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!

HOKU

The Med-QUEST Division (MQD) is in the 8th month of our new web-based system, HOKU. This is an on-line system that allows providers to enroll, update, and make changes to their information quickly and easily. New Medicaid providers are able to enroll online and existing Medicaid providers are able to register online to validate enrollment data. Go to medquest.hawaii.gov/HOKU to view the 'HOKU Website Links.' MQD encourages all existing Medicaid providers to register in HOKU. HOKU allows providers to review their provider enrollment information and make any revisions if needed. 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 1-855-946-0399 (temporary number) or send an email to HCSBInquiries@dhs.hawaii.gov if you have any questions or if you are an existing Medicaid provider and haven't received 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.

EVV (Electronic Visit Verification) Updates

- HI statewide mandatory EVV (electronic visit verification) started on 12/30/2020
- The soft launch period (no claim denial) was extended from 4/1/21 to 7/1/21
  - ~ While the claim denial is extended, it is still a Federal and State requirement to capture visits using an EVV solution.
  - ~ During the soft launch, Providers are required to utilize EVV to log in and log out of visits in real-time
- Visits are required to be scheduled
- Starting 7/1/21 claims will be denied if not verified against an EVV visit
- For additional training using Sandata Webinars/Training, etc. may be accessed here: https://sandata.wistia.com/projects/39hu84ouhv.
- Bi-weekly EVV Provider Web Meetings are held on the 2nd and 4th Thursday of every month.
  - ~ Home Health Agencies @ 2:00 pm
  - ~ Home Care Agencies @ 3:00 pm
- 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.

Medicaid Eligibility For Citizens of the Republic of the Marshall Islands, The Republic of Palau, and the Federated States of Micronesia

The Med-QUEST Division of the Hawai‘i Department of Human Services is strongly committed to ensuring every Hawai‘i resident has access to quality health care. That’s why we’re glad to report that beginning December 27, 2020, Hawai‘i residents who are citizens of the Republic of the Marshall Islands, The Republic of Palau, and the Federated States of Micronesia have been eligible for Medicaid. For more information, please review memo FFS 21-02 on the Med-QUEST website.

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/(808)692-8099 or email questions to: HCSBInquiries@dhs.hawaii.gov.

Claim Billing # of Lines Requirement

Per Provider Manual, 4.3.1, Hard Copy Claims have a maximum of 25 lines may be included on a CMS 1500 form. A maximum of 99 lines may be billed on a UB-04 claim form. Claims that exceed 25 lines must be split billed. In addition, all services rendered on the same day should be billed on the same form. Hard copy claims must be mailed to the Medicaid Fiscal Agent. All hard copy claims must have a live ink signature. Printed or stamped signatures will not be accepted, this applies to all forms including UB-04 claims. The provider or authorized agent may sign a claim form.

Refund Check Procedures

We are returning all your Financial Adjustments that are missing pertinent information. Supporting documentation must provide the information needed to clearly identify the claim to be adjusted or voided and must include the following:

- Client name and Patient Medicaid Identification Number
- Date of Service
- Claim Reference Number (CRN)
- Amount of the Check and Net Amount of Claim(s)
- Specific reason for refund
- For overpayments due to other insurance payment, a copy of the other insurer’s EOB must be included.
- For duplicate payments please provide copies of Remittance Advices or the CRN.
- Failure to provide required information will result in check being returned with a request for missing information.

Mail Refunds to the following:
Conduent Inc.
Payable: Hawaii Medicaid Or Conduent
PO Box 1480
Honolulu, HI 96807-1480

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

When submitting an adjustment or voided claim, follow these steps to ensure correct processing:

- 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 processed)
- Adjustment claims are treated as replacement claims and will keep the original claim reference number (CRN)
- 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 FL 22 will void the entire claim)
- UB04: write “Resubmission” in FL 2. In FL 4 enter bill type “XX6/XX7” to adjust or “XX8” to void. Enter the original CRN in FL 37A

Resubmitted claims must reflect the original number of claim lines. If the resubmission has less lines, Conduent will return the claim to provider (RTP).

WINASAP Claim Adjustments

Adjustment Claims using WINASAP Adjustments on a 1500– Professional Claim form

When submitting an electronic claim via WINASAP, please use frequency type code 7 to replace or 8 to Void

Adjustments on a UB04– Institutional Claim form

When submitting an electronic claim via WINASAP, please change the Bill Date to TODAYS’s date, and the Type of Bill will be changed to xx7 for Replacement and xx8 to void

Please use your WINASAP User Guide for details

** Replacement claims will void the original claim and reissue a new claim number.

WINASAP Maintenance Yearly Clean-Up

Database Backup: It is recommended that you back up the WINASAP5010 database weekly. Depending on the amount of information you enter in any given period of time, you may want to perform a backup more often.

Purge Claims: Depending on your claim volume, you should periodically purge claims from the WINASAP5010 claims database to reduce the amount of information displayed on claim inquiry windows and reports. WINASAP5010 automatically backs up the database before purging it and automatically reorganizes the database after the purge is finished. We recommend purging claims monthly to extend the systems functionality.

When error occurs while filing a claim in the WINASAP database, please review your troubleshooting companion guide. Purging old claims will help clear storage space and reduce error messages.

Returned to Provider (RTP) - Common Reasons of Return

- Missing Signature/Signature must be in live ink on a hard copy claim form
- Medicaid ID is invalid/A valid 10 digit Medicaid ID is required
- Replacement/Adjustment claim is not following the resubmission requirements
- PIN or NPI is missing in 24J of the CMS1500 claim form
- 99 line may only be omitted on an electronic or hard copy UB-04 claim form

Requesting for a Timely Filing Waiver?

If you are not able to submit your claim (including resubmissions) within the proper filing period, you must obtain a waiver of the 12 month filing deadline. Evidence must be provided showing that claims were previously submitted within the 12-month filing deadline. Claims without such documentation but with extenuating circumstances that may be considered for waiver of the filing deadline are:

a) Claims with delays resulting from third party payments. Documentation of timely filing attempts with the third party must be indicated on the request.

b) By a court order.

c) By an administrative hearing determination.

Requests to waive the filing deadline for fee-for-service claims must be submitted to:

DHS/MQD/FO
1001 Kamokila Boulevard, Room 317
Kapolei, HI 96707

You must list the names of the client, date(s) of service and Claim Record Numbers (CRNs) of previously submitted claims if applicable. Please include documentation and a description of the extenuating circumstances. If you have several claims for which you require a waiver, you may list these claims on a single request letter.

Providers will be notified by Med-QUEST of the waiver decision, and if approved, claims may be submitted to the Fiscal Agent for payment. The approval letter must be attached to the claim when submitted.

Department of Public Safety (DPS) Claims Processing

Incarcerated patients claims are processed and payable by Conduent. Please ensure you have a valid 10 digit state ID number starting with OPA. First, your claim must be sent to the Department of Public Safety for review which will then be forwarded to the fiscal agent, Conduent for claim adjudication. When billing for a prescription drug, only code J3490 will be reimbursed. Each provider is contracted to use this code based on their DPS contract. To inquire and to set rates for code J3490, please contact DPS at 1-808-587-3379.

A common reason we may not have your claim on file when you call for claim status is because the claim is not submitted with a signature in box 31 of the 1500 claim form or on the bottom of the UB04. Please remember that we need a live ink signature because ink stamped signatures are not acceptable.

Claim Submission Billing Address
Department of Public safety (DPS) - Health Care Division
Medicaid Claims
919 Ala Moana Blvd. Rm #407
Honolulu, HI 96814-4920
Office: 1-808-587-3379

Medicaid Billing Required Fields for the CMS 1500

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self 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

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

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

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

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
1	Insurance Coverage	Required	Indicate the type of insurance coverage applicable to this claim by placing an “X” in the appropriate box. Only one box can be marked.
1a	Insured’s ID Number	Required	Insured’s ID number as shown on the Medicaid ID.
2	Patient’s Name	Required	Patient’s full name as it appears on the Medicaid ID card.
3	Patient’s Birth Date, Sex	Required	Patient’s birth date (MM/DD/YYYY). Enter an “X” in the appropriate box to indicate the sex of the patient.
5	Patient’s Address	Required	Patient’s street, city, state, zip code, area code and phone #.
6	Patient Relationship to Insured	Required	Enter an “X” in the correct box to indicate the patient’s relationship to insured.
9	Other Insured’s Name	Conditional	If FL11d is marked, complete fields 9, 9a, and 9d. Otherwise leave blank. When additional health coverage exists, enter the other insured’s full name if it is different from that shown if FL2.
9a	Other Insured’s Policy or Group Num-	Conditional	Policy or group number of the other insured.
9d	Insurance Plan Name or Program Name	Conditional	Other insured’s plan or program name.
10a-c	Is Patient’s Condition Related to:	Required	Indicate whether the patient’s condition is a result of an employment, auto, or other type of accident.
11	Insured’s Policy, Group, or FECA Number	Conditional	If the patient has another TPL, indicate the TPL policy number. If FL4 is complete, this field should be completed.
11c	Insurance Plan Name or Program Name	Conditional	Insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?	Conditional	Enter an “X” in the correct box. If marked YES, complete 9, 9a and 9d.
12	Patient’s or Authorized Person’s Signature	Required	Patient’s or authorized person’s signature releases any medical or other information necessary to process a claim. If the signature is on file, indicate “Signature on file” and date.
14	Date of Current Illness, Injury, Pregnancy	Conditional	Enter the first date of the present illness, injury, or pregnancy (MM/DD/YY).
17	Name of Referring Provider or Other Source	Conditional	Name and credentials of the referring physician are only required for consults (99241—99275). Leave blank if not a referral.
17a	Other ID #	Conditional	Medicaid qualifier “1D” and the legacy number is required when referring physician is an atypical provider.

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
17b	NPI#	Conditional	Enter the NPI of the referring provider.
18	Hospitalization Dates Related to Current Services	Conditional	Required for hospitalizations only. Enter the admit date followed by the discharge date. If not discharged, leave discharge date blank (MM/DD/YY).
19	Reserved for Local Use	Conditional	If it is known that the TPL does not cover a certain service, a denial does not have to be obtained, but you must indicate "Not a (name of TPL) covered service".
21	Diagnosis or Nature of Illness or Injury	Required	List up to 12 diagnosis codes. For dates of service on or after 10/1/2015 only ICD-10 codes will be accepted. Use the highest level of specificity possible. Do not add provider narrative in this field. Relate the appropriate diagnosis code to the lines of service in FL24E using the appropriate alpha pointer.
22	Medicaid Resubmission	Conditional	Required for resubmissions only. Enter "A" (to adjust) or "V" (to void). Also enter the original 12-digit claim reference number.
23	Prior Authorization Number	Conditional	Waiver providers must indicate a "W".
24A	Date(s) of Service [lines 1-6]	Required	Date(s) of service, from and to.
24B	Place of Service [lines 1-6]	Required	Enter the 2-digit place of service. **
24C	EMG [lines 1-6]	Conditional	Required for emergency services. Enter "Y" for YES or leave blank if no. **
24D	Procedures, Services, or Supplies [lines 1 -6]	Required	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set on the date of service. **
24E	Diagnosis Pointer [lines 1-6]	Required	Enter the diagnosis reference letter (pointer) as shown in FL21 to relate the date of service and the procedures performed to the primary diagnosis. **
24F	$ Charges [lines 1-6]	Required	Do not add commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number. Symbols that denote no charge for service, such as "N/C" and slashes or dashes are not a valid charges of service.

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
24G	Days or Units [lines 1-6]	Required	Enter the number of service units, visits or days applicable to each line. If field is left blank, the number is assumed to be 1. **
24H	EPSDT/Family Plan [lines 1-6]	Conditional	For Early & Periodic Screening, Diagnosis, and Treatment relates services. Enter a "E" only when requesting follow-ups for catch-up and preventative services. **
24I	ID Qualifier [lines 1-6]	Conditional	Enter qualifier "1D" if the provider number is an atypical provider type (NPI not required for provider).
24J	Rendering Provider ID # [lines 1-6]	Required	The NPI must be indicated in the un-shaded region. If an atypical provider, enter the legacy number in the shaded area. Must indicate the 6 digit PIN with the 2 digit service location (XXXXXX-XX)
25	Federal Tax ID Number	Required	Enter the provider of service or supplier's Federal Tax ID (employer identification number) or Social Security Number. Enter an "X" in the appropriate box to indicate which number is being
26	Patient Account No.	Conditional	Enter the provider patient reference or account number.
27	Accept Assignment	Required	Enter an "X" in the correct box. Only one can be marked. Medicaid requires YES to be checked.
28	Total Charge	Required	Sum of total line charges. (I.e., total of all charges in FL24F).
29	Amount Paid	Conditional	Enter total third party amount paid.
31	Signature of Physician or Supplier	Required	Signature of Physician or Supplier Including Degrees or Credentials.
32	Service Facility Location Information	Conditional	If the service was rendered in a Facility or Hospital, or if different from billing address, enter the name and address of the facility.
32a	NPI #	Conditional	Enter the 10 digit NPI of the service facility.
32b	Other ID #	Conditional	Enter the 6 digit legacy PIN preceding the 2 digit provider locator (XXXXXX-XX).
33	Billing Provider Info & Ph #	Required	Enter the provider's or supplier's billing name, address, and phone number.
33a	NPI #	Conditional	Enter the 10 digit NPI of the service facility.
33b	Other ID #	Conditional	Enter the 6 digit legacy PIN preceding the 2 digit provider locator (XXXXXX-XX).
NOTE			** denotes that the information must be indicated in the un-shaded section of the field.

Hawaii Medicaid Promoting Interoperability (PI) Program

Program Year 2020 Submission Deadline Extended

The 2020 Program Year deadline for the Hawaii Medicaid Promoting Interoperability (PI) Program has been extended. The submission deadline is March 31, 2021, at 5:59 PM HST.

Program Year 2021

Program Year 2021 is scheduled to open on July 1 and closes on September 30, 2021. Here are some items to remember when attesting:

- The EHR reporting period for all Medicaid Eligible Professionals (EPs) is a minimum of any continuous 90-day period within calendar year 2021.
- All EPs must attest using a 2015 Edition CEHRT. The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2021. The functionality must be in place by the first day of the EHR reporting period. The product must be certified to the 2015 Edition criteria by the last day of the EHR reporting period. The 2015 Edition functionality must be used for the full EHR reporting period.
- All EPs are required to attest to the Stage 3 Objectives and Measures.
- All EPs must report on a total of six (6) Clinical Quality Measures (CQM) related to their scope of practice. EPs are required to report on at least one outcome measure. If no outcome measures are relevant to an EP's scope of practice, they must report on at least one other high-priority measure. If there are no outcome or high-priority measures relevant to an EP's scope of practice, they must report on any six (6) relevant measures. https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms.
- The 2020 Physician Fee Schedule (PFS) Final Rule established a 90-day CQM reporting period within calendar year 2021 for all Medicaid EPs in Program Year 2021.
- Protected Health Information (PHI) should not be included in any documentation uploaded to the SLR.

2021 EP CMS Promoting Interoperability Program Objectives and Measures

Providers are required to complete all eight MU objectives. The 2021 EP specification sheets are located here: https://www.cms.gov/files/document/medicaid-ep-2020-table-contents.pdf

Objective 1 – Protect Patient Health Information

An EP must conduct or review a Security Risk Analysis including addressing the security of data created or maintained by CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

- EPs must use 2015 Edition CEHRT to meet Stage 3 meaningful use.
- The Security Risk Analysis must be conducted once per calendar year.
- It is acceptable for the Security Risk Analysis to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and it must be conducted within the calendar year of the EHR reporting period.
- State Medicaid Agencies have the flexibility to require EPs to submit evidence that the security risk analysis has been completed after the incentive payment has been issued in program year 2021.
- For EPs who attest that they will be completing their 2021 SRA after the attestation date, a future date must be entered to indicate that a SRA will be completed by December 31, 2021.

The details of the Protect Patient Health Information Objective can be found here: https://www.cms.gov/files/document/medicaid-ep-2020-protect-patient-health-information-objective-1.pdf

Hawaii Medicaid Promoting Interoperability (PI) Program—Continuation

Exclusion for Broadband Access

Several meaningful use objectives for program year 2021 have an available exclusion for EPs who conduct 50% or more of their encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability, according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period. These objectives include: Patient Electronic Access, Coordination of Care through Patient Engagement and Health Information Exchange. To assist providers in efficiently finding information pertaining to the broadband speeds in their respective county, CMS provided a list of counties that did not have minimum broadband requirements (Source: Broadband Deployment Data from FCC Form 477, as of December 31, 2014) and would qualify for the exclusion. The list **did not** include any counties in Hawaii. Therefore, no EPs are eligible to take the broadband exclusion for any of the above listed objectives.

Hawaii Outreach Coordinator

Heidi Miles is the Outreach Coordinator for the Hawaii Medicaid Promoting Interoperability Program. She is available to assist providers with their attestation questions. Contact Heidi via email or telephone at Heidi.Miles@Conduent.com or (808) 561-2197.