Hawaii Medicaid Provider Bulletin

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Be Ready, Be Set, and Call!!

When calling into the Call Center, please have your individual doctor's NPI ready along with your name and contact phone number. By giving the proper NPI, the agents are able to perform claim research faster and more proficiently. To ensure we are properly handling patient information to our provider community, we have added an extra verification step by requesting patient's date of birth. If you fail to have the information ready, please call us back so we are able to assist others in the queue.

Provider Hotline Toll Free 1-800-235-4378 / 1-808-952-5570

Department of Health DDID Claims - Waiver Claims Processing

When billing your waiver claim for services that have been performed daily in the same month, please submit all service date(s) on a single claim form. We encourage our provider to use the combined billing method. This will make the payment reporting easier to view on your remittance advice as well as save time and paper for those who are submitting paper claims.

Ex. T1000 -TD billed on 01/01/2016 for 1 unit and 01/02/2016 - 01/04/2016 for 2 units can be billed on the same claim instead of two separate claims.

Please call our call center you have questions about combined billing.

Hawaii Dental Services will continue to be Medicaid Dental Third Party Administrator

The department of Human Services Med-QUEST division has awarded Hawaii Dental Service (HDS) with the contract to be Hawaii Medicaid's Dental Third Party Administrator (TPA) for the Medicaid Fee – For Service and QUEST Integration populations. HDS is responsible for processing dental claims and dental care coordination. To read more, please review the memo on the Med-QUEST website http://www.med-quest.us/PDFs/Provider%20Memos/FFS-1601.pdf

Customer Service Branch for our Medicaid Recipients

Fiscal Agent Xerox 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 1-800-316-8008, pressing option 1 then 3.

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

How to Properly Submit Claim Adjustments

Adjustment claims may be submitted only within 12 months from the date of service. When the 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 quicker than adjustment claims. Adjustment claims takes up to 30 days for processing. 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. Or if changing a code, replace with correct code and circle it.
- ☐ When deleting a line, strike through line item.
- ☐ On the top of the claim form, write the words "Resubmission" for all adjustment claims only.
- ☐ On the UB04, FL 04 ensure you have the TOB of xx7. Use TOB xx8 only to void the claim.
- ☐ The correct 12 digit claim reference number (CRN) must be on the claim.

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

Waiver of Filing Deadline

If the claim is being submitted more than 12 months from the date of service, a waiver for timely filing is required to further the claims adjudication process.

Evidence must be provided showing that the claim was previously submitted within the 12 month filing deadline. If this documentation is not available, extenuating circumstances must be described. You must submit your written request to waive the filing deadline for fee-for service

claims to:

DHS/MQD/FO

Attn: Timely Filing Waiver Request

PO Box 700190

Kapolei, HI 96709-0190

Claim Filing Deadline 4.3.5

Claims should be submitted within 12 months from date of service or 6 months from Medicare/TPL EOB date. Another exception would be a patient who has been retroactive on their medical eligibility. The filing limit for retro eligible patients is 12 months from the date the caseworker reinstated the eligible dates on file.

Why are we Returning your Financial Adjustments?

We are returning all your Financial Adjustments because it is 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 Xerox CRN.

Failure to provide required information will result in check being returned with a request for missing information.

Please update your Provider Information on file

We have been getting a lot of returned mail due to inaccurate provider addresses. When moving locations, please inform your local post office of a 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 or contact HCSB at1-808-692-8099 to inquire about your application form. To obtain the 1139 form, please go to www.med-quest.us

Guidelines for Provider Refund Checks

If your facility submits refund checks to XEROX, please ensure the following guidelines are followed.

1. Refund checks for claims paid by Hawaii Medicaid should be payable to Hawaii Medicaid Fiscal Agent and mailed to:

Hawaii Medicaid Fiscal Agent

Post Office Box 1480

Honolulu, Hawaii 96807-1206

2. Refund checks for claims paid by Prescription Benefits Management (PBM) should be payable to XEROX Prescription Benefits Management and mailed to:

Hawaii Medicaid Fiscal Agent

365 Northridge Road, Suite 400

Atlanta, GA 30350

3. The check amount must agree to match the dollar amount of the claims you are refunding.

4. Supporting documentation must include the following:

· Recipient's name, Date of Service,

· Patient's Medicaid Identification Number

· A specific reason why you are refunding the money

· For overpayments due to third party liability (TPL), you must provide a copy of the insurance carrier's explanation of benefits (EOB).

DHS Medicaid Online (DMO)– Master Accounts

If your DMO account is deleted due to 90-120 days of inactivity, you can recreate your account from the login page. If you are the first person to make an account under your NPI or Provider ID Number, you will automatically be prompted to become a master account holder. Master account holders are responsible for approving new users, resetting passwords, and elevating other individual accounts to master account status. If a master account holder forgets their password and cannot answer their security questions then they will need to contact the Provider Inquiry Unit to have their account deleted. Having another user as a master account can help prevent this since they will be able to help you reset your account.

https://hiweb.statemedicaid

Medigap Plan Name (Medicare Supplemental Plan)

The patient's Medicare Advantage Part C Plan Name must be indicated on your claim form to ensure proper claim adjudication.

In order for your claim to process in a timely manner, all claims must have the name of all other insurance listed in FL 9, 9a, 9d or 11c-d and on the 1500 claim form in FL 50-55.

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

Medicaid EHR Incentive Program

State Level Registry Updates for the Hawaii

The State Level Registry (SLR) is now open for Program Year 2016 for eligible professionals (EP) attesting to Adopt, Implement, Upgrade (AIU), or EPs who are in their first year of Meaningful Use (MU).

- Program Year 2016 is the last year that a provider may begin participation in the Hawaii Medicaid EHR Incentive Program and attest to AIU.
- Per the current CMS Final Rule, the 2016 EHR Reporting Period for returning Meaningful Users (MU year 2+) is a full calendar year from January 1, 2016 through December 31, 2016. As a result, EPs entering year 2+ of MU will not be able to create a Program Year 2016 attestation until January 1, 2017.
- EPs must successfully attest for six program years in order to receive the full incentive payment amount of $63,750. Pediatricians qualifying with a minimum of 20% Medicaid patient volume can receive a maximum incentive payment of $42,500.

Program Year 2015 is now open for eligible hospitals (EH).

- EHs must attest to 9 objectives, including one consolidated public health reporting objective.
  - EHs scheduled to be in Stage 1 MU must meet two of the total number of public health measures available to them.
  - EHs scheduled to be in Stage 2 MU must meet three of the total number of the public health measures available to them.
  - If the required public health measures cannot be met, the EH must report on any possible measure and claim exclusion for the remaining measures.
  - If no public health measures can be met, the EH may meet the objective by claiming applicable exclusions for all measures.
- For 2015, the EHR reporting period is a continuous 90-day period within the calendar year. EHs are allotted a 15 month reporting period for 2015 (October 1, 2014 to December 31, 2015), but will align with EPs to the regular calendar year for 2016 and beyond.

Beginning in Program Year 2015, the Med-QUEST Division (MQD) no longer requires the mailed hard copy attestations.

Learn more about the program by visiting the Hawaii Provider Outreach Page (POP) at http://hi.arraincentive.com. Here, you will also find links to the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System and the Hawaii State Level Registry (SLR).

xerox

Hawaii Medicaid Fiscal Agent

1132 Bishop Street, Suite 800

Honolulu, HI 96813

QUEST Integration

www.Med-QUEST.us

Updating Medicaid Provider Records for the Hawaii Medicaid EHR Incentive Program

Providers wishing to update their Hawaii Medicaid provider record for the purpose of the EHR Incentive Program may complete the DHS 1139 form, and mail it to the Hawaii Medicaid Fiscal Agent office for expedited processing. DHS 1139 forms mailed directly to MQD will be put in the normal processing queue.

Please ensure that a copy of your W-9 and license are included with the completed DHS 1139 form. Please write the word “EHR” on the top of the 1139 application.

The DHS 1139 form may be found on MQD’s website at http://med-quest.us/PDFs/Frequently%20Used%20Forms%20for%20Providers/DHS%201139.pdf.

Please mail completed forms and related documents to:

Hawaii Medicaid Fiscal Agent

Attn: Hawaii Medicaid EHR Incentive Program

P.O. Box 1220

Honolulu, HI 96807-1220

If you would like to start the registration and attestation proc
support agent, contact the Hawaii Fiscal Agent Call Center at SLRHelpdesk@xerox.com, or (800) 235-4378 and select option #7, to schedule an appointment.