Hawaii Medicaid Provider Bulletin

Volume 15, Issue 3

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Aloha!
Don't Trash it! Pass it!
Be sure to route this to:

Entire Organization and Contractors

They should be up to date with the latest news!

EVV (Electronic Visit Verification) Updates

- HI statewide mandatory EVV (electronic visit verification) started on 12/30/2020.
- The EVV claims Hard Edit (claim denial) for visits with a Date of Service (DOS) of 10/1/21 was turned on 10/1/21.
  - EVV related claims will deny if no visits are found in Sandata's Aggregator
    - *Provider agencies submitting DDD EVV related claims may see the denial edit L226.1 - NO VISIT FOUND FOR CLAIM LINE FIELD IS MISSING. This edit will be in the remittance advice.*
    - *While not the exact same wording, the five health plans give similar information in the remittance advice for NO VISIT(S) FOUND.*
  - EVV related claims will also deny if the unit count is less than what is submitted on the claim line.
    - *Provider agencies submitting DDD EVV related claims may see the denial edit L227.1 - CLAIM LINE FAILED FOR UNMATCHED UNITS FIELD IS MISSING. This edit will be in the remittance advice.*
    - *The five health plans give similar information in the remittance advice for UNMATCHED UNITS*
  - 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:
    1) Fix the visit(s) to reach a good status and resubmit the claim
    2) Adjust the units down on the claim line and resubmit the claim
- If EVV claims are submitted now for a DOS 9/30/21 or before, they will still follow the soft launch process (no claim denial).
- DDD providers will continue receiving the EVV Claims Validation Error report via email.
- Additional training for providers using Sandata is accessed here: 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.

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 do not know your HOKU Application ID letter.

HOKU Provider Enrollment System Training Videos and Slides

Med-QUEST's HOKU webpage has Provider Training Videos or Instructional Slides. Please go to medquest.hawaii.gov/HOKU and click on the 'Training' tab to view the resources.

1149A Processing Information

Conduent no longer assists with the 1149A initiation process. Providers must work with the patient's enrollment worker/eligibility branch for 1149A initiations, follow ups and questions. The provider may also contact the Health Care Outreach Branch by contacting Puanani Crabbe– Parker at pcrabbe– parker@dhs.hawaii.gov.

Submit the following sufficient forms to the patient's eligibility worker.

Emergency Room Visit

1. Date of Service(s) and name of facility
2. ER record and ER physicians written or dictated documentation

Inpatient Hospital Stay

1. Date of Service(s) and Name of hospital
2. Admission history and physical examination
3. Discharge Summary
4. Physician and nursing progress notes for the period requested.

Hawaii Medicaid EPSDT Update

The Med-QUEST Division (MQD) issued a memo to update providers on three (3) changes related to the Hawaii Medicaid EPSDT forms. For more information please review memo QI-2164 issued on November 3rd, 2021.

Claim Status and Eligibility Verification Online

Go to DHS Medicaid Online to start checking claim and eligibility statuses for free.
Log on to
https://hiweb.statemedicaid.us.

Pharmacy Benefit Manager (PBM) Claims Address

Please mail your Pharmacy claim to the following address:

Conduent– Medicaid Claims
40 W Williamsburg Rd.
Box #649
Sandston, VA 23150

Denied Claim due to missing Application Enrollment Information

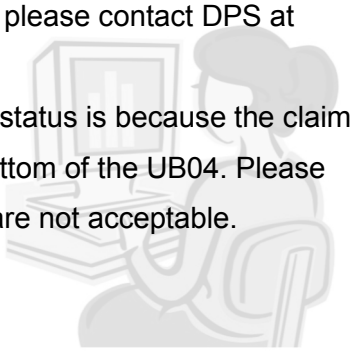
For questions or concerns about your pending or denied claim due to missing provider registration information, please contact provider enrollment at 1-855-946-0399 or email questions to:

HCSBinquiries@dhs.hawaii.gov.

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. When billing for a prescription drug, only code J3490 will be reimbursed. Each provider is contracted to use this code based on their DPS contract. To inquire and to set rates for code J3490, please contact DPS at 1-808-587-1250.

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

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.

WINASAP Modem and Storage Database Tips!

- Do not leave kinks in your USB WINASAP modem cord from PC to phone jack outlet.
- 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.

4.3.8 Additional Payment Requests

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. Please continue to follow up with the call center.

Hawaii Medicaid Promoting Interoperability (PI) Program

Promoting Interoperability Program Sunset

The sunset of the Promoting Interoperability (formerly the EHR Incentive Payment) program is rapidly approaching. CMS requires that all incentive payments must be issued no later than December 31, 2021. The related post-payment audit activities will continue through calendar year 2022; therefore, we encourage providers to maintain their records in the event they are selected for an audit. Program rules state that information related to the incentive payment attestation should be retained for six (6) years following the receipt of payment.

Post-payment audit selections for program year 2020 and 2021 will be made in the near future. Providers selected for audit should have the following information available at the time of the audit:

1. A detailed 90-day encounter listing (in Excel or CSV file format) to support the period selected for the patient volume calculation. The listing should include records for all encounters to support the numerator and dominator reported and contain a unique patient identifier, date of service, insurance type, and servicing provider.
2. If a group proxy is used for the patient volume calculation, a list of all staff members employed by the practice during the 90-day period will be needed. The list should include job titles and starting dates for each staff listed.
3. A system-generated meaningful use summary report that support the meaningful use measures for the 90-day period selected.
4. Documentation to support the functionality is enabled for the Clinical Decision Support Rules and Drug Interaction Checks (both drug-drug and drug-allergy interactions). For example, screen shots that demonstrate the alerts from the provider's perspective and include an indication that it is specific to the software used and that the timing supports the functionality was enabled during the meaningful use reporting period (e.g., screen shot shows a patient or test patient seen during the MU reporting period and includes the date of service).
5. A dated record or letter confirming active engagement for the public health measures selected.
6. A copy of the security risk analysis (assessment) completed in accordance with 45 CFR 164.308(a)(1) for the program year[1].

For program year 2021, CMS granted Hawaii Med-QUEST Division the flexibility to allow EP's to complete their security risk analysis activity after their attestation has been submitted; however, it must be completed before December 31, 2021. If a provider selects this flexibility, they will be flagged for a post-payment review.

Failure to produce any of the above items during a post-payment audit, may result in revoking the provider's incentive payment eligibility and recovery of the payment.