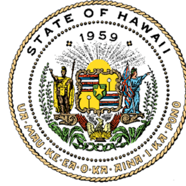
JOSH GREEN, M.D.
GOVERNOR
KE KIAʻĀINA



CATHY BETTS
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STATE OF HAWAII
KA MOKUʻĀINA O HAWAIʻI
DEPARTMENT OF HUMAN SERVICES
KA ʻOIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

August 30, 2023

MEMORANDUM

MEMO NO.
QI-2334
FFS 23-20

TO: QUEST Integration (QI) Health Plans
All Medicaid Taxi Providers

FROM: *for* Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: DENTAL GROUND TRANSPORTATION

Dental ground transportation will be provided via the taxi service for Medicaid beneficiaries who need assistance with ground transportation to their dental appointments. Dental taxi service is authorized when a Medicaid beneficiary is unable to utilize public transportation. The dental taxi trip can be one way or round-trip, between the home of a Medicaid beneficiary and to the nearest appropriate dental facility. This memo will explain how a taxi provider shall submit claims upon completion of the dental trip. Ground transportation for medical related appointments shall be excluded from this memo.

Medicaid beneficiaries seeking transportation to dental appointments will call Community Care Management Corp (CCMC) at 808-792-1070 on O'ahu and 1-888-792-1070 on neighbor islands. CCMC will confirm the dental appointment with the dentist and contact a taxi company to reserve a dental taxi trip. Side trips, including pharmacy or shopping, are not allowed and no payments will be made for any side trips. CCMC will provide a Prior Authorization (PA) code when reserving a dental taxi trip with the taxi company. The taxi company shall contact Medicaid beneficiaries no less than two (2) business days prior to the reserved dental taxi trip date to confirm their dental appointments. If Medicaid beneficiaries change their dental appointments, the taxi company shall notify CCMC immediately. No payments shall be made

for no shows.

The taxi company providing ground transportation for dental appointments shall use the following information when submitting dental taxi trip claims to Medicaid fiscal agent, Conduent. The taxi company may submit electronic or paper claims with a CMS 1500 form. The CMS 1500 form must include an original signature, be printed double sided and in color. A sample of the CMS 1500 form is attached. Taxi companies may contact Conduent for electronic claims submission process.

- A0100 is used as base code (pick-up fee) and S0215 is used as mileage (1 unit = 1 mile) billing.

Code	Description	Payment rate
A0100	NON-EMERGENCY TRANSPORTATION; TAXI	$5.25
S0215	NON-EMERGENCY TRANSPORTATION; MILEAGE, PER MILE	$2.75

- ICD 10 CM (Diagnostic code) = Y92.81 definition TRANSPORT VEHICLE AS PLACE
- Place of Service = 99 – definition OTHER PLACE OF SERVICE
- PA code provided by CCMC
- Modifiers:

Modifier for A0100	Description – Residence on the Island to the Dental Office on the same Island
RP	RESIDENCE TO DENTAL OFFICE
PR	DENTAL OFFICE TO RESIDENCE

Modifier for A0100	Description – From Neighbor Islands Residence to the Neighbor Island Airport
RI	RESIDENCE TO AIRPORT
IR	AIRPORT TO RESIDENCE

Modifier for A0100	Description – From ‘Oahu Airport to ‘Oahu Dental Office
IP	AIRPORT TO DENTAL OFFICE
PI	DENTAL OFFICE TO AIRPORT

Modifier for S0215	Description
KZ	TOTAL MILEAGE

Taxi company may call Conduent's Provider Relations Hotline at 808-952-5570 or 1-800-235-4378 on neighbor islands or email hi.providerrelations@conduent.com, for any questions related to claim submission. A copy of the blank CMS 1500 form, can be obtained here: https://www.cigna.com/static/www-cigna-com/docs/form-cms1500.pdf

Health plans may refer Medicaid beneficiaries to CCMC after September 15, 2023 if they need ground transportation for their dental appointments. CCMC requires 5 (five) business days advance notification for dental taxi trip requests.

Should you have any additional questions contact Grant Shiira by email at gshiira@dhs.hawaii.gov.

1500 Claims Crosswalk for Dental Taxi Services

Point 1 - Box 1- Insurance Name	Insurance Name - Check "Medicaid"
Point 2 – Box 1a	Please indicate the Medicaid Recipient 10-digit Identification number.
Point 3 – Box 2	Please provide the name of the Medicaid Recipient
Point 4 – Box 3	Patient's Date of Birth and Sex
Point 5 – Box 6	Always mark "SELF" for patient relationship to insurer
Point 6 – Box 10 a, b, c	Mark "N" for all three
Point 7 – Box 9 d	Indicate "Hawaii Medicaid- Dental for the Insurance plan name
Point 8 – Box 21a	Indicate ICD-10 diagnosis Y92.81, with an ICD-10 indicator of "0" in the field
Point 9 – Box 23	Must indicate the Prior Authorization #
Point 10 – Box 24a, B, D, E, F, G J	24a. Indicate the date of transportation service. In 24B indicate Place of Service 99. 24D indicate 5 digit HCPC "A0100" (base code for pick-up fee) with or w/o "S0215 KZ" for mileage. 24E is the diagnosis pointer. Indicate "1" to indicate the ICD-10 code in box 21A field. 24F Charges for each line. Charges should equal the rate x the units. ** A0100 RP is 5.25 x1= $5.25, A0100 PR is 5.25 x 1= $5.25 24G indicate "1" for base code A0100 with mod (if one way/ round trip) and indicate total mileage for code S0215 KZ. Charges for mileage is mileage rate x the mileage unit billing for. Ie. $2.75 per mileage cost x 10 units of mileage = Total Charges for S0215 (mileage) is $27.50. 24J indicate the provider NPI
Point 11 – Box 25	Indicate Tax ID #
Point 12 – Box 27	Accept Assignment is "Yes"
Point 13 – Box 28	Total Charges from column 24F
Point 14 – Box 31	Live inked signature and date
Point 15 – Box 33	Billing Information

Medicaid Billing Required Fields for the CMS 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA — CARRIER

(1) 1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

(2) 1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1112223334

(3) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Name Here

(4) 3. PATIENT'S BIRTH DATE (MM DD YY): 01/01/1975 — SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

(5) 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

(6) a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY) — SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

(7) d. INSURANCE PLAN NAME OR PROGRAM NAME: **Hawaii Medicaid– Dental**

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

(8) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Y92.81 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

(9) 23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

(10) 24.

	A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01/01/2023	01/01/2023	99		A0100	RP	1	5.25	1		NPI	1234567891
2	01/01/2023	01/01/2023	99		A0100	PR	1	5.25	1		NPI	1234567891
3	01/01/2023	01/01/2023	99		S0215	KZ	1	27.50	10		NPI	1234567891
4											NPI	
5											NPI	
6											NPI	

(11) 25. FEDERAL TAX I.D. NUMBER: 99-1234567 — SSN [ ] EIN [X]

(12) 26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

(13) 28. TOTAL CHARGE $ 32.75

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

(14) Sign Here and Date

SIGNED ______ DATE ______

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

(15) 33. BILLING PROVIDER INFO & PH # ( )

Yellow Cab 1100 Bishop St.
Honolulu, HI 96817
808-555-1234

a. 1234567891 b.

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE