F. The NET broker and the Medicaid DO must provide standard authorization decisions with reasonable timeliness. If the broker determines, or a provider indicates, the standard service authorization timeframe could seriously jeopardize the recipient's condition or circumstance, the NET broker must make an expedited authorization decision and provide notice as expeditiously as the recipient's health condition requires.

1904.2 COVERAGE AND LIMITATIONS

A. NET for eligible program recipients to and from DHCFP medical providers of covered medically necessary services is provided under the following terms:

1. The recipient is unable to provide his/her own transportation:

a. Free Transportation: Recipients must use free transportation when it is available. Free transportation is available when a vehicle is registered to the recipient or a LRI where the recipient lives and the recipient or LRI is able and capable of providing transportation.

b. Recipients or LRIs must provide documentation to demonstrate that they are unable or incapable of providing transportation to a recipient.

2. The least expensive form of transportation is utilized in accordance with the recipient's medical condition and needs:

Public Transit: Recipients who do not have free transportation available and live within the service area of the Clark County, Washoe County, or Carson City public transit systems must use public transit where possible and cost-effective.

a. Recipients are deemed to live within the public transit system service area when they reside within three quarters (3/4) mile of a transit stop. If the recipient qualifies for public paratransit service and this is available in the area where the recipient resides, the recipient is deemed to live within the public transit area, whether or not the recipient resides within three quarters (3/4) mile of the transit stop.

b. Recipient's who do not have free transportation available must ride fixed-route public transit unless they reside outside the service area; they are assessed to be medically unable to board, disembark, or ride buses; or public transit buses cannot accommodate the recipient's wheelchair or other medical equipment that must accompany the recipient in transit.

c. Recipients who reside within the service area of the public transit system and are assessed to be unable to ride fixed-route buses will be referred for

assessment for public paratransit services. If qualified for public paratransit, the recipient will be qualified to ride only public transit services, unless traveling to a destination that is outside the public transit system service area. If traveling outside of the paratransit area, the recipient must be authorized by the NET broker.

d. A recipient who requires frequent travel on fixed route transit or public paratransit will be provided with a multiple-ride pass, where this is cost effective. Recipients who are issued passes by the NET broker may use them for purposes other than accessing medical services, as long as this does not incur additional costs to the Medicaid program.

1. If a recipient who is qualified for public transit level of service requires transport to a medical appointment that is not accessible by public transit, the recipient must receive specific authorization for the transport from the NET broker, who will require evidence of medical necessity for the trip and verify that the recipient is accessing the nearest appropriate provider. The NET broker will assign the recipient to ride with the least expensive transportation provider available.

2. Recipients are required to comply with all policy and rules of the public transit system. Recipients who are suspended from service by public transit agencies because of recipient misbehavior, persistent no-shows, or failure to cancel rides in a timely manner are ineligible for other NET services unless they can provide medical evidence that inability to access medical care during the suspension period will result in serious exacerbation of their medical condition or unacceptable risk to their general health. Recipients who have been suspended will not be provided NET for routine medical appointments. Recipients who have been suspended must exhaust the public transit system appeal process before being assessed for another level of service. Recipients who are suspended indefinitely from public transit will be suspended indefinitely from access to NET, except in cases where they can provide medical evidence that inability to access medical care will result in serious exacerbation of their medical condition or unacceptable risk to their general health.

3. Mileage Reimbursement under certain circumstances, recipients, their LRI or volunteer drivers may receive mileage reimbursement for driving a recipient to medical services.

a. Recipients assigned to ride only free transportation or their LRIs may be authorized to receive mileage reimbursement if traveling more than 25 miles one-way to access medical services or more than 50 miles in one week. Reimbursement will be at the Internal Revenue Service (IRS) rate for medical/moving mileage reimbursement and will be calculated starting at the 26th or 50th mile, respectively.

b. Recipients who are assigned to public fixed-route transit or paratransit may receive mileage reimbursement if they are traveling outside the transit system service area and mileage reimbursement is the least expensive mode of transportation.

c. Volunteer drivers (private citizens who do not contract with the NET broker) who are not LRIs, nonprofit organizations, or IHS may receive mileage reimbursement for driving a recipients to medical services, where this is the least expensive mode of transportation. Friends, families and neighbors may fall into this category. Reimbursement will be at twice the current IRS rate for medical/moving mileage reimbursement, as found on the IRS website at http://www.irs.gov. Mileage reimbursement is provided to the driver for vehicles miles actually driven from the point of where a recipient has been picked up and does not exceed twice the IRS medical/moving rate no matter how many recipients are transported. In cases of disputes over actual mileage, MapQuest or other geo-mapping software will be used as the final determining factor.

d. Recipients must have prior authorization to receive NET services for drivers to be eligible for mileage reimbursement.

e. The destination utilizes the nearest appropriate Medicaid health care provider or medical facility. Recipients have freedom of choice when selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider.

f. Prior authorization has been obtained from the contracted NET broker.

B. Eligibility

The eligibility functions for Title XIX Medicaid recipients are the responsibility of the Division of Welfare and Supportive Services (DWSS).

The eligibility functions for the Title XXI NCU recipients are the responsibility of the DHCFP.

All Title XXI NCU recipients are eligible for NET services in order to access medically necessary covered services.

Title XIX recipients who are Medicaid eligible solely for the purpose of payment of Medicare premiums, co-insurance, deductibles, or co-pays i.e., Qualified Medicare Beneficiaries (QMB's), Specified Low Income Medicare Beneficiaries (SLMB's) and Qualified Individuals (QI-1s) "not qualified" non-citizens are not eligible for NET services. Residents of skilled nursing facilities (Medical Assistance to the Aged, Blind and Disabled (MAABD) Institutional and County Indigent eligibility categories) are not eligible to receive NET services. Medically necessary NET costs are included in the nursing facilities rate structure. Other Title XIX recipients are eligible for NET services in order to access medically necessary covered services.

Medicaid and NCU recipients are eligible for NET services only from the date of determination forward. No payment will be made for NET provided while a recipient's Medicaid application was pending. Retroactive eligibility does not apply to NET services.

Special payment arrangements may be made with the NET broker for special circumstances where it is in the best interest of the DHCFP to provide NET transportation to certain Medicaid or NCU recipients. These decisions will be made exclusively by the DHCFP; however the payment rate will be determined mutually by the DHCFP and the NET broker. One example is the transfer of the resident from one skilled nursing facility to another skilled nursing facility where the two parties agree to a cost-plus payment arrangement. Similarly, if the DHCFP decides to 'carve out' an eligibility group from non emergency transportation they may contract to provide service on an individual basis at a cost plus payment model.

C. Examples of circumstances for which NET will be provided to eligible recipients include:

1. A transplant candidate to be evaluated for services not available in Nevada;

2. A recipient who is being admitted to an out-of-state nursing facility. When a recipient is being admitted to an out-of-state nursing facility, the discharging facility must contact the DHCFP out-of-state coordinator for authorization prior to the admission. Please refer to the MSM Chapter 500;

3. The transport from an acute general hospital to an acute psychiatric hospital; and

4. Transportation to/from a routine Medicaid-reimbursable medical or dental appointment.

Each of these examples assume that the LOC required during transit does not exceed the scope of services of an EMT-Basic and that required timeframes allow the NET broker to make appropriate arrangements.

D. The NET broker must allow one escort, who must be at least 18 years of age (or any age if the escort is the parent of a minor child) to accompany a recipient or group of recipients when escort services are determined medically necessary or for those recipients who are minor children or adjudicated incompetent. A Medicaid recipient who is physically disabled or developmentally disabled may be authorized to be accompanied by an escort during the assessment to access NET services. A person under the age of 18 must be accompanied by one escort unless that person is married, legally emancipated, or obtaining family planning services.

1. During the Medicaid DO NET assessment, the assessor will determine whether the recipient requires an escort and specify the circumstances under which an escort may accompany the recipient while riding NET at the time of the assessment.

E. The NET broker may not charge for transport of an escort when the services of the escort are required for a minor child or when the services of the escort are determined to be medically necessary. NET services may not be authorized for minor children unless a parent (regardless of the parent's age) or LRI accompanies the child. Exceptions include but are not limited to:

1. A minor child transported for the purpose of obtaining family planning services.

2. A minor child transported from one facility to another for treatment and the parent or LRI is not available. A Consent and Release of Liability form must be signed by the parent or LRI prior to the transport.

3. A minor child with a mental disability receiving NET to a facility by ambulance where a paramedic or EMT is present and, per the judgment of appropriate medical personnel, it would be detrimental to the child if the parent or LRI is present in the vehicle. A Consent and Release of Liability form must be signed by the parent or LRI prior to the transport.

In addition and pursuant to Nevada MSM Chapter 3500, escort services are available to recipients who require approved Personal Care Services (PCS) en route to, or at, a destination to obtain Nevada Medicaid or NCU covered, medically necessary services when a LRI is unable to accompany them. An escort may be a parent or legal guardian, caretaker, LRI, friend or Personal Care Attendant (PCA) who accompanies the recipient.

An adoptive and foster parent of a program eligible child are reimbursed pursuant to the NET broker's guidelines for the costs of transporting children in out-of-home placement

to medically necessary covered services. Foster and adoptive parents are required to demonstrate a need for public assistance with transportation. The agency holding custody of a foster child must coordinate the transportation services through the NET broker.

F. Pursuant to federal regulations, eligible FFS program recipients may obtain covered medically necessary services, with limitations, from any facility, pharmacy, physician, therapist, agency or provider participating under a signed agreement with Nevada Medicaid. Eligible MCO enrollees may obtain covered medically necessary services from a provider who is a member of a contracted MCO's network of providers or from a provider who has an agreement with a contracted MCO to provide services to a recipient as an out-of-network provider.

G. In those situations in which a recipient has requested out-of-town or out-of-state covered medical services which are determined to be available in the recipient's community, a referral and justification by the local primary care provider is first required. This referral must then be authorized by the DHCFP's QIO-like vendor or contracted MCO before the NET broker may authorize services depending on unique circumstances. NET services will not be authorized in those instances in which a recipient has requested out-of-town and/or out-of-state medical services until such time as the NET broker can confirm that authorization and justification for such services has been obtained.

The same provision applies to FFS recipients who wish to utilize a health care provider or medical facility that is located within the boundaries of his/her city but is not the nearest appropriate health care resource.

H. Out-of-Area and Air Travel: Recipients may be eligible to receive NET for out-of-town, out-of-state or airline travel if certain conditions are met.

1. Recipients must receive prior authorization for out-of-area medical services from the DHCFP's utilization management agent or their MCO prior to requesting authorization for transportation.

2. Recipients are only eligible for NET to out-of-area services if no comparable services are available in the area.

3. Recipients must request authorization for out-of-area and airline NET a minimum of 14 days prior to the travel date.

a. Exceptions to the 14 calendar day requirement may be granted if the recipient has a medical necessity to travel and could not have known 14 days in advance, as in the case of a donor organ becoming available for a transplant surgery that must occur out of the area.

b. Exceptions to the 14 day requirement may be granted for recipients who are discharged to or from an out-of-area acute-care facility or out of state nursing facility.

c. Other exceptions may be granted from time to time if they are in the best financial interest of the State.

4. Recipients are required to travel by the least expensive mode of transportation available that will accommodate their medical requirements.

5. Recipients are required to make use of any low-cost accommodations available for out-of-area travel, such as Ronald McDonald houses, and will not be authorized or reimbursed for higher costs unless the recipient can demonstrate to the NET broker that the low-cost accommodations in the area were unavailable at the time the recipient required them.

6. Recipients may incur higher costs for accommodations if they demonstrate that this will reduce the overall cost of out-of-area travel.

7. Out-of-area costs for lodging, meals, and other necessary items are reimbursed in accordance with the current DHCFP travel policy with the following exceptions: Transportation, including mileage, is reimbursed according to the terms of this Chapter. For all reimbursement except mileage, the recipient is reimbursed at actual costs up to limits set by DHCFP travel policy and the recipient or escort must submit receipts documenting expenditures to receive reimbursement. When two parents accompany a child under three months old, they will receive a single reimbursement for lodging. Each parent will not receive an individual reimbursement. Meals will be reimbursed for both parents.

8. Recipients and their escorts are not reimbursed for the cost of meals if free meals are available at meal time.

9. Recipients must submit their request for reimbursement within 60 calendar days after completing the out-of-area trip.

10. Recipients who have recurring requirements to receive out-of-area trips for a single treatment or multiple treatments for the same diagnoses, may have up to five trips a month authorized at the same time for mileage reimbursement only.

I. Transportation services and per diem are covered for new parent(s) to care for a newborn up to 3 months of age receiving treatment on an inpatient basis in a facility. This transportation may be authorized when needed to encourage bonding between parent and child, and to promote confidence in the ability to care for the newborn.

J. NET services may be authorized for a recipient residing in an inpatient treatment facility to allow the resident to attend a therapeutic home visit, in-state or out-of-state, when such visits are part of the resident's treatment plan. It is the responsibility of the inpatient treatment facility to obtain transportation for eligible recipients for all therapeutic home visits by calling the NET broker. NET services are not available to family members to visit a recipient residing in an inpatient treatment facility. The NET broker may authorize NET services for therapeutic home visits within the following criteria:

1. Acute care:

   The QIO-like vendor must prior authorize absences beyond eight hours. No prior authorization is required for absences of less than eight hours in duration;

2. Acute rehabilitation:

   The QIO-like vendor must authorize all absences;

3. Intermediate Care Facility for the Mentally Retarded:

   At the facility's request, a maximum 24 days per calendar year is allowed for therapeutic leaves of absence;

4. Residential Treatment Center:

   At the facility's request and as ordered by the attending physician, a maximum of three (3) 72 hour home therapeutic passes per calendar year is allowed. Please refer to MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services.

5. Residential Group Care:

   A maximum of 25 days per calendar year is allowed for therapeutic home passes. Duration of each pass may be no more than 72 hours.

K. Per 42 CFR 440.170, the costs of meals and lodging may also be covered for one attendant, if an attendant is required to ensure that the recipient receives required medical services. As noted in Section 1903.2A (8) above, the cost of meals and lodging may be covered for two attendants when those attendants are the parents of a child under three (3) months of age. Costs of meals and lodging for an attendant/attendants will be covered when traveling to and from services or while the recipient is receiving medical care when such travel requires the attendant/attendants to be away from their legal or primary residence over night or as long as medically necessary. Costs will not exceed a per diem rate set forth in DHCFP policy.

L. Eligible program recipients who live out-of-state may obtain NET services similarly to those eligible recipients who reside within the State of Nevada. Such out-of-state recipients may include foster children, children placed in an adoptive home under the auspices of an Adoption Assistance Program (AAP) agreement, or children in Residential Treatment Centers (RTCs). Authorization of NET services for eligible recipients residing out-of-state is the same as for those eligible recipients who reside within Nevada.

M. Nevada residents living near the state line or border may be geographically closer to out-of-state providers than to in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the DHCFP refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation.

The primary catchment areas are listed in the MSM Chapter 100, Medicaid Program:

N. Several tribes and/or IHS clinics offer ambulance and/or van services for both emergency and NET. Community Health Representatives (CHRs) may provide NET services to recipients who are eligible for NET services in private vehicles to medically necessary covered services and are reimbursed at a per mile rate that is double the IRS medical/moving mileage rate. The IHS NET services do not require prior authorization. All IHS claims for reimbursement for non emergency transportation services are submitted to the NET broker for adjudication and payment.

O. If a recipient is transferred to/from an out of state nursing facility or ICF/MR facility during a month where they were eligible for NET, and capitation was paid for them, then that transfer is a covered benefit. If the transfer happens in a month after their initial admission, where no capitation has been paid, then the NET broker will arrange the transportation and will be reimbursed on the mutually agreed upon cost plus payment model.

P. Medicaid and NCU funds may not be used to pay for transportation services that are otherwise available without charge to both Medicaid and non-Medicaid recipients.

In addition, Medicaid is generally the payor of last resort except for certain Federal programs such as Title V Maternal and Child Health Block Grant funded services or special education related health services funded under the Individuals with Disabilities Education Act (IDEA).

Q. The following are non-covered NET services:

1. When one or more eligible recipients make the same trip in a private vehicle or van, reimbursement is made for only one recipient;

2. Transportation to or from any non-covered service, except for exclusion due to Third Party Liability (TPL) coverage under the Medicaid program;

3. Travel to visit a recipient in an inpatient treatment facility, except in the case of a parent or parents visiting a newborn that is in a facility [see 1903.2A (6)];

4. Transportation between hospitals for outpatient or inpatient care or services (e.g., MRI, CAT scan, etc.); exceptions may be granted when services to treat the recipient's condition are not available at the originating hospital and/or are not part of the all-inclusive prospective rate, or if the recipient is transferring to a hospital closer to home following an out-of-area hospital stay;

5. "Deadheading," this refers to a provider's return trip when the eligible recipient travels only one way of a two-way trip;

6. The cost of renting an automobile for private vehicle transport;

7. A non-transport charge for a recipient who did not show up for their scheduled ride;

8. Wages or salary for attendants;

9. Charges for waiting time, stairs, plane loading; and/or

10. Routine or special supplies including: oxygen; special services such as: defibrillation; IVs; intubation, ECG monitoring; or extra attendant; or, air transport excise tax;

11. Transportation of a recipient in a personal care attendant's private vehicle is not a reimbursable service;

12. Transportation from a nursing facility to a medical appointment;

13. Stretcher, basic life support, and advanced life support transports are beyond the scope of NET broker and are not NET broker covered services.

    Stretcher is a covered NET service. Claims for stretcher transport should be submitted to the State's fiscal agent.

1904.3 NET BROKER RESPONSIBILITY

A. The NET broker provides all or most services ancillary to transporting Medicaid recipients, but provides transportation only through subcontracting or non-contract arrangements with third parties.

1. NET broker shall not hold ownership in any NET provider with whom the broker sub-contracts or arranges NET through non-contractual relationship. This prohibition applies to the corporation, if the broker is incorporated, and to owners, officers, or employees of the broker.

2. The broker will submit all subcontracts or other documentation pertaining to the terms and conditions for provision NET by third parties to DHCFP for approval.

3. The broker shall advise DHCFP in writing of all financial relationship and transactions between itself and a NET provider (for instance, loans, grants, etc.) that are not included in the NET instrument, specifying the nature of the relationship and the terms and conditions governing it. Such relationships and transactions are not permitted without written approval of the DHCFP administrator.

B. Commercial Transportation Vendors: The NET broker may subcontract with various private vendors to provide transportation to Medicaid recipients.

1. The NET broker shall directly facilitate transportation for recipients requiring bus passes, public paratransit and mileage reimbursement. Recipients who request higher levels of service will need to be assessed for level of service by the Medicaid DO.

2. Recipients may not be assigned to ride with a commercial vendor if they have been prior authorized for a lesser level of service, unless the authorized level of service does not provide access to necessary medical care that complies fully with Medicaid NET policy. For instance, if a recipient is authorized for a bus pass, but the bus does not pass within 3/4 of a mile of the provider’s office, then the NET broker may authorize a higher level of transportation.

3. Recipients must be assigned to the least expensive commercial vendor who provides the level of service and geographic access required.

4. Where there is public transit available in a rural county, and that provider is capable of offering the level of service required by the recipient, commercial vendors may not be used for the convenience of the recipient or the NET broker.

5. Recipients may not be assigned to higher level of service than they are authorized by the assessment to use because the lower level of service is unavailable at the time of the medical appointment unless the recipient provides documentation that inability to access medical care at the appointed time will result in serious exacerbation of their medical condition or unacceptable risk to their general health.

6. When the recipient is authorized for use of commercial vendors, the Medicaid DO will stipulate the maximum level of service that the recipient is authorized to access.

C. Using monthly enrollment downloads from the DHCFP or systems maintained by the DHCFP's QIO-like vendor, the NET broker is solely responsible for verifying program eligibility for each recipient prior to authorizing and scheduling the NET service. The NET broker must also verify the existence of an appointment and that the appointment is a Medicaid covered service, which may require contacting the health care provider, the DHCFP's QIO-like vendor, or the contracted MCO.

D. Neither the NET broker nor its providers shall release information related to a recipient without the written consent of the recipient or the recipient's legal or authorized representative, except as required by law or except to verify medical appointments in accordance with policy. The NET broker and any of its providers meeting the definition of a "covered entity" as defined in the HIPAA Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

E. The DHCFP expects that the NET broker and its provider network will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable, in accordance with NRS 200.508 and 200.509.1.

F. Pursuant to 42 CFR 438.100(c), the NET broker shall ensure that each recipient is free to exercise his or her rights and that by the exercise of those rights, no adverse affect will result in the way the NET broker treats the recipient.

G. Recipients have freedom of choice when selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider.

1. The NET broker will be responsible for verifying that the recipient is using the nearest Medicaid provider for the applicable services.

2. The NET broker will develop written procedures, approved by DHCFP for verifying that the nearest Medicaid provider is being used.

3. The procedures shall include an exception procedure that specifies the conditions under which the recipient may access a provider other than the nearest, if exception to the requirement might, in some cases, be appropriate.

4. The recipient must use the nearest appropriate provider when utilizing NET. Referral by a physician to a provider who is not the nearest appropriate provider is not an authorized exception to the nearest appropriate provider requirement. The NET broker procedure will include a requirement that exceptions to the nearest appropriate provider requirement include a written justification that can be provided to DHCFP upon request.

5. DHCFP will provide the NET broker with a list of Medicaid providers and their addresses, including fee-for-service providers and providers within each HMO's network quarterly.

6. DHCFP will periodically review rides to verify that the NET broker has transported to the nearest appropriate provider.

7. Where DHCFP determines that a recipient has employed NET to access a provider other than the provider located nearest to the recipients residence and there is no justification documented, the NET broker will refund the capitation payment for that recipient for all months that the recipient accessed a geographical inappropriate provider.

8. If historical transportation costs are used to determine rates, all geographically inappropriate rides will be disqualified from consideration in setting NET rates.

H. A transportation provider must wait at least ten minutes after the scheduled pick-up time before "no-showing" the recipient at the pick-up location. The NET broker or contracted transportation providers shall not charge recipients for transportation services or for no shows.

I. Recipients who are repeated no-shows or fail to cancel in a timely manner for rides provided by its commercial vendors may be subject to suspensions of services. Recipients who receive a suspension will have the right of a fair hearing.

J. Access to transportation services shall be at least comparable to transportation resources available to the general public. Capacity shall include all of the modes of transportation listed in Section 1904 of this chapter.

K. The NET broker shall ensure all drivers of vehicles transporting Medicaid and the NCU program recipients meet the following requirements:

1. All drivers, at all times during their employment, shall be at least 18 years of age (NRS 450B.180) and have a current valid driver's license from the State of Nevada to operate the transportation vehicle to which they are assigned.

2. Drivers shall have no more than one chargeable accident and two moving violations in the last three years. Drivers shall not have had their driver's license, commercial or other, suspended or revoked in the previous five years. Drivers shall not have any prior convictions for substance abuse, sexual abuse or crime of violence. Approval of any such driver who has been convicted of a felony shall be obtained from the DHCFP before employment by the vendor.

3. All drivers shall be courteous, patient and helpful to all passengers and be neat and clean in appearance.

4. No driver or attendant shall use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time. The transportation provider shall not use drivers who are known abusers of alcohol or known consumers of narcotics or drugs/medications that would endanger the safety of recipients.

5. All drivers and attendants shall wear or have visible, easily readable proper organization identification.

6. At no time shall drivers or attendants smoke while in the vehicle, while involved in recipient assistance, or in the presence of any recipient.

7. Drivers shall not wear any type of headphones or use cell phones, except for dispatch purposes, at any time while on duty. Drivers shall not use cell phones while operating vehicles.

8. Drivers shall assist passengers in the process of being seated and confirm that all seat belts are fastened properly and wheelchairs and wheelchair passengers are properly secured.

9. Drivers shall provide necessary assistance, support, and oral directions to passengers. Such assistance shall include assistance with recipients of limited mobility, and movement and storage of mobility aids and wheelchairs.

10. The NET broker shall provide, or ensure that its subcontractors provide, classroom and behind-the-wheel training for all drivers within 30 days of beginning service under this agreement. Driver training shall, at a minimum, include defensive driving techniques, wheelchair securement and lift operation, cultural and

disability sensitivity training, passenger assistance techniques, first aid, and general customer service. The training curriculum is subject to DHCFP approval.

L. The NET broker shall ensure that all transportation providers maintain all vehicles adequately to meet the requirements of the contract. Vehicles and all components shall comply with or exceed State, Federal, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations. All vehicles shall meet the following requirements:

1. The transportation provider shall provide and use a two-way communication system linking all vehicles used in delivering the services under the contract with the transportation provider's major place of business. Pagers are not an acceptable substitute.

2. All vehicles shall be equipped with adequate heating and air-conditioning.

3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position when required by law. Each vehicle shall utilize child safety seats when transporting children as prescribed by NRS.

4. All vehicles shall have a functioning speedometer and odometer.

5. All vehicles shall have two exterior rear view mirrors, one on each side of the vehicle.

6. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.

7. The interior and exterior of the vehicle shall be clean and the exterior free of broken mirrors or windows, excessive grime, major dents or paint damage that detract from the overall appearance of the vehicles.

8. The vehicle shall have passenger compartments that are clean, free from torn upholstery or floor or ceiling covering, damaged or broken seats, protruding sharp edges and shall also be free of dirt, oil, grease or litter.

9. All vehicles shall have the transportation provider's name, vehicle number, and the NET broker's toll free and local phone number prominently placed within the interior of each vehicle. This information and the complaint procedures shall be available in written form in each vehicle for distribution to recipients on request.

10. Smoking is prohibited in all vehicles while transporting Medicaid and NCU program recipients. All vehicles shall have the following signs posted in all vehicle interiors, easily visible to the passengers:

"NO SMOKING"
"ALL PASSENGERS MUST USE SEAT BELTS"

11. All vehicles shall include a vehicle information packet containing vehicle registration, insurance card and accident procedures and forms.

12. All vehicles shall be provided with a fully equipped first aid kit.

13. Each vehicle shall contain a current map of the applicable State(s) with sufficient detail to locate recipients and medical providers.

    All vehicles shall have a minimum of $1,500,000 combined single limit insurance coverage for vehicles at all times during the contract period in accordance with State regulations and contract requirements. This is per NAC 706.191.

14. Any vehicle or driver found out of compliance with the contract requirements, or any State or Federal regulations shall be removed from service immediately until the NET broker verifies correction of deficiencies. Any deficiencies and actions taken shall be documented and become a part of the vehicle's and the driver's permanent records.

15. The NET broker shall develop and implement an annual inspection process in addition to the applicable State vehicle inspection requirements to verify that vehicles used by transportation subcontracted providers meet the above requirements and that safety and passenger comfort features are in good working order (e.g., brakes, tire, tread, signals, horn, seat belts, air conditioning/heating, etc.).

M. The NET broker shall ensure adequate oversight of subcontracted transportation providers and ensure that providers comply with all applicable State and Federal laws, regulations and permit requirements. This duty includes, but is not limited to verification that each provider maintains at all times:

1. Insurance which complies with the standards at 49 C.F.R. 387 subpart B, N.A.C. §191(1-3), and which provide for notice of the status of the policy to the Administrator of Nevada Medicaid upon expiration, termination, or at any time requested by the Administrator;

2. An alcohol and substance abuse testing program which complies with standards at 49 C.F.R. Part 382;

3. Criminal background checks conducted periodically that assure criteria at MSM § 103.12A are met;

4. Signage on all vehicles identifying those operating under any exemption from Nevada Transportation Authority (NTA) regulation;

5. Documentation in each vehicle of any exemption from NTA regulation;

6. Current provider agreements with Nevada Medicaid.

As a contracted agent of the Director of the Department of Health and Human Services (DHHS), subject to the requirements of NRS § 422.2705 and NRS § 706.745. The NET broker may utilize the services of motor carriers that are exempt from certain certification requirements of the NTA of the Department of Business and Industry. Prior to exercising this option, the NET broker shall, with the assistance of the NTA, establish and utilize an inspection program designed to ensure that vehicles used by these motor carriers, and their operations, are safe. The NET broker shall also require these same motor carriers to submit proof of a liability insurance policy, certificate of insurance or surety which is substantially equivalent in form and is in the same amount or in a greater amount than the policy, certificate or surety required by the Department of Motor Vehicles (DMV) pursuant to NRS 706.291 for a similar situated motor carrier. The NET broker shall certify the transportation providers meet insurance requirements, vehicle safety standards, and driver background and drug tests cited in this chapter before a letter of exemption will be issued by DHCFP for that transportation provider.

N. The NET broker is encouraged and expected to use recipient vouchers and/or volunteer programs to provide the most cost efficient transportation service to the recipient if such transportation is appropriate to meet the needs of the recipient. The broker shall verify and document vehicles and drivers used in reimbursement and volunteer programs that comply with appropriate State operating requirements, driver's licensure, vehicle registration and insurance coverage.

O. The NET broker will be available as a resource to the DHCFP's QIO-like vendor or contracted MCO when medically necessary covered services must be provided outside a recipient's community. The NET broker will advise the QIO-like vendor or contracted MCO regarding such factors as distance and transportation availability.

1904.4 RECIPIENT RESPONSIBILITY

The recipient or LRI shall:

a. Use personal transportation or transportation of a LRI whenever possible;

b. Explore alternative resources first, and when such a resource exists at no cost to the recipient, use the alternative transportation resource;

c. If free transportation is not available, use public transportation when residing within 3/4 of a mile of a bus stop;

d. Participate in the assessment process to determine the appropriate level of service needed for transportation. The recipient must follow through when referred for public paratransit evaluation;

e. If eligible for Paratransit, the recipient is required to access available Paratransit programs;

f. Make and keep all appointments and travel schedules, and telephone to cancel when an unforeseen event makes it impossible to keep an appointment;

g. Recipients who are not using public transit or their representatives are responsible to schedule rides by contacting the NET broker;

1. Recipients must schedule rides (except out-of-the-area travel) not less than five and not more than 30 days prior to travel.

2. Recipients assigned to public paratransit are responsible to contact the public transit authority to schedule rides.

h. Recipients are required to be ready and available to ride from 15 minutes before the scheduled ride to 30 minutes after the scheduled time;

1. Recipients using public paratransit will contact public transit system to cancel rides, including late rides, according to the transit system rules.

2. Recipients who are using commercial transportation vendors will follow the NET broker policy concerning late rides.

i. Notify the NET broker immediately when an urgent service need for NET transportation is discovered;

j. Notify the NET broker of all third party insurance information, including the name of other third party insurance, or any changes in insurance coverage at the time of service, if possible, or in a timely manner thereafter;

k. Not refuse service of a provider based solely or partly on the provider's race, color, national origin, sex, religion, disability or age;

l. Provide car seats, wheelchairs, other devices or equipment, and any extra physical assistance, not required of providers, necessary to make the trip.

1904.5 GEOGRAPHIC AREA

The NET broker provides services statewide and in catchments areas. The NET broker provides services to and from out of state facilities.

1904.6 SPECIAL REQUIREMENTS FOR SELECTED COVERED NET SERVICES

A. Out-of-Network Providers

The NET broker generally uses transportation providers who have executed a contract to be part of the NET broker's network. However, occasionally it may be necessary for enrolled recipients to obtain NET services from an out-of-network provider (e.g., the recipient needs specialized transportation for which the NET broker has no such specialist in its network), the broker must:

1. Arrange transportation with out-of-network providers with respect to services and payment;

2. Offer the opportunity to the out-of-network provider to become part of the network; and

3. Negotiate a contract to determine the rate prior to services being rendered.

B. Family Planning Services

Pursuant to policies set forth in Section 603.3, Chapter 600 of the Nevada MSM, the NET broker will authorize NET services to family planning services for any eligible recipient to any qualified provider.

C. Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs.

Transplant services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. When a transplant

recipient's care needs during transit are within the scope of the NET broker, transportation should be prior authorized and provided through the NET broker. When the recipient's care needs during transit exceed the capabilities of the NET broker (e.g., Specialty Care Transport is required) and/or the timeframe for transport is less than four hours, transportation may be treated as an emergency. (Refer to Section 1903.1 for guidance regarding Emergency Medical Transportation.)

D. Paratransit Transportation

Paratransit transportation may be provided based on assessed medical need. When Paratransit transportation is indicated, such transportation services shall be "curb to curb" or "door-to-door", whichever service is necessary for the recipient. Paratransit providers are responsible for assisting riders into and out of the vehicle, but are not responsible for lifting recipients using a wheelchair or gurney up or down stairs.

1904.7 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of DHCFP and the DWSS. The NET broker shall accept each recipient who is enrolled in or assigned to the NET broker by DHCFP and/or its enrollment sections.

Pursuant to The State of Nevada's Medicaid State Plan §3.1 for NET Services, eligible recipients do not have the option of disenrolling from the NET broker, nor does the NET broker have the option of disenrolling any eligible recipient. Copies of the State of Nevada Medicaid State Plan §3.1for NET Services are available upon request by contacting the DHCFP Business Lines Unit at (775) 684-3692.

"Pending" Medicaid recipients (those whose applications for assistance have been submitted but not adjudicated) are not eligible for transportation services provided by the NET broker.

The NET broker is not financially responsible for any services rendered during a period of retroactive eligibility.

1904.8 INFORMATION REQUIREMENTS

The NET broker must have written information about its services and access to services available upon request to recipients. This written information must also be available in English and Spanish. The NET broker must make free, oral Spanish interpretation services available to each recipient, if necessary. Broker may supply telephone interpretation services for other non-English languages. DHCFP must approve all materials distributed to recipients.

a. The NET broker's written material must use an easily understood format. The NET broker must also develop appropriate alternative methods for communicating with people with

vision or hearing impairments and must accommodate recipients with a physical disability in accordance with the requirements of the ADA. All recipients must be informed that this information is available in alternative formats and how to access those formats.

1905 NET GRIEVANCES, APPEALS AND PROVIDER DISPUTES

1905.1 NOTICE OF DECISION

The NET broker may take action on a recipient's request for transportation based on Medicaid coverage policy and guidelines as set forth in the Nevada MSM. The request may be approved, denied, or limited (i.e. denied in part, or reduced) based on these eligibility and coverage policies. The broker shall notify each recipient in writing of the reason for any action which is taken to deny or otherwise limit a recipient's request within five business days of such action; such notification is called a Notice of Decision (NOD).

Pursuant to 42 CFR 438.10 (h), the NOD shall include information regarding the recipient's right to a State Fair Hearing (see Chapter 3100 of the Nevada MSM), the method for obtaining a State Fair hearing, and the rules that govern the recipient's right to representation. The broker must also provide a NOD to the requesting provider, if applicable.

The NOD must include the following information:

a. The action the broker or its network provider has taken or intends to take;

b. The reasons for the action;

c. The recipient's right to request a State Fair Hearing;

d. The method of obtaining a State Fair Hearing;

e. The rules that govern representation at a State Fair Hearing;

f. The right of the recipient to request a State Fair Hearing and how to do so;

g. The right to request to receive benefits while the hearing is pending and how to make this request; and

h. That the recipient may be held liable for the cost of those benefits if the hearing decision upholds the broker's action.

The NET broker shall provide any reasonable assistance to recipients in filing a State Fair Hearing.

The NET broker is required to maintain records of all grievances received and NODs provided, which the State will review as part of the State's contract monitoring and management oversight.

1905.2 RECIPIENT GRIEVANCES AND PROVIDER DISPUTES

The NET broker must have a process with which to address recipient grievances and provider disputes. DHCFP will refer all recipient grievances and provider disputes to the NET broker for resolution. The NET broker must provide information about its recipient grievance process to all providers and subcontractors, at the time they enter into a contract.

The NET broker is required to dispose of each recipient grievance and provide notice as expeditiously as the recipient's health condition requires or no more than 90 days from the date the grievance is received by the NET broker or a network provider. The NET broker shall attempt to respond verbally to recipient, authorized representative, DHCFP or provider grievances and disputes within 24 hours of receipt of the grievance or dispute. The NET broker shall issue an initial response or acknowledgement to written grievances and disputes in writing within 72 hours.

In addition, the NET broker must:

a. Provide recipients any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability;

b. Acknowledge receipt of each recipient grievance;

c. Ensure that the individuals who make decisions on recipient grievances were not involved in any previous level of review or decision-making; and

Notify the recipient of the disposition of grievances in written format. The written notice must include the results of the resolution process and the date it was completed.

1906 REFERENCES AND CROSS REFERENCES

1906.1 APPLICABLE MEDICAID SERVICES MANUAL (MSM) CHAPTERS ARE AS FOLLOWS:

Medicaid Services Manuals:

Chapter 100 Medicaid Program
Chapter 200 Hospital Services
Chapter 300 Radiology Services
Chapter 400 Mental Health and Alcohol/Substance Abuse Services
Chapter 500 Nursing Facilities
Chapter 600 Physicians Services
Chapter 700 Rates and Cost Containment
Chapter 800 Laboratory Services
Chapter 900 Private Duty Nursing
Chapter 1000 Dental
Chapter 1100 Ocular Services
Chapter 1200 Prescribed Drugs
Chapter 1300 DME, Disposable Supplies and Supplements
Chapter 1400 Home Health Agency
Chapter 1500 Healthy Kids Program
Chapter 1600 Intermediate Care Facility for the Mentally Retarded
Chapter 1700 Therapy
Chapter 1800 Adult Day Health Care
Chapter 1900 Transportation
Chapter 2000 Audiology Services
Chapter 2100 Home and Community Based Waiver – Mental Retardation (MR)
Chapter 2200 Home and Community Based Waiver (HCBW) for the Frail Elderly
Chapter 2300 Physical Disability Waiver
Chapter 2400 Comprehensive Outpatient Rehabilitation (COR) Services
Chapter 2500 Case Management
Chapter 2600 Intermediary Service Organization
Chapter 2700 Home and Community-Based Waiver (HCBW) for the Elderly in Adult Residential Care
Chapter 2800 School Based Child Health Services
Chapter 3100 Hearings
Chapter 3200 Hospice
Chapter 3300 Program Integrity
Chapter 3500 Personal Care Services Program
Chapter 3600 Managed Care Organization (MCO)
Chapter 3900 Home and Community-Based Waiver (HCBW) for Assisted Living

1906.2 SECTION 3.1 of THE STATE OF NEVADA MEDICAID STATE PLAN for NON-EMERGENCY TRANSPORTATION SERVICES

Copies of the State of Nevada Medicaid State Plan § 3.1 for Non-Emergency Transportation Services are available online at http://dhcfp.nv.gov.