

reimbursement and to make decisions granting or denying payment.

3. Medicaid has certain requirements that must be met before it will pay for transportation costs. One requirement is a certification from a primary care physician that trips outside of the usual service area (more than thirty miles) are necessary for the recipient's medical treatment. This certification must be accompanied by a list of the provider physicians outside of the area and an estimate of the frequency of the patient's visits. A second requirement is that all trips be approved in advance other than those made on an emergency basis.

4. The coordinator at the Medicaid transportation brokerage agency says that she talked with the petitioner in April of 2004 telling her that she had to call in before a medical appointment to have the trip approved under Medicaid requirements. She says that she also told the petitioner that she had to get a physician provided necessity form on file for all out of area medical trips. She felt following the conversation that the petitioner was frustrated but understood the requirements.

5. The petitioner does not recall this conversation, although she does recall talking to the brokerage agency in

April about a bill sent to her for \$100 for transportation services. She was told that the bill was sent to her in error and would be billed through Medicaid. The petitioner said that part of her disability is that she has a poor memory, a fact which was not disputed by DCF and was, in fact, affirmed by the testimony of the brokerage coordinator.

6. The brokerage coordinator did not send written Medicaid reimbursement rules to the petitioner in April of 2004 when she began the Medicaid program. The coordinator said that she did not send the rules because she assumed the petitioner understood the requirements after speaking with her on the telephone.

7. The petitioner needed transportation for several trips more than thirty miles outside of the area. The petitioner was not provided with forms used by the broker to verify this information. No verification information appeared in her file. At the time, no follow up was done by the brokerage agency to advise the petitioner or to assistance her with coming into compliance.

8. The brokerage agent said that the petitioner called for preapproval of eight trips between April 20 and August 18, 2004. The agent recalls speaking to the petitioner herself on occasion with regard to these requests. The

petitioner does not recall requesting preapproval for any trips. The petitioner's regular driver does not recall ever requesting preapproval either. All eight trips were approved, including the out of area visits, even though the brokerage admits it did not have the appropriate documentation on file. This payment occurred due to an "oversight" on the part of the brokerage agency.

9. In August of 2004, the agency discovered that the petitioner did not have the PCP forms for out of area visits on file. The petitioner was sent the forms which she mistakenly gave to her out of area providers rather than her PCP to return to the transportation broker. Those incorrect forms were provided in late August of 2004. The fact that they were incomplete because they were not filled out by the primary care physician was not brought to the petitioner's attention at that time.

10. The petitioner's personal driver took her to three appointments on November 23, 2004, December 6, 2004 and December 23, 2004. The latter trip was an emergency visit to a dentist when a cap came off the petitioner's tooth.

11. The brokerage denied payments for those three trips on January 28, 2005 because the petitioner had not called for

preapproval and because the out of area necessity form from her PCP was not on file.

12. With the assistance of the brokerage agency, the petitioner resubmitted letters from all her physicians on February 7, 2005, this time including her primary care physician.

13. Following the denial, the petitioner asked for a written copy of the rules so she could have something on hand to refer to. She did not get a response to her first request but on February 17, 2005 she received a copy of a form letter dated December 10, 2004 and a copy of a regulation. The form letter said nothing about the Medicaid requirements for payment and primarily involved procedures for asking the brokerage agency to arrange transportation. However, a page from the Medicaid transportation procedures manual regarding the prior authorization rule was included. The rule about service beyond thirty miles was not sent to the petitioner.

14. The hearing officer finds the testimony that the petitioner was advised of and understood the rules to be unreliable in light of the petitioner's credible testimony to the contrary, the poorly kept records (particularly with regard to the out of area forms) prior to August of 2004 and the failure of the agency to address the pertinent

requirements in its form letter dated December 10, 2004, which was sent to the petitioner only on her request.

15. The hearing officer further finds that the agency knew or should have known that the petitioner returned the wrong out of area forms in August of 2004 yet did nothing to advise her of that fact until after the denials.

ORDER

The decision of DCF on all three denials is reversed.

REASONS

The Medicaid program provides "transportation to and from necessary medical services" with the following limitations:

1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)
2. Transportation is not otherwise available to the Medicaid recipient.
3. Transportation is to and from necessary medical services.
4. The medical service is generally available to and used by other members of the community locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.
5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.

6. Reimbursement for the service is limited to enrolled transportation providers.
7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.
8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listing in the Table of Contents.

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The petitioner does not disagree that the above regulation justifies the transportation provider in requesting prior approval for non-emergency visits and requiring documentation on the necessity of out of area trips for medical care. Her grievance arises from the fact that she received inadequate notice of her obligations under the transportation program before she incurred transportation expenses for medical trips.

There is no question that DCF "has an affirmative obligation to provide Medicaid applicants . . . with information concerning Medicaid eligibility requirements." Stevens v. Department of Social Welfare, 159 VT 408, 414 (1992). The federal regulations governing the Medicaid program specifically provide that:

- (A) The agency must furnish the following information in written form, and orally as appropriate, to all applicants and to all other individuals who request it:
 - (1) The eligibility requirements
 - (2) Available Medicaid services
 - (3) The rights and responsibilities of applicants and recipients.

- (B) The agency must publish in quantity and make available bulletins or pamphlets that explain the rule governing eligibility and appeal in simple and understandable terms.

42 CFR 435.905(a)

There is no dispute in this matter that the petitioner received no written information regarding her rights and responsibilities in the form of any bulletin or pamphlet at the time she applied to the brokerage agency for transportation services under Medicaid. Any oral information which the transportation broker thought it provided to the petitioner was, as it turns out, inadequate and ineffective due to the petitioner's memory problems. Furthermore, it is not at all clear what might have been communicated to the petitioner initially, underscoring the need for written communication of her obligations.

What is clear is that the petitioner was confused about her obligations and did not know the correct actions to take. What is also clear is that there was no communication

whatsoever, oral or written, with the petitioner when she submitted the incorrect forms in August of 2004. The petitioner had a right to expect correct information from the brokerage agency and to rely on that information. The failure of the brokerage agency to live up to its obligation caused the petitioner to fall short of the requirements for reimbursement and to bear the costs of her transportation to medical appointments herself.

It must be concluded that DCF (acting through this brokerage agency) has failed in its responsibilities to the petitioner and cannot now use this lack of information to bar reimbursement for her transportation. The petitioner has shown that she meets the four essential elements of estoppel needed to prevent DCF from denying her benefits due to her

violations of the rule. Stevens, id. at 421.¹ Thus, DCF's decision denying her payment must be reversed.

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¹ The Court relied in its decision on the test set out in Burlington Fire Fighters' Ass'n. v. City of Burlington 149 Vt.293, 299: (1) the party to be estopped must know the facts; (2) the party to be estopped must intend that its conduct shall be acted upon or the acts must be such that the party asserting the estoppel has a right to believe it is so intended; (3) the party asserting estoppel must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped.