



Chapter 16

Medicaid Provider Manual

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16.1 EMERGENCY/AMBULANCE SERVICES

Ambulance services may be covered when the client's medical condition contraindicates the use of other forms of medical transportation.

Emergency ambulance is covered without prior authorization to the nearest medical facility capable of meeting the medical needs of the client.

Air ambulance is covered when life support services are needed during transport or in emergencies when no scheduled carrier is available to accommodate the client. The transportation request must specify the need for an air ambulance and must be prior approved.

Providers must submit a completed Request for Medical Authorization Form 1144 to the CSO (See Appendix 1). For emergency inter-island air ambulance authorization after office hours, Prior Authorization and Transportation Provider Claim Form 208 must be submitted within three (3) working days after the date of emergency with appropriate medical justification. If this is not submitted within the timeframe given, the request shall be denied.

Emergency transportation does not require prior authorization or approval; however, payment will be denied for any emergency travel, which is not clearly documented showing medical necessity. Claims for emergency ground and air medical transportation must be billed with ambulance destination modifiers.

Ambulance services in emergency situations in which delay of more than 24 hours could result in very severe pain, loss of life, limb, eyesight, or hearing, or injury to self or bodily harm to others.

16.2 NON-EMERGENCY GROUND TRANSPORTATION

16.2.1 Taxi Services

a) Taxi services shall be authorized when a client is unable to utilize public transportation or has a vehicle and are unable to drive themselves or has no one to drive them. Services are only to be provided between the home of a client and to the nearest appropriate medical facility and back. Side trips are not allowed and will not be paid. In addition, payment will not be made for waiting time.

b) To be authorized, only licensed physicians are allowed to assess and justify the need for taxi services.

c) The physician must certify on the DHS Form 1160 "Request for Individualized Transportation Services" that a client is unable to utilize public transportation or has a vehicle and are unable to drive themselves or have no one to drive them to obtain necessary medical treatment.

DHS Form 1160 is:

- To be appropriately completed; otherwise authorization will not be given and the form will be returned to the referring physician.
- Required when the need for taxi services is on going or for a specific period of time and must be updated at least annually, or when the authorized period ends.
- Not required when taxi services are for an emergency or "one time" episode due to an illness; and, when a client is being transported between medical institutions (hospital and LTC facility, LTC facility to hospital, hospital to hospital) for necessary medical work-ups which are not available in a medical institution.

d) The client's Eligibility Worker (EW) shall review and authorize the request for taxi services. The EW will use available case information and consult with the requesting physician to determine the client's physical and/or mental conditions that necessitates the use of taxi services.

The criteria for authorizing taxi services for clients are the following: The client is unable to utilize public transportation, has a vehicle but are unable to drive themselves or does not have anyone to drive them, and is

- Mentally alert and aware of their surroundings;
- Able to understand and respond to verbal commands;

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- Able to ambulate independently without assistance, including an individual with any type of walking device:
- If wheelchair-bound, able to self propel for curbside pick-up and able to transfer into and out of the taxi with a minimum of assistance;
- Exceptions are made to the above criteria when an escort is present to assist the client.

e) When taxi services are approved, the EW will fax or mail DHS Form 1135 "Taxi Authorization/Invoice" to the taxi provider that was selected by the client. This form shall serve as the authorization to the taxi provider to perform the services listed on the form, only for the authorized period.

f) For after hours emergency trips, which the Medicaid taxi provider is seeking reimbursement, the taxi provider will have to contact the MQD/CSO the next working day. If the CSO verifies the medical necessity for the emergency visit, it will instruct the client's EW to issue a DHS Form 1135 to the taxi provider.

g) If a client paid for taxi services to a Medicaid taxi provider and the CSO or the client's EW can verify either the need for emergency services, the EW will reimburse the client by way of a purchase order.

h) In the event that a hospital, medical facility or anyone other than the client paid for the taxi services, the participant involved will be reimbursed by P.O after the MQD/CSO or the client's EW confirms the need for emergency services.

i) The authorized agent for the taxi provider shall verify that all the information on each DHS Form 1136 "Taxi Trip Record" is complete and accurate. Verified information documented on the DHS Form 1136 is to be transposed onto the DHS Form 1135 ("Other Charges and Reason for Other Charges" – to be completed only if applicable).

j) DHS Form 1135 (and DHS Form 1136 which is attached to the upper left back corner of DHS Form 1135) shall be forwarded to Fiscal Management Office/Benefit Payment for reimbursements. (See Appendix 1 for contact information)

k) Ground transportation authorization is not required when a one way trip is necessary to transfer clients between long-term care (LTC) facilities or nursing homes; between LTC and acute facilities; between acute hospital and nursing home; between two acute hospital facilities and from acute hospital to care home

16.2.2 Curb-to-Curb Services

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- a)** This service is authorized when clients have the physical and mental ability to get to their designated pick-up location independently. Exceptions are made if the client does not have the physical or mental ability but has an attendant who will assist the client to and from the pick-up and drop-off locations.
- b)** Drivers are only required to pick up and drop off clients at curbside. Clients independently must be able to access medical facilities.
- c)** Wheelchair-bound clients, as well as clients with walking devices, must be able to be at a designated curbside pick-up location at the requested time.
- d)** Clients on Oahu must visit their EW who will authorize and dispense coupons.
- e)** For clients not on Oahu, providers should submit all claims for services rendered on CMS (formerly HCFA) 1500 form to the Medicaid Fiscal Agent.

16.2.3 Door-to-Door Services

- a)** Door to door type service is authorized when a licensed physician indicates that a client does not have a caregiver and is unable to get to the curbside alone. The service is from the entrance of the originating location to the entrance of the destination location.
- b)** To request this service, a licensed physician must complete the DHS Form 1160 and forward this to the client's EW. The need for door to door services should be rare.
- c)** The CSO shall authorize the service when the client meets the criteria for door to door services. The authorization period must reflect the licensed physician's response to Section III of the DHS Form 1160.
- d)** The DHS Form 1160 is not required for clients being transported between medical institutions (hospitals and LTC facilities) for necessary medical work-ups not available in a long term care facility; such as x-rays and lab work-ups or discharges.
- e)** A CMS (formerly HCFA) 1500 form is then submitted to Medicaid for payment of services.
- f)** Door to door type service is available on Oahu, Maui, and Hawaii and is a more expensive mode of transportation than curb to curb service.
- g)** Door to door services when a licensed physician certifies and clearly documents that a client is bed bound and/or non-ambulatory; and unable to transfer or receive assistance that will make her/him eligible for curbside pickup.

16.2.4 Claims Submittal

For non emergency transportation billing, please review the guidelines below.

The base code for non-emergency transportation is A0130 and it is **MANDATORY** to use a modifier with this base code. **This code should never be billed alone.** Please refer to the table below which identifies the modifiers, the description and the payment rate.

Modifiers for A0130	Description	Payment rate
WQ	Curbside pickup and discharge	\$9.00
WX	Door to door with assistance (wheelchair not required)	\$22.50
WY	Wheelchair service (non-emergency)	\$25.00
WS	Stretcher service (non-emergency)	\$63.00

The code used for billing mileage is A0425 (1 unit = 1 mile). The destination codes listed in the table below **MUST** be added to A0425. Pick-up origin and destination modifiers are **MANDATORY**. These modifiers identify where the client was picked up and where the client was dropped off.

Each **PAIR** of alpha characters creates one modifier. The first alpha represents the origin and the second alpha represents the destination. These modifiers do not have additional payment attached to them as they are considered information only modifiers.

Pick-up origin and destination modifiers	Description
D	Diagnostic or therapeutic site other than "P" or "H"
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g. from airport)
J	Free standing ESRD facility

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N	Skilled Nursing Facility (SNF)
P	Physician's office
R	Residence

An example of a correct use of the destination modifiers is "A0425-RP". In this example, use of these modifiers indicates that the client was picked up at their residence and dropped off at their physician's office.

MM	From		To		PLACE OF SERVICE	EMG	CPT/HCPCS	(Explain Unusual Circumstances) MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	UNITS OR UNITS	SP-2011 Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #		
	DD	YY	MM	DD											YY	
01	01	08	01	01	08	99	A0425	RP	1	39	00	20	NPI	0000000001		
													NPI			
													NPI			
													NPI			
													NPI			
													NPI			
													NPI			
25. FEDERAL TAX I.D. NUMBER					SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
					[] []				[] YES [] NO		\$ 39.00		\$ 0.00		\$ 39.00	

16.3 INTER-ISLAND TRAVEL

a) Inter-island medical transportation services are authorized to clients when necessary medical care is not available on the island of their residence; or, if available, is not readily accessible in emergency situations or when medical care performed on another island is cost effective. Appointments should be scheduled during the weekday (Monday through Thursday) to minimize the need for an overnight or weekend stay.

b) To request authorization, the client's attending physician must complete Form 208 "Air Transportation Request for Prior Authorization and Transportation Provider Claim Form." Form 208 must be approved prior to the date of travel because it serves as the client's authorization for travel. A sample form is located in Appendix 3. Completed authorization forms must be forwarded to and be received by the Medicaid Contracted Agent by mail or fax within normal business hours. If the travel is of an urgent nature (same day travel), the Form 208 must be faxed to the Medicaid Contracted Agent and the Med-QUEST Division will contact the requesting provider by phone and/or fax. Refer to Appendix 1 for the fax number and mailing address. Incomplete 208 forms will be denied and returned to the requestor. Please note that the Form 208 will serve only as the authorization for travel. Airline carriers will no longer accept the Form 208 as an airline ticket. All travel must be ticketed through the Med-QUEST Division.

c) The following information must be indicated on the form: complete medical and related needs of the client, such as: attendant or escort; ground transportation; oxygen, (if needed include flow rate per minute and the maximum usage per hour); lodging and meals for overnight stay or longer; attending physician's provider number and phone number; date and time of the scheduled appointment.

d) Authorization is determined by a CSO consultant or staff. A copy of the completed 208 form will be returned back to the requesting provider via fax or mail.

e) When the client's medical treatment requires meals, lodging, and/or ground transportation, providers must instruct the client to work with Medicaid's Contracted Agent. If a client does not work with Medicaid's Contracted Agent, his/her expenses will not be reimbursed by Medicaid. Please refer to Appendix 1 for contact information.

f) Additional services other than for meals and lodging should follow the usual authorization procedures.

16.4 OUT OF STATE TRAVEL

a) Out-of-state medical transportation services are authorized when appropriate medical treatment is unavailable in the State of Hawaii. The MQD/CSO medical consultant is responsible for the authorization and the consultant's decision is final. All follow-up care will be performed in Hawaii. The only exception is for medically necessary follow-up care that is not available in Hawaii.

The Medicaid program will not be financially responsible for any non-emergency out-of-state medical service(s) that failed to receive prior approval.

b) To request authorization, the referring provider must complete Medicaid Form 1144, "Request for Medical Authorization"; and the following information below must be provided. A licensed physician must complete the Request for Prior Authorization for Out of State Medical Treatment. This requesting physician will be responsible for establishing initial and on-going contacts with the rendering out of state provider(s).

- Client's full name, Date of birth, Medicaid number, Sex
- Medicare coverage or other insurance coverage, and specify if primary or secondary
- Oxygen, (if needed flow rate per minute and the maximum usage per hour)
- Specify if an attendant or escort is needed, the medical reason for the attendant, and the name of the adult attendant.
- Date of Services, including end date of services. If end date of services is not provided, a date will be specified by the MQD after which prior authorization will again be needed. Authorization generally expires after 30 days unless otherwise noted by the consultant.
- Procedure/Services including procedure codes
- Diagnoses
- Reason for out of state medical treatment, including adequate medical justification for out of state treatment.

c) Completion of the Rendering Provider Information is also the responsibility of the referring provider. If services are to be performed in a hospital, the name of the hospital and contact person and phone number at the hospital must be provided.

d) Request for airfare, lodging and meals and ground transportation should be done on a Form 1144 that is separate from the medical authorization request.

e) In addition, each referral shall contain at a minimum the following:

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- Comprehensive clinical summary of client's condition
- Documentation of justification for out of state services. This may include a copy of clinical notes or formal letter, preferably from a specialist or a primary provider in consultation with a specialist. If the prior authorization is for an extension of service, clinical documentation of services from the rendering provider must also be provided.
- Letter of acceptance from the out-of-state provider that Hawaii's Medicaid payments will be accepted as payment in full.

f) Only the dates of services and specific procedures listed on the 1144 will be covered. If additional procedures are required, a new 1144 shall be initiated.

g) If the recipient has a primary health insurer other than Hawaii Medicaid, authorization must be obtained from the primary insurer. Unless SPECIFICALLY approved by Hawaii Medicaid, services non-covered by the primary insurer will not be covered by Hawaii Medicaid.

h) On recipient return, a copy of a discharge summary or clinical notes, including plan of care must be submitted.

i) If the prior authorization request is for travel for a permanent nursing facility placement in another state, please provide the following:

- Documentation of Medicaid eligibility in the receiving state;
- Documentation of nursing facilities contacted in Hawaii, date(s) contacted, and reasons for refusal; and
- Signed documentation of consent for nursing facility placement in another state by the recipient and/or the recipient's family or legal guardian.

j) When out-of-state medical services and transportation are approved, the client will make all travel arrangements with the State contracted travel agent. Refer to Appendix 1 for contact information. The transportation and services are subject to department approval.

k) Clients will be responsible for claiming meals and ground transportation reimbursements through MQD/CSO.

l) Submit form(s) to the Medicaid Clinical Standards Office (CSO).

16.5 ATTENDANT/ESCORT

Medicaid will cover the transportation, meal, and lodging for an attendant or escort for recipients traveling inter-island or out-of-state. Written justification must be submitted if an attendant or escort is requested. These expenses will be covered as long as the attendant or escort is:

- an adult accompanying a minor child, or
- an adult needed to assist the client with his/her special needs and travels with the client in both directions

Authorization will be not given for the following:

- An attendant or escort for companionship or social reasons
- Children accompanying an adult client
- More than one attendant or escort
- Personal care items for clients and for attendants.

16.6 EXCLUSIONS AND LIMITATIONS

16.6.1 Exclusions

The following are not covered or will not be approved or authorized:

- 1) Transportation between two acute facilities solely for the benefit of the attending physician (i.e., no privileges at the first hospital).
- 2) Ambulance transportation to the Hawaii State Hospital. (The Department of Health, Adult Mental Health Division should be billed for such transfers.)
- 3) Transportation in order to access experimental or non-medically necessary services.
- 4) Payment to travel agencies or clients for air fares, except on a case by case basis
- 5) Taxi charges for no-show or cancellation and/or taxi waiting time.
- 6) Side trips not directly related to patient's medical treatment such as but not limited to:
 - Pharmacy;
 - Shopping;
 - Visiting;
 - Pick up or drop off for durable medical equipment;
 - Supplemental Security Income (SSI) Determination medical appointments or Medicaid eligibility; and
 - Trip to classes, support groups, clubhouse, community events, etc., unless included as part of the client's plan of care.
- 7) Tips, gratuities, and baggage fees
- 8) Mileage and/or time when the client is not in the vehicle.
- 9) An attendant or escort for companionship or other non-medical reason, and children accompanying an adult client.
- 10) More than one attendant or escort without prior authorization.

16.6.2 Limitations

The following services may be permitted or authorized:

- 1) One round trip when transfers are necessary between two acute hospitals for services not available at the acute hospital in which the client has been admitted. In the event repeated trips will be required, the client should be permanently transferred.
- 2) If a change is needed after arranged travel (inter-island or out of state) has been finalized, it must be coordinated with MQD/CSO. Return dates will be changed only when there is a medical reason for an extended stay. An updated request noting in large print that the request contains updated information to a previously approved request must be submitted.

16.7 FOREIGN LANGUAGE AND SIGN LANGUAGE INTERPRETATION

DHS has contracts for statewide foreign language translation and sign language interpretation services. A list of languages is provided in Appendix 6. Note that there are about 30 languages on the list, and the languages most frequently requested are Cantonese, Vietnamese, Ilocano, Korean, and Laotian. For sign language interpretive services, refer to Appendix 4.

To request a translator for services in a setting other than a provider's office, please follow the directions in Appendix 4. Services to be provided in an office setting do not require prior authorization and the provider can call one of the contractors directly to make arrangements for up to 12 units. More than 12 units will require the provider to follow the directions in Appendix 4. Services rendered in a facility are the financial responsibility of the facility as part of care. Refer to Appendix 1 for a list of the contractors and their contact information.

It is best to call approximately 2 weeks ahead of time if possible. In case of emergencies, please call the contractor's 24-hour hotline and inform the operator about the urgency of the message.

When requesting a translator, please provide the following:

- a. The physician's name
- b. The physician's telephone number(s)
- c. Language
- d. Client's/patient's full name
- e. Date and time of appointment
- f. Location

An appointment that was previously arranged can be canceled. However, if the translator is on his/her way to the appointment when the cancellation notice gets to the contractor providing the translation services, then he/she will get one hour pay. If the patient does not attend the appointment, the translator still gets paid if he/she is at the pre-arranged appointment.

The translator will ask the provider to sign off on an Encounter Form. It will have the date of service, client name, service provider and the end time. This form is used to calculate the translator's payment.

As much as possible, translation services must be done by telephone. The translator can contact the client to help set up appointments, change dates, etc. Translation services are paid based on a 15-minute unit. Written reports for translation services exceeding 1 ½ hours (6 units) need to be submitted with the claim.