



Hawaii Medicaid Provider Bulletin

<p>Volume 12, Issue 2 October 2018 Inside this issue:</p>		<h2>Surf the new Med-QUEST Website!</h2>	
<p>Med-QUEST Website-Surfing for current documents/ Resubmitting your claims/Customer Service Branch for Medicaid Recipients/Pass it On!</p>	1	<p>Please visit the new Provider Med-QUEST Website at: https://medquest.hawaii.gov/</p> <p>There you are able to find the Provider Manual, Provider Bulletins and Memos under heading "Plans & Providers".</p> <p>Provider Memos are located here: https://medquest.hawaii.gov/en/plans-providers/provider-memo.html</p> <p>Provider Bulletins are located here: https://medquest.hawaii.gov/en/plans-providers/fee-for-service/provider-bulletins.html</p> <p>Assistance Directory is located here: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/provider-manuals/provider-manual-appendices/Appendix_01_Combined.pdf</p> <p>240 Request for reconsideration form is located here: https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-forms/dhs-240---request-for-reconsideration-form/Form-240.pdf</p> <p>239 Medicaid Correspondence Inquiry Form is located here: https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-forms/dhs-239---medicaid-correspondence-inquiry/Form-239.pdf</p> <p>It is also best practice to search for your topic or form using key words and enter in the search box that is located on the top right of the Med-QUEST website.</p> <p style="text-align: center;">Customer Service Branch for our Medicaid Recipients</p> <p>Fiscal Agent Medicaid has been getting an abundance of calls from the Medicaid Recipient Community. Please discourage your patients from contacting the Provider Hotline. Instead, please have your patients contact the Customer Service Branch at 1-800-316-8005/1-808-524-3370.</p>	
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		<p style="text-align: center;">DO NOT write the words "RESUBMISSION" if not an Adjustment Claim</p> <p>If you are submitting a NEW claim for processing, do not write the words "RESUBMISSION" on it. Simply submit a new claim if your previous claim is denied.</p> <p>When submitting an adjustment claim, please indicate corrections on the claim itself by either circling or crossing out the changes. For guidance on how to submit an adjustment, please review page 2 of this Provider Bulletin.</p>	<p style="text-align: center;">Pass It On!</p> <p>Everyone needs to know the latest information on Medicaid. Be sure to route this to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Entire Office <input type="checkbox"/> All Billing Departments <input type="checkbox"/> Billing Professionals <input type="checkbox"/> Affiliated Billing Vendors

How to Properly Submit a Hard Copy Claim Adjustment

Adjustment claims may be submitted **only within 12 months** from the date of service. When an original claim is denied and you want to make a correction on the claim, simply submit a new claim. The adjudication time for new claims is much shorter than adjustment claims. Here are tips on how to properly submit an adjustment claim:

- Circle actual changes only. i.e., if adding a line, circle entire line including total charges. If changing a code, replace with correct code and circle it.
- When deleting a line, strike through the line item.
- On the top of the claim form, write the words "Resubmission"
- On the UB04, in FL 04, please ensure you have the TOB of xx7. Use TOB xx8 only to void the claim.
- If submitting an adjustment on the on the CMS 1500, please indicate "A," in FL 22 under resubmission code. Also notate the 12 digit CRN under Original Reference No. If voiding the claim, simply indicate "V" in FL 22 and notate the CRN.

If Conduent frequently returns your claims for the same reasons, we will contact your organization as additional training may be necessary.

Why your claims are being returned to you!

Conduent examines each and every claim to search for invalid fields. Please contact our Provider Hotline to follow up on your claim if you do not see your claim submission on your weekly remittance advice. Here are the top 8 reasons why your claim may have been returned to your office.

1. Missing Signature (Hawaii Medicaid requires a live ink signature on both the CMS 1500 and on the bottom of the UB04 claim)
2. Invalid Medicaid ID# (Medicaid ID consists of 10 digits)
3. Incorrect ICD indicator (ICD-10 should have an indicator of "0")
4. Invalid Provider ID#
5. Claims are black and white copies
6. ICD-10 Diagnosis Codes are Invalid and cannot be entered (Contact the Provider Hotline to Inquire)
7. HCFA resubmission require a resubmission code, A for adjustment or V for Void, and an original CRN # in box 22
8. "Out of State" claim forms are likely to have manage care eligible recipients

Refund Check Procedures

We are returning all of 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 Claims(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.

Enhanced Reimbursement to Eligible Primary Care Physicians and Obstetricians for Managed Care

This Med- QUEST Division (MQD) memorandum is an update to FFS M17-08 that was issued on September 15, 2017 for enhanced reimbursement to eligible primary care physicians and obstetricians for managed care. The purpose of this memorandum is to inform eligible primary care physicians (PCPs) that the enhanced reimbursement for Hawaii Medicaid PCP's will continue going forward. However, there will be some changes in how new provider to this program sign up for the enhanced reimbursement after January 1, 2018.

To read more about the enhanced reimbursement for new eligible providers and the code enhancement rates, please review memo dated February 8, 2018, memo no. FFS M17-08A on the Med-QUEST website: [PCP Enhancement Memo](#)

Please update your Provider Information on file

We are receiving an abundance of returned mail due to inaccurate provider addresses. Please inform your local post office of the new forwarding address. This will ensure you receive all important correspondence from Medicaid. To update your address, please submit form 1139 to the Health Care Services Branch (HCSB). To follow up on your inquiry, you may contact the Call Center at 1-800-235-4378/1-808-952-5570 or contact HCSB at 1-808-692-8099 to inquire about your application form. To obtain the 1139 form, please go to [Med-QUEST Website](#) and search for the Provider Application Change Request Form 1139.

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.

The patient's Medicare Advantage Part C plan name must be indicated on your claim form to ensure proper claim adjudication. In order of for you claim to process in a timely manner, all claims must have the name of all other insurance listed in FL9, 9a, 9d or 11c-d and on the 1500 claim form in FL50-55.

For further assistance in regards to the Medigap Plan and it's indications on your claim form, please contact the provider hotline at 1-800-235-4378/1-808-952-5570.

Below are some of the recognized State Medicare Advantage Plans:

AlohaCare Advantage
AlohaCare Advantage Plus
HMSA 65C+
Akamai Advantage (EOB Member # starts with A)
Health Net - Pearl Option
Humana - Gold Choice
Humana - Choice PPO
Kaiser Senior Advantage
Sterling Life Insurance – Sterling Option II

UniCare

Save Well – Plan I and II

Unicare Life & Health Ins.

Security Choice Classic Security Choice Enhanced

United Healthcare

AmeriChoice
Medicare Complete
AARP Medicare Complete
Evercare
Secure Horizons/ Medicare Complete
United Behavioral Health- UHC Dual Complete

Universal American

Today's Option- premier and value

WellCare

Summit Duet Concert Melody
Ohana Prelude Quartet Serenade Sonata

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

DHS Medicaid Online- FAQ

What are the Individual and Master Account Holders (MAH)?

The Master Account should be created before an individual account to ensure proper user account administration. A Medicaid Provider Number can have multiple Individual and Master Holders for their organization. The individual account is activated or deactivated by the Master Account Holder (MAH). In the event an Individual Account Holder forgets their password, they should contact the MAH for a password reset.

The current Master Account Holder is no longer with the company or the MAH account needs to be deleted

Please call Provider Relations at 1-800-235-4378/ 808-952-5570, please have your Provider ID or NPI and username/email address ready. Our on-site DMO Specialist will assist.

The provider does not know who the organization's MAH are

The MAH is usually the office Doctor, office Manager, Supervisor or an authorized associate for the organization. Please ask your organization before contacting the Provider Hotline. If the organization does not know who the MAH are, please call Provider Relations at 1-800-235-4378/ 808-952-5570, and 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/email address ready. Our on-site DMO Specialist will assist.

Provider is locked out/user inactivity of account after 120 days

If the account is a MAH, please call Provider Relations at 1-800-235-4378/ 808-952-5570 and have your Provider ID or NPI and username/email address ready. Our on-site DMO Specialist will assist.

The MAH is able to perform a password reset or username removal for individual account holders. If the individual account has been removed, the individual user must re-register.

Can 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.

Max date span providers can check eligibility on DMO

Providers have a max of 365 days per date span when checking patient eligibility.

Can there be more than one master account for each PIN/NPI?

Yes. Once the first master account holder is activated, they can click on the "Admin" link on the lower left hand side of 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 "Active Users" drop-down list and upgrade the account to a MAH

1149a Emergency Processing

Undocumented aliens are covered by Medicaid only for true emergencies. Approval for Medicaid coverage for emergencies is given only to hospitals. The approval covers the services provided by the hospital and professionals providing care at the approved hospital during the approved dates. It is specific to a hospital. Thus, if a patient is seen at two (2) separate hospitals for an emergency on the same day, both hospitals must obtain approval.

The following services are not covered:

- Facility and professional services at nursing facilities or at acute waitlisted skilled nursing facility (SNF) or intermediate care facility (ICF) levels of care.
- Services at clinics, provider offices, independent laboratories,
- Outpatient hospital services not connected to an approved facility emergency service

To expedite processing of emergency services, please submit medical records for the entire acute hospital stay (not just the emergency room visit leading to the inpatient stay). For inpatient stays, please submit the admission history and physical exam, progress notes, discharge note, and discharge planner notes. If possible, please do not submit laboratory values, nursing notes and physician orders.

If an undocumented alien, such as a COFA (Compact of Free Association) citizen or a permanent alien, may meet the Social Security criteria for disability, please submit the Medicaid disability forms (DHS 1127, 1128, 1180 and 1100B) with the request for approval for emergency services.

Friendly Reminder – 1500 and UB04 Claim Form Instructions

- Share of cost or volunteer payment 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.

Billing Code Updates

Admission Type Code

The following are **admission types** accepted by Medicaid Hawaii on the UB-04 claim form.

1. Emergency
2. Urgent
3. Elective
4. Newborn
9. Info Not Available

Patient Status 62

not used by Medicaid Hawaii, use patient status 05

Patient Status 21

not used by Medicaid Hawaii, use patient status 05

Locum Tenens

Modifier Q6 indicates services completed by a locum tenen.

Code 80101 replaced with code G0431

Fee Schedule

Please contact our call center to inquire about the FFS Fee Schedule if it is not found on the Med-QUEST website

The Hawaii Medicaid EHR Incentive Program

Part of the CMS Promoting Interoperability Program

Since the launch of the Hawaii Medicaid EHR Incentive Program in 2013, **more than \$56 million in incentive payments** have been made to eligible health care professionals and hospitals.

The Hawaii Medicaid EHR Incentive Program runs until 2021; however, **2016 was the last year** a provider could begin participation in the program. If you have attested at least once in the program and received payment, you can attest for remaining years and receive incentive payments if you are eligible. Eligible Professionals (EPs) can participate for a **total of six (6) years** and participation years do not have to be consecutive.

Program Year 2017 closed with 267 providers successfully submitting attestations.

To prepare for Program Year 2018, EPs will have the option of attesting to Modified Stage 2 or Stage 3 depending on EHR Certification. All providers must attest using EHR technology that is certified (at a minimum) to the 2014 Edition in Program Year 2018.

All EPs will report on a continuous 90-day EHR reporting period with a CQM reporting period of

- a full year for returning meaningful users; or
- 90 days for first time meaningful users.

Six (6) CQMs must be reported, regardless of Stage. Modified Stage 2 will report on 10 Meaningful Use Objectives. Stage 3 will report on eight (8) Meaningful Use Objectives.

Visit the CMS website for details on the Program Year 2018 Medicaid Requirements: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html>

Eligible Professional		
Program Year	2018	
EHR Reporting Period	Continuous 90 days	
CQM Reporting Period	Full Year for returning EPs Continuous 90 days for first time meaningful users	
# of CQMs	6	
MU Stage	Modified Stage 2	Stage 3
MU Objective	10 Objectives including 2 Public Health Measures	8 Objectives including 2 Public Health Measures

Available Resources

Visit the **Hawaii Provider Outreach Page (POP)** at <http://hi.aincentive.com>. Here, you will find links to the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System and the Hawaii State Level Registry (SLR). Be sure to click on the “Jump Start” section for details!

Contact the SLR Helpdesk: Email SLRHelpdesk@conduent.com or call (800) 235-4378, select option #7. You can work with a Helpdesk agent and also request to schedule an appointment or a call to work directly with the Outreach Coordinator. The Outreach Coordinator can provide detailed assistance and walk through the attestation process with you.

www.Med-QUEST.us
QUEST Integration

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