

Hawaii Medicaid Provider Bulletin

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**Aloha!
Don't Trash it!
Pass it!**
Be sure to route this to:
Entire Organization and Contractors
They should be up to date with the latest news!

EVV (Electronic Visit Verification) Updates

- HI statewide mandatory EVV (electronic visit verification) started on 12/30/2020.
- The EVV claims Hard Edit (claim denial) for visits with a Date of Service (DOS) of 10/1/21 was turned on 10/1/21.
 - EVV related claims will deny if no visits are found in Sandata's Aggregator
 - EVV related claims will also deny if the unit count is less than what is submitted on the claim line
 - The units only 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 Verified/Approved/Processed status and resubmit the claim
 2. Adjust the units down on the claim line and resubmit the claim
- If EVV claims are submitted now for a DOS 9/30/21 or before, they will still follow the soft launch process (no claim denial).
- DDD providers will continue receiving the EVV Claims Validation Error report via email.
- MQD continues to hold regular EVV meetings for Providers to address EVV related questions.
 - Home Health meetings occur on a monthly basis.
 - Home Care, Nursing and DDD meetings occur twice per month.
- MQD held EVV Town Hall meetings for QI members and DDD Participants.
 - MQD will continue to hold Quarterly EVV Town Hall meetings on the following dates in 2022: 4/19, 7/19, 10/19, 1/19 (in 2023).
 - Please see the flyer posted on our MQD EVV website.
- Additional training for providers using Sandata is accessed here: <https://sandata.wistia.com/projects/39hu84ouhv>
- 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 in 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 or send an email to HCSBInquiries@dhs.hawaii.gov if you have any questions or if you are an existing Medicaid provider do not know your HOKU Application ID letter.

HOKU Provider Enrollment System Training Videos and Slides

Med-QUEST's HOKU webpage has Provider Training Videos or Instructional Slides. Please go to medquest.hawaii.gov/HOKU and click on the 'Training' tab to view the resources.

Electronic Visit Verification (EVV) Denial Information Updates

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

EPSDT Is Now Available Online!

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is a federally mandated benefit under Title XIX of the Social Security Act. This benefit provides preventive and comprehensive health services for Medicaid-eligible individuals under age 21. The EPSDT benefit is provided to Medicaid-eligible infants, youth and participants up to the age of 21. The primary goal is to offer prevention, early diagnosis and medically necessary treatment of conditions.

We are proud to announce we are modernizing the EPSDT process. Providers can go paperless! EPSDT providers will be able to submit EPSDT visit data online.

For more information please visit: <https://medquest.hawaii.gov/en/plans-providers/managed-care-providers/provider-epsdt.html>

Fillable and printable forms are located here: <https://medquest.hawaii.gov/en/plans-providers/managed-care-providers/provider-epsdt/Forms.html>

No Access to the Internet to obtain old or new EPSDT Forms?

If you do not have access to the internet to obtain **EPSDT** forms, please contact our Call Center at 1-800-235-4378 / 1-808-952-5570 to request for hard copies to be mailed to your office.

Claim Status and Eligibility Verification Online

Go to DMO "DHS Medicaid Online" to start checking claim and eligibility statuses for free.

Log on to <https://hiweb.statemedicaid.us>.

Denied Claim due to missing Application Enrollment Information

For questions or concerns about your pending or denied claim due to missing provider registration information, please contact provider enrollment at 1-855-946-0399 or email questions to:

HCSBinquiries@dhs.hawaii.gov.

1149A Initiation

Please initiate the 1149A with the provider's enrollment worker at Department of Human Services. If the provider is unable to get a hold of the patient's enrollment worker, please work with the Health Care Outreach branch by contacting

[Puanani Crabbe-Parker at pcrabbe-parker@dhs.hawaii.gov](mailto:Puanani.Crabbe-Parker@dhs.hawaii.gov).

Outlier Claims Billing Tips

The following helpful tips may help to increase faster processing time on your outlier claim.

- The first claim (interim bill type 112) should indicate in FL06 (Statement Covers Period) the date of admission through the date the covered charges equal the outlier threshold amount specified for your facility.
- All claims (bill type 112, 113, 114) must have condition code 61 (FL24-30)
- All claims (bill type 112, 113, 114) must have the same admission date (FL17)
- Bill type 112 must be approved before bill type 113 or 114 claims will approve
- In order for the claim to brand as surgical, all interim claims must indicate the surgical ICD-10 procedure code and surgical date.
- Psychiatric and out of state claims do not qualify for outlier rates.
- Please refer to Medicaid Provider Manual 11.1.4.4 (chapter 11, page 7) for additional information on outlier claims.

Points to Note When Submitting an Adjustment or a Void on a Hard Copy Claim

Please follow these steps below when submitting an adjustment or voided claim.

- To void a field: Strike a line through the unwanted claim detail line and circle it. This process will remove the line item from claim. Use resubmission code A.
- To adjust: draw a circle around the claim line item with the change (only changes that are circled will be corrected)
- Adjustment claims are treated as replacement claims
- CMS 1500 form: write "Resubmission" on the top of the claim. In FL 22 enter an "A" to adjust or "V" to void along with the original CRN (Entering "V" in box 22 will void the entire claim)
- UB04 form: write "Resubmission" in box 2. In box 4 enter the bill type "xx6/xx7" to adjust or "xx8" to void. Enter the original CRN in FL37A.

4.3.8 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.

Pharmacy Benefit Manager (PBM) Claims Address

Please mail your Pharmacy claim to the following address:

**Conduent – Medicaid Claims
40 W Williamsburg Rd.
Box #649
Sandston, VA 23150**

DPS Claims with Denial Edit H313.2

Facility claims billed on UB04 claim forms may receive the denial edit, H313.2, ATTENDING PROVIDER ID TEST PRV TYP CANNOT BE ATTENDING PR. Provider Types 08- MD (Doctor of Medicine) and 31- DO (Doctor of Osteopathy) are the only two provider types that Medicaid allows to be “Attending Providers”. The claim will deny if an MD or DO is not the attending provider.

The Department of Public Safety (DPS) allows other provider types to be “Attending Providers.” A DPS exception approval is required before payment can be made. If you need information on how to submit a DPS exception approval, please contact our Call Center at 1-800-235-4378/1-808-952-5570.

Below are requirements needed on your request letter.

The exception letter must have the following:

- ATTENDING PROVIDER NAME, AND NPI (Box 78 of UB04)
- NAME OF FACILITY PROVIDER AND MEDICAID PROVIDER ID # (Box 56 on UB04)
- CRN
- DATE(S) OF SERVICE
- PATIENT NAME AND DPS ID #
- ATTENDING PROVIDER TYPE (agent may provide the provider type on file if PIN is in MMIS)
- IF PROVIDER TYPE IS QMB ONLY OR DEFAULT PROVIDER, TELL FACILITY THAT THE SPECIFIC PROVIDER TYPE MUST BE ADDED—MD, PA, DO, APRN, ETC.
- ATTENDING NPI/PIN=ACTIVE/TERMINATED/NOT ON FILE
- JUSTIFICATION REQUESTING FOR EXCEPTION

Claim Submission Billing Address

Department of Public safety (DPS) - Health Care Division

Medicaid Claims

1177 Alakea Street #602

Honolulu, HI 96813

Office: 1-808-587-1250

