Hawaii Medicaid Provider Bulletin

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Inside this issue:

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!

HOKU

The Med-QUEST Division (MQD) is in the 11th month of our new web-based system, HOKU. This is an on-line system that allows providers to enroll, update, and make changes to their information quickly and easily. New Medicaid providers are able to enroll online and existing Medicaid providers are able to register online to validate enrollment data. Go to https://medquest.hawaii.gov/HOKU to view the 'HOKU Website Links.' MQD encourages all existing Medicaid providers to register in HOKU. HOKU allows providers to review their provider enrollment information and make any revisions if needed. The HOKU webpage (https://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 haven't received 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 https://medquest.hawaii.gov/HOKU and click on the 'Training' tab to view the resources.

EVV (Electronic Visit Verification) Updates

- HI statewide mandatory EVV (electronic visit verification) started on 12/30/2020.
- The soft launch period (no claim denial) was extended from 4/1/21 to 8/1/21.
    - While the claim denial is extended, it is still a Federal and State requirement to capture visits using an EVV solution.
    - During the soft launch, Providers are required to utilize EVV to log in and log out of visits in real-time.
- Visits are required to be scheduled.
- DDD providers are now receiving an EVV Claims Validation Error report via email.
- Additional training for providers using Sandata is accessed here: https://sandata.wistia.com/projects/39hu84ouhv.
- Bi-weekly EVV Provider Web Meetings are held every other week on Thursday's.
    - Home Health Agencies @ 2:00 pm.
    - Home Care Agencies @ 3:00 pm.
- Monthly Alternative EVV Vendor Web Meetings are held on the first Tuesday of each month @ 10:00am.
- Additional information and FAQ'S regarding EVV can be accessed on our Hawaii EVV website: https://medquest.hawaii.gov/EVV.
- Please send all EVV inquiries and requests to https://medquest.hawaii.gov/EVV.

Updated Guidelines for Submittal and Payment of Induced/Intentional Termination of Pregnancy (ITOP) claims

With few exceptions, medical services provided to persons eligible for Medicaid in Hawaii are funded by both the federal government and the State of Hawaii. However, Hawaii Medicaid has elected to cover ITOPs with 100% State funds and is carved out of the QUEST Integration (QI) plans. Therefore, ITOPs need to be billed to our Fee-For-Service program rather than the QI plan. For more information, please refer to FFS Memo 21-04 which replaces memorandum FFS 15-12. Memos are located here: https://medquest.hawaii.gov/en/plans-providers/provider-memo.html.

Orally Administered Drugs to Terminate a Pregnancy During the Public Health Emergency (PHE)

The Med-QUEST Division (MQD) covers an oral "medical abortion/intentional termination of Pregnancy (ITOP)" using orally administered drugs to terminate a pregnancy under the following conditions:

- The pregnancy must be in the early first trimester within ten (10) weeks gestation; and
- The drugs used are Mifepristone (S0190), one 200 mg tablet in combination with misoprostol (S0191) up to four (4) 200 mcg tabs and taken within the first ten (10) weeks.

For more information, please refer to FFS Memo 21-05 on the Med-QUEST website.

HOKU Provider Enrollment System

HOKU is an alternative to the current paper application provider enrollment process. “Frequently Asked Questions” and “Training” resources is available online on the Med-QUEST website at https://medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html. For general questions or concerns on your provider application, please contact Koan’s customer service helpline at (808) 692-8099 / (855) 946-0399 or by email HCSBInquiries@dhs.hawaii.gov.

Requesting more EPSDT Forms?

Please contact the Conduent Call Center at (800) 235-4378 / (808) 952-5570 to request EPSDT forms to be mailed to your office. The maximum amount of an order consists of one pack of 8015s or 25 sheets of 8016s. To ensure all providers have access to these forms, Conduent is limiting an order to once a week per provider request. Requested orders may take up to seven business days for mail delivery.

Medicaid Prisoners

CMS (Centers for Medicaid and Medicare Services) allows inmates of public institutions to be enrolled in Medicaid Fee-For-Service (FFS) when they are inpatients for more than 24 hours in medical institution such as a hospital or nursing facility. During their enrollment in Medicaid FFS, Medicaid professional and facility services are covered and paid at Medicaid FFS rates. Medicaid FFS payments cannot be made for outpatient services or for stays in half-way houses, residential treatment facilities, etc. when the patient does not have freedom of movement. When an individual is a DPS (Department of Public Safety) client and has a Medicaid ID that covers his/her stay as an inpatient in a hospital or nursing facility, facilities are urged to submit claims under his/her Medicaid FFS ID number.

New Billing Address for the Department of Public Safety (DPS) Claims

Conduent is processing claims for the DPS. To follow up on your claims, please contact Conduent at (808) 952-5570 or at (800) 235-4378. Please mail your claims to the following address:

Department of Public Safety - Health Care Division
Medicaid Claims
1177 Alakea St. Ste. 602
Honolulu, HI 96813

Check Claim Status and Eligibility Online for Free

DHS Medicaid Online (DMO) is a free online resource available to all Hawaii Medicaid providers. DMO allows providers to verify recipient eligibility and claim status via the internet. To access DMO, go to website address: https://hiweb.statemedicaid.us. In order to access DMO, you must first complete the registration process. It is recommended to register multiple Master Account Holders for your registered Provider Number. Upon activation of your account, you can verify eligibility information for recipients enrolled in FFS and QUEST plans, check FFS claim status and prior authorization information for waiver providers.

Eligibility, plan enrollment, and TPL can be verified by supplying the recipient's:
1) Medicaid ID # and Date of Birth (DOB)
2) Last Name, DOB and SSN
3) Medicaid ID, Name and DOB

When checking claim status and payments, you must:
1) Enter the Medicaid ID # and date of service

Claim status can be verified for claims submitted under the rendered PIN provided during the registration process. Go to: https://hiweb.statemedicaid.us today and start checking eligibility and claim status with ease. The information supplied via DMO is pulled directly from the Hawaii Medicaid claims processing system. This means the information you receive from DMO is the most up to date information available. If you require assistance with DMO, please contact the Conduent Call Center at (800) 235-4378 / (808) 952-5570.

EDI/WINASAP Claim Submission Concerns

Providers with concerns such as missing 835 reports, missing 837 response files, WINASAP issues, modem issues (connectivity), and to validate if providers are enrolled for SFTP may be inquired through the EDI helpdesk. Please email the EDI help desk at hi.ecstest@conduent.com. Please follow up with the call center if you have not received a response from our EDI Coordinator.

Outlier Claims Billing Tips

The following helpful tips may help to increase faster processing time on your outlier claim.

- The first claim (interim bill type 112) should indicate in FL06 (Statement Covers Period) the date of admission through the date the covered charges equal the outlier threshold amount specified for your facility.
- All claims (bill type 112, 113, 114) must have condition code 61 (FL24-30)
- All claims (bill type 112, 113, 114) must have the same admission date (FL17)
- Bill type 112 must be approved before bill type 113 or 114 claims will approve
- In order for the claim to brand as surgical, all interim claims must indicate the surgical ICD-10 procedure code and surgical date.
- Psychiatric and out of state claims do not qualify for outlier rates.
- Please refer to Medicaid Provider Manual 11.1.4.4 (chapter 11, page 7) for additional information on outlier claims.

Pharmacy Contact

See Chapter 19 (https://medquest.hawaii.gov/en/plans-providers/fee-for-service/provider-manual.html) of the Medicaid Provider Manual for a description of the Med-QUEST Division (MQD) pharmacy services.

For any questions regarding Hawaii Medicaid FFS drug coverage and/or reimbursement, please contact Gary Peton, Pharmacy Services Manager for Conduent State Healthcare LLC, the Hawaii Medicaid Fiscal Agent, at gary.peton@conduent.com or 808-952-5591. Thank you.

Cost Share/Share of Cost (SOC) Reporting's

The provider may report a patient's SOC in fields 39-40 with value code 23 on a UB04 and field 29 on the 1500 claim form.

Fee Schedule Updates

Fee Schedule for Fee-For-Service (FFS) Professional claim services reimbursements are derived from the Medicare payment pricing methodology. Medicare Part A services and the facilities technical components are reimbursed by hospital contract for inpatient and outpatient surgery care. Please continue to review the June 2020 Hawaii Medicaid Fee Schedule for FFS reimbursement which is located on the Med-QUEST Website at https://medquest.hawaii.gov/en/plans-providers/feefor-service/fee-schedules.html. The Medicaid Fee Schedule may change without notice.

To confirm rate changes on a specific code, please contact the Conduent Call Center at (800) 235-4378 / (808) 952-5570 or email your inquiry to hi.providerrelations@conduent.com.

Please contact the health plan directly if you are inquiring for fee schedule on codes for a patient who is enrolled in the Quest Integration (QI) plan.

1149A Document Initiation by Conduent

Undocumented aliens who apply for the EMG SVC benefit may receive the benefit for service(s). These service(s) requires an 1149A approval. Please contact our call center and our agents will initiate your medical records on your behalf.

The provider will need to submit the following:

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

To ensure your records will be processed accordingly, it is best to address the name of the call center agent on the cover sheet along with the CRN and all required medical records attached. We also encourage that you follow up with the call center on the progress of your initiated 1149A.

1149A Denial & Appeal Process

If the program requirements are not met, then your 1149A may deny. Below are the "Hawaii Administrative Rules" for a one-time emergent.

§17-1723.1-10 (b) Has a sudden onset of a medical condition, including emergency labor and delivery, manifesting itself in acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in: (1) Placing the individual's health in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part.

§17-1723.1-21 (b) Benefits shall be limited to coverage of emergency medical services to stabilize the emergency medical condition described in section 17-1723.1- 10(b).

1149A's are reviewed on a case by case bases after a Conduent Initiation. After an 1149A denial, the provider may request for an appeal. Please contact the Conduent Call Center at (808) 952-5570 to assist with your 1149A appeal.

Hawaii Medicaid Fiscal Agent
PO BOX 1220
Honolulu, HI 96807-1220

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: _____

_____

_____

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 Number:	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

Revised 05/2021 **FORM 240**

Hawaii Medicaid Promoting Interoperability (PI) Program

Program Year 2021

Program Year 2021 is scheduled to open on July 1 and close on September 30, 2021. Here are some items to remember when attesting:

- The EHR reporting period for all Medicaid Eligible Professionals (EPs) is a minimum of any continuous 90-day period within calendar year 2021.
- All EPs must attest using a 2015 Edition CEHRT. The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2021. The functionality must be in place by the first day of the EHR reporting period. The product must be certified to the 2015 Edition criteria by the last day of the EHR reporting period. The 2015 Edition functionality must be used for the full EHR reporting period.
- All EPs are required to attest to the Stage 3 Objectives and Measures.
- All EPs must report on a total of six (6) Clinical Quality Measures (CQM) related to their scope of practice. EPs are required to report on at least one outcome measure. If no outcome measures are relevant to an EP's scope of practice, they must report on at least one other high-priority measure. If there are no outcome or high-priority measures relevant to an EP's scope of practice, they must report on any six (6) relevant measures. https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms.
- The 2020 Physician Fee Schedule (PFS) Final Rule established a 90-day CQM reporting period within calendar year 2021 for all Medicaid EPs in Program Year 2021.
- Protected Health Information (PHI) should not be included in any documentation uploaded to the SLR.

2021 EP CMS Promoting Interoperability Program Objectives and Measures

Providers are required to complete all eight MU objectives. The 2021 EP specification sheets are located here: https://www.cms.gov/files/document/medicaid-ep-2020-table-contents.pdf

Objective 1 – Protect Patient Health Information

An EP must conduct or review a Security Risk Analysis including addressing the security of data created or maintained by CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

- EPs must use 2015 Edition CEHRT to meet Stage 3 meaningful use.
- The Security Risk Analysis must be conducted once each year.
- It is acceptable for the Security Risk Analysis to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and it must be conducted within the calendar year of the EHR reporting period.
- State Medicaid Agencies have the flexibility to require EPs to submit evidence that the security risk analysis has been completed after the incentive payment has been issued in program year 2021.
- For EPs who attest that they will be completing their 2021 SRA after the attestation date, a future date must be entered to indicate that a SRA will be completed by December 31, 2021.

The details of the Protect Patient Health Information Objective can be found here: https://www.cms.gov/files/document/medicaid-ep-2020-protect-patient-health-information-objective-1.pdf

Exclusion for Broadband Access

Several meaningful use objectives for program year 2021 have an available exclusion for EPs who conduct 50% or more of their encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability, according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period. These objectives include: Patient Electronic Access, Coordination of Care through Patient Engagement and Health Information Exchange. To assist providers in efficiently finding information pertaining to the broadband speeds in their respective county, CMS provided a list of counties that did not have minimum broadband requirements (Source: Broadband Deployment Data from FCC Form 477, as of December 31, 2014) and would qualify for the exclusion. The list **did not** include any counties in Hawaii. Therefore, no EPs are eligible to take the broadband exclusion for any of the above listed objectives.

Hawaii Outreach Coordinator

Heidi Miles is the Outreach Coordinator for the Hawaii Medicaid Promoting Interoperability Program. She is available to assist providers with their attestation questions. Contact Heidi via email or telephone at Heidi.Miles@Conduent.com or (808) 561-2197.

New 1149A Processing Information

Conduent will no longer assist 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.