Hawaii Medicaid Provider Bulletin

Volume 18, Issue 1

April 2023

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The federal PHE, related to the COVID-19 pandemic will end on May 11, 2023.

EVV (Electronic Visit Verification) Updates

- MQD has issued Memo QI-2305 with guidance on manually editing/entering visits.
  - Manual edit monitoring began on 2/1/2023.
  - Providers should refer to the memo to ensure standards are being met.
  - Providers are able to monitor their manual edits with two Sandata reports "Auto Verification Report Detail" and "Auto Verification Report Summary".
- MQD Provider Agency meetings have ended and guidance will now be provided by the Health Plan or DDD.
- EVV Provider meeting presentations and documents from previous meetings are posted on our MQD EVV website.
- MQD Town Hall meeting series has been completed and the latest presentations have been posted to our MQD EVV website.
- 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.
- If a claim line is denied for EVV reasons, there are two options:
  - Fix the visit(s) to reach a Verified/Approved/Processed status and resubmit the claim.
  - Adjust the units down to match the claim line and resubmit the claim. Be sure to contact your payer on claim resubmission requirements.
- 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

Provider Enrollment

As of 01/03/2023, the new Provider Enrollment Customer Service Call Center toll-free number is 1-833-909-3630. The Provider Enrollment Customer Call Center will assist with all provider application processes and inquiries.

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, 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.

MQD has issued memo QI-2301, updating guidance with current standards for provision of Applied Behavioral Analysis (ABA) for the treatment of autism spectrum disorder (ASD).

Adult Dental Benefits

Effective January 1, 2023, State of Hawaii has expanded its dental benefits to the Medicaid adult population. This means that eligible adult beneficiaries can now receive a range of dental services including preventative, restorative and some denture coverage. Fee-for-Service Medicaid Dentists shall contact Hawaii Dental Service (HDS) if there are any questions on coverage and claims submissions. HDS's dedicated Medicaid Customer Service line is 808-529-9345 or toll-free 855-819-9117.

Covered adult dental benefits include the following:

Preventative Services
Endodontic Therapy Services
Oral Surgery
Prosthodontic Services
Diagnostic and Radiology Services
Restorative Services
Periodontal Therapy Services
Emergency and Palliative Treatment

(Some limitations and prior authorization may apply)

As a reminder, prescriptions written by Medicaid dental providers for Medicaid children and adults are submitted to and paid by the MQD fee-for-service fiscal agent, Conduent. Dental prescriptions for drugs on the Medicaid dental formulary are processed using BIN: 610084 and PCN: DRHIPROD. For questions regarding dental procedure claim submission and processing, please contact the Hawai'i Medicaid FFS Call Center (operated by Conduent) at 1-877-439-0803. For questions about drug coverage, contact Conduent Pharmacist, Gary Peton, at (808) 952-5591.

DHS Medicaid Online FAQs

- **The current Master Account Holder (MAH) is no longer with the company or the provider does not know who is the organization's MAH**
  Please call Provider Relations at 1-800-235-4378/ 808-952-5570, have your Provider ID or NPI and username/email address ready. Our on-site DMO Specialist will assist.
- **The MAH is locked out of the account**
  Please call Provider Relations at 1-800-235-4378/ 808-952-5570 and have your Provider ID or NPI and username or email address ready.
- **Can there be more than one master account for each provider?**
  Yes. Once the first master account holder is activated, they can click on the "Admin" link on the web page (after logging in) where they will be directed to a User Account maintenance page. From the maintenance page, the MAH may select one of the usernames from the drop down of "Active Users" list and upgrade the account to a MAH.
- **Can a provider access all servicing PINs associated with the group ID?**
  Yes, provider should create account using the group PIN. When performing a claim search, the provider will select the appropriate PIN from a drop down from the menu page.

Any issues with DHS Medicaid Online, please call Provider Relations at 1-800-235-4378/808-952-5570. To register for the DHS Medicaid Online or to start checking claim and eligibility statuses, go to https://hiweb.statemedicaid.us.

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.

Repair Claim Provider Data: When a user updates a detail in the Provider Reference tab, changes made aren't immediately reflected on the claims in which that provider was used. To fix this, use WINASAP5010's Repair Claim Provider Data function which allows users to automatically fix the previous claims with the new provider's data. Unlike resaving the claim, this tool does not perform compliance checks, but is still useful if the provider is used in multiple claims for expediency.

WINASAP Modem and Storage Database Tips!

- The USB WINASAP modem cord from PC to phone jack outlet should always remain untangled.
- Having a phone jack splitter may interrupt and slow data transmission. It is best to have the WINASAP modem connected from the PC directly to the wall jack.
- We suggest a limit of two years worth of claims kept in the database warehouse.
- The USB mini external modem (Zoom 3095) is inexpensive and is popular with the provider community.

Adjustment or 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.

Resubmitted claims must reflect the original number of claim lines. If the resubmission has less lines, Conduent will return the claim to provider (RTP). Conduent claim adjustment takes up to 30 days processing. Please follow up on your adjustment claim 25-30 days from when Conduent received it if you haven't seen an adjustment on the RA after processing time. If you do not get an RA with the CRN being adjusted, please contact our call center to inquire why claim cannot be adjusted. Your claim may be subject for return.

Timely Filing Waiver Process

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 DPS (Department of Public Service) and OYS (Office of Youth Services) enrollees. With all other NON-DPS 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 should be submitted to:

DHS/MQD/FO
1001 Kamokila Blvd, Rm 317
Kapolei, HI 96707

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

1099-MISC Form

If a provider received payments from Hawaii Medicaid in the amount of $600 or greater during the 2022 calendar year, they will receive a 1099 Misc. Income form and are required to report this amount to the IRS. The form was mailed on January 31, 2023. For returned 1099(s) due to insufficient or incorrect address, Banking Operations will reach out to the provider to submit a request in writing for an address to send their 1099 form to. Provider will need to follow up with Provider Enrollment to update the change of address. The Post Office will not forward the 1099(s), they will be returned to Conduent.

EPSDT ONLINE ASSISTANCE

The new EPSDT process can be done in three different ways: Complete online, submit fillable PDF, or print the filled PDF. FAQ's are located here:

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

The DHS 8015 and 8016 have been converted to one fillable PDF. The DHS 8015 is used to submit comprehensive EPSDT visit data and the DHS 8016 is used to submit follow-up EPSDT visit data. If printing forms, BOTH pages of the 8015 or 8016 must be printed and mailed with the CMS 1500 attached. Email us at EPSDT@dhs.hawaii.gov

EPSDT Helpdesk: 1-808-900-8650
Hours of Operation: 8AM to 5PM (Monday to Friday)

Out of State Claims

Submit application with proper documentation along with the claim to the Provider Enrollment Department- MQD. No license information document is required for OUT OF STATE PROVIDERS. For faster processing, notate on the top of the application "Out of State" and for the provider to follow the 1139 application instructional sheet and mail to the following address:

Med-QUEST Division
Health Care Services Branch, Provider Enrollment
"OUT OF STATE PROVIDER"
601 Kamokila Blvd., Room 506A
Kapolei, Hawaii 96707

Proper Documentation Includes:

- Includes entire 1139 signed, with W9, ***license not required***
- Documentation showing they are a Medicare/Medicaid/CHIP Provider in their State
- Existing providers in the system with currently enrollment status – Termination- no activity 24 months need to submit an application as if they were a new provider.

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. 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
1177 Alakea Street #602
Honolulu, HI 96813
Office: 1-808-587-1250

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.

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.

Emailed Medicaid Correspondence Inquiries

Send to hi.providerrelations@conduent.com

CLAIMS inquiries—include CRN, PA inquiries—include PA. Please indicate if attaching 239 Form to email.

Common RTP reasons

- The MEDICAID ID is invalid or missing. The ID # consists of 10 digits.
- All claims with no authorized signature on your CMS 1500 or UB04 claim forms will be returned back to you. The UB04 does not have a designated field for a signature so the authorized signer may sign anywhere on the bottom of the claim form. The authorized signature for a CMS1500 claim form is located in box 31.
- The patient is enrolled in a QUEST Integration Plan. Claim should be sent to the recipient's health plan.

Cost Share/Share of Cost Reporting

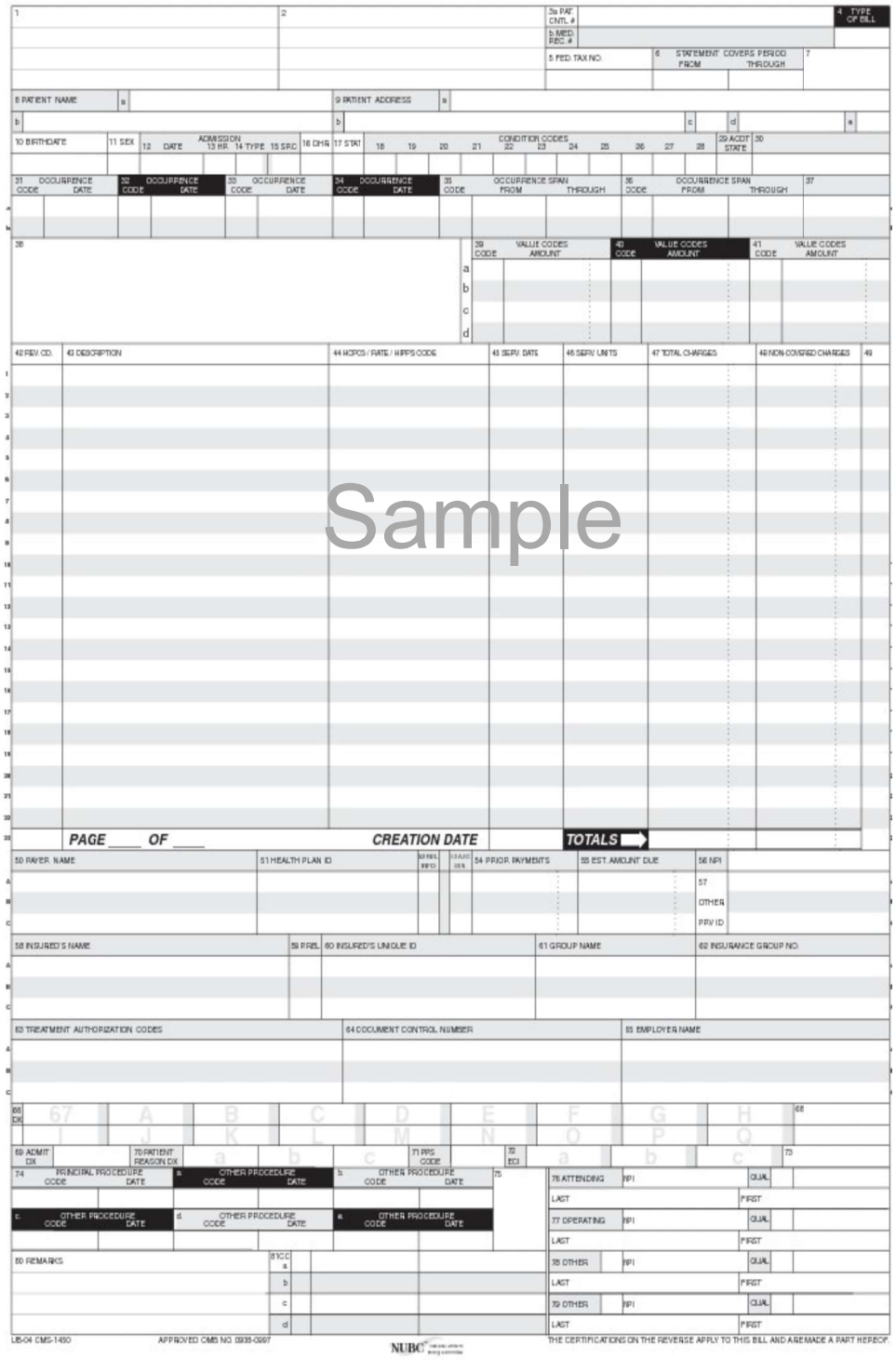
The provider may report a patient's SOC in fields 39-40 with value code 23 on the UB04 and field 29 on the 1500 claim form.

Claims/Medical Documents—DROP BOX!

Located in the basement level next to the Fed-EX bin.

1001 Bishop St Honolulu HI 96813

Medicaid Billing Required Fields for the UB04



FL #	Field Name	Requirement	Information Required
1	Provider Name, Address, & Phone #	Required	Enter the provider's name, and service address and ph. #.
2	Pay-to Name, Address, and Secondary ID	Conditional	Required when the pay-to name and address information is different than the Billing Provider information in FL1.
4	Type of Bill	Required	This is a 3-digit alphanumeric code that identifies the type of facility, type of care, and the billing sequencing.
5	Federal Tax #	Required	Enter the Provider's Tax ID#.
6	Statement Covers Period	Required	From and through dates for this billing period. (MM/DD/YY).
8b	Patient Name	Required	Medicaid Recipient's last name, first name and middle initial as it appears on their Medicaid ID card.
9	Patient Address	Required	Patient's street number and name of post office box, city, state and zip code.
10	Patient Birth Date	Required	Month, day and year of the recipient's birthday (MM/DD/YYY). This information must correspond with the birthday on the Medicaid ID card.
11	Patient Sex	Required	Enter "M" for male, "F" for female.
12	Admission Date	Conditional	Required if patient was admitted (01-24 hrs.).
13	Admission Hour	Conditional	Required if patient was admitted. (01-24 hrs.).
14	Type of Admission / Visit	Conditional	Required if patient was admitted. Enter the admission type code.
16	Discharge Hour	Conditional	Discharge hour is required if patient is discharged on end date of service. This field must be left blank if no discharge hour applies. "00" is not a valid entry (01-24 hrs.).
17	Patient Status	Conditional	Required if the patient was admitted. Enter patient status code.
18-28	Condition Codes	Conditional	Required if the patient was admitted. Enter patient condition code.

FL #	Field Name	Requirement	Information Required
31-34	Occurrence Code/Date	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
35-36	Occurrence Span Code/Date	Conditional	If occurrence code is billed, occurrence span date (both from and to date) is required (MM/DD/YY).
39-40	Value Codes	Conditional	When Medicare is the TPL, coinsurance/deductible amount must be indicated along with the corresponding value code. If the patient has a cost share, enter "23" and the amount.
42	Revenue Code	Required	Enter the appropriate 4-digit revenue codes to identify specific accommodation and / or ancillary charges.
44	HCPCS/Rates	Conditional	Required for outpatient services (except for outpatient rev. codes 025x or 063x). Enter the HCPCS code for all services.
45	Created Date (line 23)	Required	Date of signature (MM/DD/YY).
46	Units of Service	Required	Required when billing with revenue codes.
47	Total Charges	Required	Sum charges. You will no longer be required to use revenue code 0001 to sum charges.
48	Non-covered Charges	Conditional	Non-covered charges must be indicated here.
50A-C	Payer Name	Required	Enter the names of the appropriate payers listed in order of primacy (primary payer on Line A, secondary on line B and tertiary on line C). Indicate “Medicaid” as the payer on the appropriate line.
54	Prior Payments	Conditional	Required when TPL applies. Enter the total amount paid by TPL on every line. If no payment was made, enter “0”.
56	NPI	Required	10-digit NPI
58	Insured’s Name	Conditional	On the same lettered line (A,B, or C) that corresponds to the line on which Medicaid payor information is shown in FLs 50-54, enter the patient’s name as shown on the Medicaid ID card.

FL #	Field Name	Requirement	Information Required
59	Patient’s Relationship to	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
60	Insured’s Unique ID	Required	On the same lettered line (A, B, or C) that corresponds to the line on which Medicaid Payor information is shown in FLs 50-54, enter the Patient's Medicaid ID.
61	Insurance Group Name	Conditional	Indicate the insurance group name that coordinates with the insured indicated in FL58 A-C.
62	Insurance Group #	Conditional	Enter the ID#, control # or code assigned by the appropriate insurance carrier that corresponds to group FL61 A-C.
64	Document Control #	Conditional	Required for resubmission. The original 12-digit claim reference number must be indicated in FL64 A.
66	Diagnosis Code Indicator	Required	For dates of service 10/01/2015 going forward please enter “0” for ICD-10 CM diagnosis code.
67	Principal Diagnosis Code	Required	Enter the Principal Diagnosis Code.
67A-Q	Other Diagnosis Codes	Conditional	Hawaii Medicaid allows for the entry of up to 10 diagnosis codes. Provider may not duplicate the principal diagnosis listed in FL67.
69	Admitting Diagnosis Code	Conditional	Required if the patient was admitted.
74	Principal Procedure Code & date	Conditional	Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
76	Attending– NPI/Qual/ID	Required	Required when the claim contains any services other than non-scheduled transportation services.
80	Remarks	Conditional	Enter remarks needed to provider information that is not shown elsewhere on the bill but which is necessary for proper payment.)I.e. “Not a three day qualifying stay” or “Not a TPL/ Medicare covered benefit”).
80	Remarks	Required	The State of Hawaii requires a live signature - in the Remarks field or near the bottom of the UB04 form