Hawaii Medicaid Provider Bulletin

Volume 14, Issue 3

September 2020

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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!

Med-QUEST Division's New Provider Enrollment System – HOKU

On August 3, 2020, the Med-QUEST Division (MQD) launched a new web-based system, HOKU, that will allow providers to enroll, update, and make changes to their information quickly and easily. New Medicaid providers are now able to enroll online. Go to medquest.hawaii.gov/HOKU to view the 'HOKU Website Links.' For existing Medicaid providers, MQD will be phasing provider registration in waves and would like to encourage all Medicaid providers to register in HOKU at the appropriate time. HOKU allows providers to review their provider enrollment information and make any revisions if needed. MQD mailed out an updated provider memo (QI-2006B) and updated the website with information around the go-live date, registration periods for each wave (group of providers) and training opportunities. Continue to visit the HOKU website (medquest.hawaii.gov/HOKU) for the most recent news, updates and training materials. Please call MQD's Provider Hotline at 692-8099 or send an email to HCSBInquiries@dhs.hawaii.gov if you have any questions.

Electronic Visit Verification (EVV)

The new mandatory statewide Electronic Visit Verification (EVV) project is on schedule.

Provider Training: Sandata EVV provider training registration opens in September 2020 and training will begin early October 2020.

3rd Party EVV vendors: If your provider agency is using a 3rd Party EVV vendor, testing with Sandata has started. If testing is not completed by 10/16/20 your provider agency will be required to attend Sandata EVV training.

Authorizations: The Health Plans will be ending existing authorizations with EVV related service codes on 9/30/20. The Health Plans will be issuing new authorizations for EVV related service codes and modifiers to be effective on 10/1/20. Claims submitted for EVV related visits/services MUST align to the EVV service codes and modifiers starting 10/1/20. The Developmental Disabilities Division (DDD) authorizations are not impacted due to the service codes and modifiers not being changed.

Sandata EVV System: The Soft Launch / Parallel Testing will run from 10/5/20 - 12/29/20. This is a ramp up time that Providers can use the live EVV system to schedule and record EVV visits. Providers using Sandata for EVV billing can have 837s generated for validation. DDD and the Health Plans can execute Visit Validation against Sandata stored visits during this time to ensure a smooth transition.

EVV Claims processing: DDD and the Health Plans are starting the "Soft Edits" for EVV related claims on 12/30/20. The soft edits will indicate if there were any issues with the claim payment in relation to EVV that should be resolved. Claim denial "Hard Edits" will begin on 4/1/21 if there was no EVV visit found for the claim.

EVV Mandatory usage state-wide (including 3rd Party EVV vendors) is 12/30/20.

Required Quantity Prescribed Field

Effective September 21, 2020, all pharmacies are required to enter the prescribed quantity for schedule II drugs Point of Sale (POS) submitted claims. The quantity dispensed must be less than or equal to the quantity prescribed.

Hawaii allows by state law for inventory shortage of the prescribed schedule II drug as well as for a patient in a long-term care facility or with a medical diagnosis documenting a terminal illness. Use of the Quantity Prescribed field facilitates monitoring of schedule II drugs to be partially filled under these conditions and restrictions as defined in HRS 329-38(k)(1) and (3).
Please see provider memorandum FFS 20-12 for more information at the MQD website: https://medquest.hawaii.gov/en/plans-providers/provider-memo.html

New Memos!

FFS 20-13
Interim Caries Arresting Medicament Application—D1354 Adult Dental Emergency Coverage
In an effort to reduce aerosolizing generating procedures associated with tooth extractions, and the burden of treating tooth related pain in Emergency Room departments, the Med-QUEST Division (MQD) is allowing the use of silver diamine fluoride (SDF) as an eligible procedure to address adult dental emergencies. Please refer to memo FFS 20-13 on the Med-QUEST website.

FFS 20-12
Required Quantity Prescribed Field In Point Of Sale Claim Submission For Schedule II Drugs
For more information, please read **memo FFS 20-12** on the Med-QUEST website.

FFS 20-11 (Addendum to FFS-M15-05)
The Department of Human Services, Med-QUEST Division (MQD) is issuing this memorandum to provide additional guidance regarding provision of personal protective equipment (PPE) for individuals receiving At– Risk services and Home and Community-Based Services (HCSB) in the QUEST Integration (QI) program. PPE includes but is not limited to single use disposable gloves, gowns, masks and face shields. To read more, please review memo FFS 20-11.

FFS 20-10
Effective August 1, 2020, all FFS, except Dental, programs will observe no more than 120 MME as the total daily amount of opioid the patient takes for chronic pain treatment by opioid medication. For more information, please read memo FFS 20-10 on the Med-QUEST website.

FFS 20-09
Coverage of Services for Autism Spectrum Disorder via Telehealth, please review memo FFS 20-09.

FFS 20-08
Teledentistry and Telephonic Guidance During the Public Health Emergency Period in Response to COVID-19
During the public health emergency that limits person to person interaction, Med-Quest Division (MQD) is issuing this memorandum to inform dental providers of an additional CDT code to Attachment A. To see the attachment and additional information, please read memo FFS 20-08 on the Med-QUEST website.

A listing of all news updates may be found on the Med-QUEST website at https://medquest.hawaii.gov/en/plans-providers/provider-memo.html

Coronavirus (COVID-19) - Contract Awards

In response to the COVID-19 pandemic, Med-QUEST Division (MQD) announced it is rescinding the contract awards made to managed care organizations on January 22, 2020, and canceling the QUEST Integration Request for Proposal (RFP-MQD 2019-0002) released in August 2019. MQD will issue a new RFP in the fall to address the evolving needs of the community.
For more news and updates visit https://medquest.hawaii.gov/en/about/recent-news/2020/CoronaVirus.html

Medicare Advantage Plan (Med-Gap Plans)

A patient may be enrolled in a Medicare Advantage Plan. When submitting to Medicaid for secondary payment, please ensure you have the proper explanation of benefits (EOB) attached, along with the name of the supplement plan in box 9d or 11C on the 1500 or in box 50 on the UB04 claim form. Please contact the Conduent Call Center at 1-800-235-4378/1-808-952-5570 for more information about Medigap Plan listings.

EDI/WINASAP Claim Submission Concerns

Providers with concerns such as missing 835 reports, missing 837 response files, WINASAP issues, modem issues (connectivity), and to validate if providers are enrolled for SFTP may be inquired through the EDI helpdesk. Please 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.

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.

Billing for Administration of Vaccines / Toxoids

Providers must bill for the administration of the vaccines using CPT code 90476-90749. While these codes are used to indicate the specific vaccine/toxoid product, Hawaii Medicaid also recognizes these code for the administration of vaccine. If the vaccine/toxoid is covered by the Vaccines for Children (VPC) Program, the reimbursement fee is part of the global EPSDT fee. If the vaccine is administered to an adult or is not covered through the VFC Program, please submit a 204 claim form using the NDC number on the vial and the quantity given to the Pharmacy Benefits Manger (PBM) Claims, 2810 North Parham Rd. Ste 210, Richmond, VA 23294. For questions, call (877) 439-0803.

Requesting more EPSDT Forms?

Please contact the Conduent Call Center at 1-800-235-4378 / 1-808-952-5570 to request EPSDT forms to be mailed to your office. The maximum amount of an order consists of one pack of 8015s or 25 sheets of 8016s. To ensure all providers have access to these forms, Conduent is limiting an order to once a week per provider request. Requested orders may take up to seven business days for mail delivery.

Check Claim Status and Eligibility Online for Free

DHS Medicaid Online (DMO) is a free online resource available to all Hawaii Medicaid providers. *DMO* allows providers to verify recipient eligibility and claim status via the internet. To access *DMO,* go to website address: https://hiweb.statemedicaid.us. In order to access *DMO,* you must first complete the registration process. It is recommended to register multiple Master Account Holders for your registered Provider Number. Upon activation of your account, you can verify eligibility information for recipients enrolled in FFS and QUEST plans, check FFS claim status and prior authorization information for waiver providers.

Eligibility, plan enrollment, and TPL can be verified by supplying the recipient's:
1) Medicaid ID # and Date of Birth (DOB)
2) Last Name, DOB and SSN
3) Medicaid ID, Name and DOB

When checking claim status and payments, you must:
1) Enter the Medicaid ID # and date of service

Claim status can be verified for claims submitted under the rendered PIN provided during the registration process. Go to: https://hiweb.statemedicaid.us today and start checking eligibility and claim status with ease. The information supplied via *DMO* is pulled directly from the Hawaii Medicaid claims processing system. This means the information you receive from *DMO* is the most up to date information available. If you require assistance with *DMO*, please contact Conduent Call Center at 1-800-235-4378/1-808-952-5570.

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. Please allow ample time for the request for waiver letter to be reviewed. Providers will be notified by Med-QUEST of the waiver decision via mail. The approval waiver letter must be attached to the claim when submitted to Conduent for processing.

Rules For Billing Medicaid Waiver Services And Reconciling Payments

1. Use the DHS Medicaid Online (DMO) to verify that clients are Medicaid eligible and approved for waiver services during the entire billing period. Call the Conduent Call Center to confirm suspension period dates. Do not bill for any of the dates included in the recipient's suspension period.

2. Wait for a prior authorization letter that specifies the billing procedure code and number of units approved for each client.

3. Verify that services were actually performed and bill in accordance with the client's individual service plan and prior authorization.

5. Use DMO to check claims status.

6. Use the weekly remittance advice to identify corrective actions for all claims not paid in full:

- Fix billing errors and resubmit claim in accordance with appropriate instructions.
- Call case managers for underpaid claims due to insufficient PA units or services
- Call Conduent to correct data entry errors.
- Call your Case Management Unit (CMU) to fix suspensions.

Friendly Reminders

1500 and UB04 Claim Form Instructions

- Share of cost amount should be entered in FL29 on the CMS 1500 claim form
- Attending Physician in FL76 on a UB04 must have a registered NPI. Please contact the call center to analyze your claim on what needs to be done.
- The State of Hawaii requires a live ink signature for claims processing. Please sign anywhere on the bottom of the UB04 claim form.
- Please indicate the ID qualifier '**1D**' in box 24I, and the full 8-digit provider number in box 24J/32/33 for providers w/out an NPI billing on form 1500.

Medicaid Billing Information and Guidelines

- Hawaii Medicaid FFS Fee Schedule has been updated. Review the fee schedule on the MQD Website https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html.
- Billing Medicare / Medicare Supplement Advantage Plans and TPL primary claims needs to be submitted with an EOB and not submitted via electronically except for Medicare crossover claims.
- All claims for Medicaid services must be submitted to Medicaid for payment within 12 months of the date of service. This includes all claims submitted to the Fiscal Agent whether initial claims, resubmitted outstanding claims, or additional payment requests. When Medicare or any other Third Party Liability (TPL) are primary, providers must submit claims within (6) months from the date listed on the Explanation of Benefits (EOB) or 12 months from the date of service, whichever is greater. For additional information, please review chapter 4.3.5 of the Medicaid Provider Manual.

Hawaii Medicaid Fiscal Agent
1001 Bishop Street, Ste. 575
Honolulu. HI 96813

Medicaid Correspondence Inquiry
Form 239

1. Date of Inquiry	2. Provider Name (Last, First, Middle Initial)		
3. Provider Number	4. Address: ☐ Pay to Address ☐ Service Address		
5. Telephone Number	6. Name of Contact		
7. Claim Number (if applicable)	8. Purpose of Inquiry ☐ Questionable Payment ☐ Claim Status ☐ Claims ☐ Filing Procedure ☐ Other *Do **not** use this form for claim adjustments. Send resubmissions to the appropriate Hawaii Medicaid Fiscal Agent Claim PO Box.		
9. Patient Name	10. Medicaid ID #		
11. Date of Service	12. Payment Date	13. Charge	14. Allowance
13. Remarks			

Response to Provider**: (For Office Use Only) Completed by _____ Date_____**

☐ Claim paid on _____ Amount _____

☐ Denied on _____ Reason _____

☐ Claim sent to Claims Dept. for reprocessing.

☐ Patient name and ID # not in DHS files.

☐ Claim is in the processing system. Please allow additional processing time.

☐ Claim is being researched. (We are currently working to resolve the issue.)

☐ Unable to match above claim data with computer file data.

Please submit claim with :

☐ Medicare/TPL EOB

☐ Approved waiver of filing deadline

☐ Other

☐ Submit copy of FFS or Waiver claim to: Hawaii Medicaid Fiscal Agent
PO Box 1220
Honolulu, HI 96807-1220

☐ Submit filing waiver request letter to: DHS/MQD/Finance Office
1001 Kamokila Blvd. , Rm. 317
Kapolei, HI 96707

Comments: _____

_____

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Hawaii Medicaid Fiscal Agent
1001 Bishop St. Ste. 575
Honolulu, HI 96813

Request for Reconsideration Form

Directions: Providers may use this form to request reconsideration of the allowed reimbursement amounts for specific services. Please limit your reconsideration requests to one claim per Form 240. All fields on the Form 240 are required and must be completed. Upon completion, please send Form 240 and any attachments to Hawaii Medicaid Fiscal Agent, 1001 Bishop Street. Ste. 575 Honolulu, HI 96813. Upon receipt, we will conduct the preliminary research to verify that the claim was processed and paid in accordance with Medicaid policy. Claims processed incorrectly will be submitted for reprocessing. If we determine that the claim was processed correctly, we will forward the request for reconsideration to Med-QUEST (MQD) for review. MQD will make the final determination. A request for reconsideration of payment amount or adjudication must be made within sixty days from the payment or adjudication date.

Date of Request:	Provider Number:	Contact Name:
Provider ID#:	Provider Phone #:	Provider Fax #:
Provider Address (Street Address, City, State and Zip Code):		Provider E-mail Address:
Claim Reference Number:	Medicaid ID #:	Date(s) of Service
List of Attached Documents		

Reconsideration Justification:

Date FA Completed Research: _____
Completed By:

Forwarded to ☐MQD
☐Claims Resolution

Hawaii Medicaid Promoting Interoperability (PI) Program

Are you ready for Program Year 2020?

Program Year 2020 is scheduled to open on December 1, 2020. Here are some items to remember when attesting:

- The EHR reporting period for all Medicaid EPs is a minimum of any continuous 90-day period within calendar year 2020.
- All EPs must attest using a 2015 Edition CEHRT. The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2020. 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 Measures and Objectives.
- 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 for all Medicaid EPs in Program Year 2020
- The Security Risk Analysis must be completed within calendar year 2020. EPs are required to attach documentation of the Security Risk Analysis to their attestations. We will accept the actual Security Risk Analysis document OR the SRA Tool Summary Report from Office of National Coordinator (ONC). EPs that are part of a large group do not need to include their individual provider information, i.e. name and NPI, on the Security Risk Analysis.
- Protected Health Information (PHI) should not be included in any documentation uploaded to the SLR.

2020 EP CMS Promoting Interoperability Program Objectives and Measures

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

Objective 7 – Health Information Exchange

An EP must attest to all three measures and meet the threshold for two measures for this objective. Examples of how to meet this objective include:

- If an EP meets the criteria for exclusion from one measure, they must meet the thresholds for the remaining two measures.
- If an EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure.
- If an EP meets the criteria for exclusion from all three measures, they qualify for exclusion from this objective.

The details of the Health Information Exchange Objective can be found here: https://www.cms.gov/files/document/medicaid-ep-2020-health-information-exchange-objective-7.pdf

Exclusion for Broadband Access

Several meaningful use objectives for program year 2020 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.