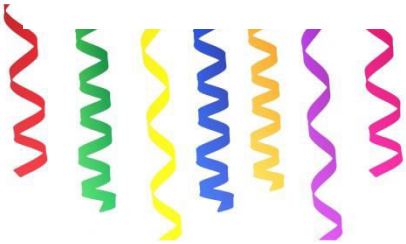
Hawaii Medicaid Provider Bulletin



Happy New Year 2017!

We are now CONDUENT!!!

After Xerox decided to separate its business services from its document and technology services in January 2016, a new company emerged. As of January 1, 2017, we are now CONDUENT. Please inform everyone in your organization of our name change. We will continue to work as normal with no changes to our structure and how we perform our business.

Our call center hotline announcement changed from saying XEROX to CONDUENT, so please do not assume you have contacted the wrong call center. Please continue to contact us and we will continue to serve you!

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Inside this issue:

DHS Medicaid Online– Updates and Reminders!

There are individual and master account holders for the DHS Medicaid Online Site. There may be multiple Individual and Master Account Users for each DHS Medicaid Online Account. Only the Master Account Holders will have an admin link on the lower left side the web page after logging in. When clicking on the link, the Master User will be directed to the User Account Maintenance Page. From the maintenance page, the master user will be able to view active users, deactivate and activate accounts. They are able to also initiate password resets. If you forget your password, contact your Master Account Holder!

If there are no active accounts under the Provider Number when registering, the first account created will be a Master Account. The user will have to follow on screen instructions for the account to be activated. This new update allows DMO to have more than one Master Account Holder. A current Master Holder is able to upgrade an individual account to a Master Holder.

For any reason the provider PIN is unable to administer it's own Master Account User, please contact our Provider Inquiry Unit Call Center at 1-800-235-4378/1-808-952-5570.

Providers Should Be Proactive!

Help resources located here:

Provider Bulletins:

http://www.med-quest.us/providers/ProvidersBulletins.html

Provider Memos:

http://www.med-quest.us/providers/ProvidersMemos.html

Provider Manuals:

http://www.med-quest.us/providers/ProviderManual.html

Pass It On!

Everyone needs to know the latest information on Medicaid. Be sure to route this to:

- Entire Office
- All Billing Departments
- Billing Professionals
- Affiliated Billing Vendors

How to Submit an Adjustment and Voided Claim

The provider may want to make changes to their existing claim on file. In order to make an adjustment the provider will need the following points made on the claim:

On a CMS 1500 Claim form, in box 22 under resubmission code, enter “A” means to adjust and under the original reference number section, the provider will need the claim reference number “CRN” which may be found on the weekly Remittance Advice. Top of the Claim Form, please write “Adjustment Claim”.

On a UB04 claim form, in box 4, bill type will need to be change to “XX6” or “XX7”. Enter the original CRN in box 64. Top of the Claim Form, in box 2, please write “Adjustment Claim”
When adjusting the claim, please draw a circle around the claim changes. (Only changes that are circled will be processed). If you need to void an unwanted line item, you may draw a line through the unwanted item and circle that change.

Examples: if originally billed 20 units, but wanted 25 units, the provider will replace the 20 units with 25 and circle the change. If the provider wants to remove modifier AA from the original claim, the provider may cross out the AA mod and circle the change. That will tell the claims adjuster to remove the AA modifier from that line item.

The provider may want to void the entire claim. In order to make the void, the provider will need to the following points made on the claim:

On a CMS 1500 Claim form, the provider will enter a “V” in box 22 under resubmission code, enter the original 12 digit number under the “claim reference number” that is located on the weekly remittance advice. Top of the Claim Form, please write “VOID CLAIM”.

On a UB04, in box 4, bill type will need to be changed to “XX8”. Enter the original CRN in box 64. Top of the Claim Form, in box 2, please write “VOID CLAIM”.

Once the claim is voided, HI Medicaid Fiscal Agent is unable to reverse the process. The provider will need to submit a new claim to generate another claim reference number.

If you have questions about the adjustment or voiding process, please contact our Provider Inquiry Unit Call Center at 1-800-235-4378/1-808-952-5570.

Need to Update your Contact Information on File?

Always update your office contact, billing address, phone numbers and credentialing information with the Medicaid Provider Enrollment Department– Health Care Services Branch (HCSB). By updating your information, this will prevent any future delays with important correspondence and delay in check payments.

Please submit a provider change request application to the Health Care Services Branch. You may find the application here: http://www.med-quest.us/providers/ProvidersApp.html
If you have questions about the provider change request form, please contact our Call Center at 1-800-235-4378/ 1-808-952-5570.

Need to Order Medical Claim Forms?

Call Rainbow Printers, Inc.
593-9782

Rainbow Printers, Inc.
875 Waimanu St. Room 507
Honolulu, HI 96813

New Updates

New HCPC~ Conduent is currently working with our Systems

Administrators to uploading new 2017 HCPC codes.

Provider Relations Email Address~ hi.providerrelations@conduent.com

EDI Helpdesk~ hi.ecstest@conduent.com

Popular Reasons Why we are Returning your Claims

- Missing Signature
- Signature must be in live ink
- Use the original red and white medical claim form, no copies
- Medicaid ID # is incorrect, must be 10 digits
- Explanation attached does not match claim
- TAX id is invalid or missing
- Missing the resubmission code "A" and claim number in box 22 of the 1500 claim form when submitting an adjustment claim
- Only ninety-nine lines may be submitted on an electronic or manual UB-04 claim forms. Otherwise it will be returned.

Billing to Pharmacy Benefit Manager "PBM"

Provider who needs to bill for a drug prescription that is not covered through our local office needs to bill our PBM office. To prevent system claim errors, the provider will need to ensure they are registered as a "pharmacy provider before submission. For more information on registration and billing with NDC, please contact our PBM office helpdesk at:

1-877-439-0803

For paper claim submissions, please mail your claims to:

Conduent PBMS
Attn: Hawaii Medicaid Paper Claims
PO BOX 967
Henderson, NC 27536-0967

Claim Filing Period and Provider Request for Reconsideration

Per Provider Manual Chapter 4.3.5, the time limit for claims submittal is twelve months from 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.

No Medicaid payment shall be made for any claim submitted after this period except for the following:

Cases involving retroactive eligibility for a client. 12-month filing period will begin from the date that DHS approved the client's application. Or if the claim is a Department of Public "DPS" claim.

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. There are no timeframe for 240 reconsideration requests. Please continue to follow up with the call center.

Please send your Request for Reconsideration on a 240 Form which may be obtained from the med-quest website.

http://www.med-quest.us/PDFs/Frequently%20Used%20Forms%20for%20Providers/240.pdf

Follow the instructions on the form and mail, fax or encrypt email to Conduent.

For more information about the process, please contact the Provider Call Center at 952-5570 or 1-800-235-4378.

Common Claim Denials Provider Should Know About

· **Denial: Attending Provider ID Test PRV Type Cannot Be Attending PR (H313.2)**

Provider Types 08- Med physician and 31- Physician Osteopath are the only two provider types that are considered "Attending Providers". All other provider types will deny.

· **Non-FFS Reimbursement type, provider not authorized to bill for service (L054.1)**

Provider have not enrolled with FFS reimbursement, please contact the Provider Enrollment Department to Enroll

· **Recipient Exception Code Indicates that Recipient is Suspended (L169.6)**

DHS Eligibility Workers are able to update suspension dates with the Fiscal Agent. Check with a call center agent to check patients suspension dates.

· **Other coverage amount field is missing (L045.1)**

Always check to see if the patient has other insurance on file. Also if you have submitted a 1500 claim form with box 10 marked yes, you are advising that there are other insurance. Please ask a call center agent to assist on payment.

· **ASC claim begin/end dates not equal, unacceptable with Med-QUEST policy (H281.2)**

ASC claims are billed no more than a 24 hour stay. Claims spanning midnight may be less than 24 hours. Review chapter 13 of the manual or inquire with a call center agent.

· **Same referring and service provider unacceptable… (H261.2)**

Same referring and service provider is a long standing Medicaid policy where the provider is unable to refer themselves as the referring provider when rendering service to patient.

PY2016 REMINDERS for Eligible Professionals!!!

Great news!

The 90-day reporting period is now available! The SLR is open for Program Year 2016 to **ALL** Eligible Providers. This means that while the SLR continues to be open to EPs attesting for Program Year 2016 AIU and MU Year 1 attestations, it is **now also open to EPs attesting to Year 2 and beyond. Please remember that the deadline for ALL PY 2016 Eligible Professional attestations is March 31, 2017 at 5:59pm HST.**

1139 REMINDERS!!!

The 1139 forms pertaining to the EHR Incentive Program must be mailed directly to the FA Office, not to MQD. Other 1139 applications however, NOT related to any updates/provider enrollments for the EHR Incentive Program, should be mailed directly to MQD.

Providers must also include a copy of their license and W-9 with the updated 1139. The top of the 1139 form should have "EHR Incentive Program" written on it.

Please note the **FA office address** below for your convenience.

Hawaii Medicaid Fiscal Agent
Attn: Hawaii Medicaid EHR Incentive Program
P.O. Box 1220
Honolulu, HI 96807-1220

Also if you need to inquire about the status of provider enrollment, please contact the **FA Call Center at 1-800-235-4378, option #3.**