Hawaii Medicaid Provider Bulletin

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Inside this issue:

EVV / Hoku	**1**
Hoku Registration / Taxi Dental Transportation / DPS is now DCR	**2**
DMO Tips / EVV Common Denials / 835 & 837 Concerns / SFTP URL – Postponed	**3**
Adjustment Claim Updates / Rate Increase Adjust-ments for DOH Claims / Timely Filing Deadline	**4**
Emergency Patients AD120 & AD121 Denial / 240 Form for Additional Review / 8015 & 8016 EPSDT Form Request / EPSDT Visit Data	5
APR DRG Claims / Common RTP Reasons / Other Important	6

Use our Claim Drop Box!

For your convenience, you may drop of your claims at our Conduent Drop Box located on the basement floor of our office location.

Mail is checked twice a day!

EVV (Electronic Visit Verification) Updates

- EVV provider agency payment withhold will begin on April 1, 2024.
- The payment withhold process was paused due to the Maui wildfire and other EVV technical issues.
- EVV monitoring resumed with date of service (DOS) beginning February 1, 2024, HP/DD to initiate payment withhold for DOS beginning April 1, 2024.
- The Provider Agency – Corrective Action Timeline table was updated with the revised dates starting in month 7 in the latest update to the EVV memo QI-2305B.
- Here is the link to the memo: https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2024/QI-2305B%20Electronic%20Visit%20Verification%20(EVV)%20Manual%20Editing%20and%20Entry%20of%20Visits%20(Update%20to%20QI-2305A)%20(part%201)%20-%20signed.pdf
- SD/CD payment withhold will be determined at a future date.
- Providers should continue to open a ticket with Sandata or their alt EVV vendor for all encountered issues impacting manual edits and keep a log to provide to the payer upon review.
- Providers using Sandata EVV for visit capture can access training at the two sites below:
- Hawaii Caregiver Video Library: https://fast.wistia.com/embed/channel/x564zgak7t
- Sandata Training Site: https://sandata.wistia.com/projects/39hu84ouhv
- If your agency cannot see a member or authorization in Sandata, please contact your payer for assistance.
- If your agency is having claims payment issues relating to EVV, please contact your payer. If not resolved after two weeks escalate to MQD at EVV-MQD@dhs.hawaii.gov.
- Member/participant services should not be stopped due to an EVV issue such as, missing authorization or EVV device issues.
- Additional information and FAQ'S regarding EVV can be accessed on our Hawaii EVV website: https://medquest.hawaii.gov.

Please send all EVV inquires and requests to EVV-MQD@dhs.hawaii.gov.

HOKU

All new and existing Hawaii Medicaid providers can enroll, update, and make changes to their information quickly and easily on the Med-QUEST Division's (MQD) web-based system, HOKU.

Go to medquest.hawaii.gov/HOKU to view the HOKU Website Links. MQD encourages all existing Medicaid providers to register on HOKU.

The HOKU webpage (medquest.hawaii.gov/HOKU) will have the most recent news and updates on training materials/opportunities, provider resources and updated/new provider memos.

Please call MQD's Provider Hotline at 808-692-8099, 1-833-909-3630 or send an email to HCSBInquiries@dhs.hawaii.gov if you have any questions or if you are an existing Medicaid provider and do not know your HOKU Application ID.

Requirement for New Medicaid providers to register with HOKU

All providers who provide services to Hawaii Medicaid members must first register as a Medicaid provider with Hawaii's Online Kahu Utility (HOKU), the web-based provider management system that Med-QUEST Division MQD launched in August 2020.

HOKU training opportunities are available on-line through instructional slides and videos. A list of all HOKU opportunities can be found on the HOKU webpage under the 'Training' tab: medquest.hawaii.gov/HOKU. Should a provider require additional assistance with their HOKU application they may contact the HOKU Provider Hotline Monday through Friday during standard business hours, 7:45am 4:30pm HST at (808) 692-8099 or (833) 909-3630 for neighbor islands and via email HCSBInquiries@dhs.hawaii.gov.

Please continue to visit the HOKU webpage for the most recent news and updates: medquest.hawaii.gov/HOKU. Health plans can refer interested providers to HOKU through this page using the available HOKU direct link.

Medicaid Taxi Providers—Dental Ground Transportation

Dental ground transportation will be provided via taxi service for Medicaid beneficiaries who need assistance with ground transportation to their dental appointments and are unable to utilize public transportation. The Community Care Management Corp (CCMC) will contact the taxi company to reserve a dental taxi trip. The trip can be one way or round trip from the home of the Medicaid beneficiary to the nearest appropriate dental facility. No side trips, including pharmacy or shopping, are allowed. Taxi company is responsible for contacting the Medicaid beneficiaries no less than two business days prior to the dental taxi trip to confirm pick up for dental appointment. No payments will be made for no shows.

MQD has issued Memo QI-2408 FFS 24-05 to replace the previous Memo QI 2334 FFS 23-20 on April 12, 2024 with the increased taxi mileage fee, new wheelchair lift and stretcher van fee in addition to the guidance on how to submit a claim for payment after completing a dental taxi trip.

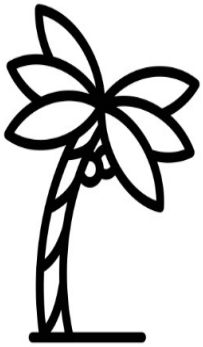
https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2024/QI-2408,FFS24-05.pdf

For more information on claim submission, please contact:

Conduent's Provider Hotline at (808)-952-5570 or via email at hi.providerrelations@conduent.com.

Department of Public Safety (DPS) Name Changed to DCR

Department of Public Safety has changed their name to Department of Correction and Rehabilitation (DCR). Going forward, the Provider Relations Department will address the department as DCR.



As a friendly reminder, incarcerated patient's claims are processed and payable by Conduent. Please ensure you have a valid 10 digit state ID number starting with OPAxxxxxxx.

First, your claim must be sent to the DCR for review and eligibility update. Then, your claim will be forwarded to the fiscal agent, CONDUENT for claim adjudication and payment.

If we receive your claim and the patient ID is not valid, we may return the claim back to you so you can work with DCR.

Claim Submission Billing Address
Department of Correction and Rehabilitation (DCR) Healthcare Division Medicaid Claims
1177 Alakea Street #602
Honolulu, HI 96813
Office: 1-808-587-1250

DHS Medicaid Online- Special Tips!

- Always remember your passwords!
- There are two types of accounts. Master Account Holders (MAHs) and Individual Accounts
- Please ensure you have multiple Master Account Holders for an organization.
- MAHs will get email notification if there is a new user register. The MAHs must log into their account and activate their new user.
- Only the MAHs can activate and delete accounts instantly with no wait.
- MAHs cannot reset individual account holders passwords if locked out. For faster processing on an account, it is best if the MAH deletes the in individual account and have the individual user re-register. This will take about 1-2 days only.
- A user will get locked out of the account after 120 days of inactivity. Try and logging in your account monthly if you use it sparingly.

Electronic Visit Verification (EVV) Common Denial Information Updates

NO VISIT FOUND FOR CLAIM LINE FIELD MISSING (L226.1)

This denial means that there are NO VISITS collected in the EVV aggregator. The provider must ensure that EVV has the visits entered.

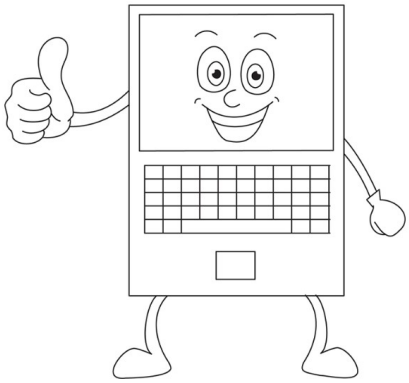
You may verify with a CONDUENT agent showing the collection of the visit for the dates in question. If claim continues to deny, our agents will advise to work the EVV helpdesk. Please email EVV-MQD@dhs.hawaii.gov to check the units in Sandata and to confirm there are units collected and why claim continues to deny.

Denial Edit - CLAIM LINE FAILED FOR UNMATCHED UNITS FIELD IS MISSING (L227.1)

Scenario 1. This is an EVV hard Edit (claim denial) for visits. This denial means that there were EVV related visits found in Sandata's Aggregator but the unit count is less than what is submitted on the claim line.

Explanation: The units are counted if the visit status is Verified / Approved / Processed. If a claim line is denied for EVV reasons, there are two options:

1. Fix the visit(s) to reach a good status and resubmit the claim
2. Adjust the units down on the claim line and resubmit the claim



EDI/WINASAP Concerns for 835 / 837

Providers with concerns about missing 835 reports, missing 837 response files, WINASAP issues, modem issues (connectivity), and validating if providers are enrolled for SFTP, please inquire through the EDI helpdesk. Email the EDI help desk at hi.ecstest@conduent.com. Emails are checked daily. Please follow up with the call center if you have not received a response from our EDI Coordinator.

SFTP URL UPDATES– POSTPONED

In our communication to our providers, we had stated: Med-QUEST (MQD) had previously announced the launch of a new SFTP tool on May 13th. Due to technical difficulties, the go live date is postponed. Please continue to use the same URL and credentials as you do today.

Adjustment Claim Updates to Remember!

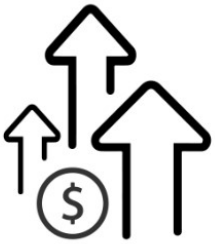
When to write the word - "RESUBMISSION" on the top of your claim form

- On the top of the claim form: When submitting a correction on a previous claim that is in the system, please indicate the words - "**RESUBMISSION"**
- On hard copy claim forms, the **CMS 1500**, should have the CRN and adjustment code in box 22. On the **UB04**, the CRN should be in box 64a with the TOB xx6/xx7.
- The provider should be submitting a replacement claim using frequency type code 7 in WINASAP or EDI or 6/7 when billing electronically.
- On hard copy claim form, please correct and circle the changes when submitting. If submitting via electronically, please follow the replacement claim instructions. Do not write the words "RESUBMISSION" on the top of the claim if submitting a new claim with no corrections or with one that does not exist in the system.

Hard Copy Claim Adjustment Instructions for DOH Rate Increase Claims

If your claims are affected by the Department of Health (DOH) Rate Increase and you must submit a hard copy adjustment, please ensure you do the following:

- Please replicate a claim with the same original information as previously submitted on file
- On the top of the claim, indicate "RESUBMISSION Claim"
- Include the resubmission code "A" and original CRN in box 22 on the claim form (CMS 1500)
- **In Box 19** indicate and circle **"DOH Rate Increase, Reprocess Claim"**
- If there is a change of the total charge in box 28, **please circle** the new change or any other changes that need to be corrected, please circle.



It is significantly important you follow these specific instructions, otherwise your claim will be returned to and payments will be delayed.

If you have questions on how to submit an adjustment, please contact our Provider Hotline at 1-800-235- 4378 / 1-808-952-5570 and you may request to speak to our Field Representative.

Timely Filing Deadline

- Claims for Medicaid Fee-For-Service (FFS) enrollees must be submitted within 12 months from the date of service which includes initial submissions, resubmitted claims, or additional payment requests.
- Claims for FFS enrollees with Medicare or any other Third Party Liability (TPL) insurance coverage, shall also submit claims within 12 months from date of service or within 6 months from the date listed on the Explanation of Benefits (EOB), whichever is greater. There is no timely filing deadline for claims for DCR (Department of Corrections and Rehabilitation) and OYS (Office of Youth Services) enrollees.
- Claims for services past the 12 month deadline must be pre-approved by submitting a waiver of the filing deadline prior to claim submission. The waiver request letter should be submitted to:

Attn: Timely Filing Dept. DHS / MQD / FO 1001 Kamokila Blvd, Rm 317 Kapolei, HI 96707 or Fax to 692-7989

Please provide the following information on your request: Provider Name and NPI / PIN, Name of Patient with Medicaid ID#, CRN and Date of Service **Justification of why your claim is late**

Emergency Eligible Patients – Denial edit AD120 / AD121 for emergency processing

Patient enrolled in the EMGSVC plan does not mean they are approved for service. The provider must ensure an approved 1149A is on file.

The hospital should work with the patient's caseworker to obtain an 1149a approval by providing medical documentation to support the medical necessity of the visit. Once approved, Conduent will receive a copy to data enter on file and process all claims related to the service.

If you received a denial on your claim, please contact the Call Center and inquire and follow up on the 1149a approval process.

Additional Payment Requests

Per Provider Manual Chapter 4.3.8 Additional Payment Requests (Request for Reconsideration), the provider may submit form 240– Request for Reconsideration form up to 60 days from the initial date of adjudication (payment or denial of the claim). As long as the 240 form has been received, date stamped within 60 days from adjudication, Conduent will escalate for further request and review. Please continue to follow up with the call center.

You may contact the call center to inquire if your claim qualifies for a 240 form submission or if your claim can be sent to our in medical consultant to review first.

8015/8016 EPSDT FORMS REQUESTS

https://medquest.hawaii.gov/en/plans-providers/managed-care-providers/provider-epsdt/Forms.html

- ***EPSDT FORMS ARE ONLY FOR DOS 01/01/2022 going forward. Older dates will need to be submitted on the old EPSDT forms.***
- Please request hard copies for old or new forms if you **do not** have access to the internet or unable to print. CONDUENT's Provider Relations staff provides print outs of the 8015 / 8016 forms. The form is on one sheet just simply need to fill out the proper form type and fill out sections specifically to your form you are submitting.
- EPSDT Form Limitation (1 Pack per provider per address)
- Request may be emailed by using the E239 template and email to hi.providerrelations@conduent.com or call into our Provider Hotline at 1-808-235-4378 / 1-808-952-5570.

How to submit EPSDT visit data

Online: Login —>Complete form —> Submit Online

Fillable PDF: Access the DHS 8015 / 8016 Fillable PDF —>Submit Online

Print and Mail: Access the DHS 8015 / 8016 PDF—> Fill on device and print—> attach the CMS 1500 and Mail

EPSDT Resources

FAQ's are located here: EPSDT (hawaii.gov)

Email us at: **EPSDT@dhs.hawaii.gov**

EPSDT Helpdesk: **1-808-900-8650**

Hours of Operation: 8AM to 5PM (Monday to Friday)

APR/DRG Claims

Med-QUEST (MQD) implemented a new All Patient Refined Diagnosis Related Group (APR DRG) payment methodology for Medicaid fee-for-service (FFS) inpatient payment purposes for admissions beginning **July 1, 2022**. APR DRGs are a patient classification system developed by 3M™ and used by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups with similar average resource requirements. APR DRGs provide a mechanism for healthcare payers to make a single case rate payment for similar services provided in a hospital inpatient stay.

MQD's new inpatient APR DRG methodology is applicable to in-state general acute hospitals and children's hospitals, excluding Critical Access Hospitals, freestanding rehabilitation hospitals, freestanding psychiatric hospitals, long-term acute care hospitals, military hospitals, out-of-state hospitals, and State of Hawaii Organ and Tissue Transplant (SHOTT) services. MQD has directed the Medicaid Managed Care Organizations (MCOs) to pay applicable hospitals under this new APR DRG methodology and rates.

QI-2211 APR DRG Billing Guidance Memo Update

Common RTP Reasons

- Not a registered Medicaid Provider—NPI number in box 24J or 33A on the CMS 1500 is not a Medicaid registered provider.
- Provider needs to contact Provider Enrollment or enroll online through the HOKU portal
- Missing live signature in Box 31 on the CMS 1500 health claim form and near the bottom of the UB04 health claim form.
- Invalid or missing Medicaid ID number. The ID number consists of 10 digits.
- Box 24J on the CMS 1500 health claim form is invalid or missing. FFS (Non-Waiver / SSD) claims are required to have the NPI in Box 24J. Waiver / SSD claims are required to have the 8 digit legacy ID (preceded by the "1d" qualifier) in Box 24J.
- Adjustment claims - corrections / additions are not circled or marked for change.
- The ICD Indicator is invalid. The proper ICD Indicator located in FL 21 on the CMS 1500 or in FL 66 of the UB04 claim form should be 0 for ICD-10 or 9 for ICD-09 diagnosis code.

Other Important Guidelines to Remember!

Checking Patient Enrollment

When calling into the call center, please ensure you have the members Medicaid ID, name and date of birth. If you do not have the Medicaid ID#, you may inquire using the patient's social security number, name and date of birth. If the patient is incarcerated, simply provide the patient's name and DOB.

Three Inquiries Per Phone Call

When calling the hotline, please ensure you have your information ready. This will help process your inquiries more effectively in a timely manner. Please do not put our agents on hold for more than 2 minutes. There may be calls waiting in queue. The call center agents wants to ensure they are able to assist you as to resolve your call in a timely manner.

Providing the correct NPI

When calling into the call center please provide rendering or individual provider NPI not the group NPI. Claim searches in our system requires a rendering servicing NPI. Giving us your group payment ID will result with no claim on file.