Hawaii Medicaid Provider Bulletin

Volume 17, Issue 3

December 2022

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New CONDUENT DROP BOX

For your convenience, drop off your claims / records in the DROP BOX!

1001 Bishop St.
Honolulu, HI 96813
Basement Level
Checked Twice Daily!

EVV (Electronic Visit Verification) Updates

- Member/participant services should not be stopped due to an EVV issue such as, missing authorization or EVV device issues.
- Remind caregivers that members/participants (or their designees) need to confirm at the end of each visit that services were provided so the agency gets paid.
- MQD will be issuing a Manual Edits Memo with guidance on manually editing/entering visits soon.
  - In support of the memo, Sandata has released two new reports "Auto Verification Report Detail" and "Auto Verification Report Summary" to help with monitoring of manual edits.
- Various EVV fixes were applied to the Sandata portal and devices resolving technical issues.
- 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.
- 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:
    - 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 and contact your payer on claim resubmission requirements.
- MQD held the EVV Town Hall meeting for QI members and DDD Participants on 10/19/2022.
- Next Quarterly EVV Town Hall meeting for QI members and DDD Participants will be held on 1/19/2023.
  - The EVV Town Hall Meeting flyer is posted on our MQD EVV website.
- MQD continues to hold regular Monthly EVV Provider meetings for Home Health, Home Care, Nursing and DDD to address EVV related questions.
- 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
- 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

Effective 01/03/2023, the Provider Enrollment Customer Service Helpline will have a new toll-free number 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 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 letter.

Adult Dental Benefits

Effective January 1 2023, Medicaid will cover adult dental benefits. Med-QUEST is currently working with dental partner Community Case Management Corporation (CCMC) and will be accepting calls in January 2023. Please encourage your patients to contact CCMC for more information at 1-808-792-1070 or toll-free at 1-888-792-1070. CCMC will be able to explain covered dental benefits and help beneficiaries find a participating dentist.

Adult dental benefits include the prevention and control of oral disease including cleanings and dental procedures such as x-rays and fillings. Coverage will also include restoration of chewing functions which, based on the individual case, may include root canals, crowns and/or dentures. Like any medical benefit, coverage will depend on the medical necessity of each case.

Timely Filing Deadline 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.***

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

APR DRG BILLING GUIDANCE

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.

The memo is intended to give new and modified billing guidance to affected hospitals and health plans related to the Med-QUEST (MQD) implementation of the All Patient Refined Diagnostic Related Groups (APR DRG) effective July 1, 2022 going forward.

For more information about APR DRG Billing Guidance, please refer to Memo No. QI-2211 on them Med-QUEST website.

EPSDT Forms 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 primary goal is to offer prevention, early diagnosis and medically necessary treatment of conditions.

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

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.

Claim Submission Billing Address

Department of Public Safety (DPS)
Healthcare Division
Medicaid Claims
1177 Alakea Street #602
Honolulu, HI 96813
Office: 1-808-587-1250

What is an EMGSVC Recipient Eligible Patient?

The Emergency Medical Treatment & Labor Act defines an emergency medical condition as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the

woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part .

If you have questions about the patient's 1149a authorization please work with the patient's case worker over at the Department of Human Services.

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 new 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.

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 email

HCSBinquiries@dhs.hawaii.gov

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.

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.

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

Emailed Medicaid Correspondence Inquiries

- Send to hi.providerrelations@conduent.com
- For CLAIMS inquiries—include CRN
- For PA inquiries—include PA
- Indicate if attaching 239 Form to email

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.

Mahalo!

Hawaii Medicaid Fiscal Agent
PO Box 1220
Honolulu. HI 96807-1200

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
PO Box 1220
Honolulu, HI 96807-1220

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, PO Box 1220 Honolulu, HI 96807-1220. 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 Name:	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