Hawaii Medicaid Provider Bulletin

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Inside this issue:

Have a Merriest Christmas and a Safer New Year from our Family to yours!

HOKU

The Med-QUEST Division (MQD) is in the 5th 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 now able to enroll online. Go to medquest.hawaii.gov/HOKU to view the 'HOKU Website Links.' For existing Medicaid providers, MQD is phasing provider registration in waves and would like to encourage all Medicaid providers to register in HOKU at the appropriate time. HOKU allows providers to review their provider enrollment information and make any revisions if needed. 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 692-8099 or send an email to HCSBInquiries@dhs.hawaii.gov if you have any questions.

EVV (Electronic Visit Verification) Updates

- The third instructor-led training session was held early December
- Held 7 public EVV Town Hall meetings
- All members loaded into Sandata
- All ***active*** Provider IDs now loaded to Sandata production
- All MCOs completed authorization submission testing with Sandata
- The authorization allows the provider agency to see the member
- EVV Soft Launch 10/5/20 to 3/31/21 (no claim denial)
- **HI statewide mandatory EVV use 12/30/20**
- Claims denial begins 4/1/21

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 Provider Enrollment System Training Webinars

HOKU, is Med-QUEST new web-based provider enrollment system. The new system is designed to enroll, update, and make quick changes to the provider information quickly and easily online.

Med-QUEST will be asking providers to register in waves corresponding to their specific provider types. Webinar-based provider training sessions will be available for each of the four waves. Some training sessions will be enrollment type specific, and some will be provider type specific; please read the training descriptions carefully. Please review the "HOKU Waves and Provider Type Enrollment Type" document to review webinar training session dates. To register for training, please click on the "Training" tab. More information please visit medquest.hawaii.gov/HOKU on the Med-Quest website.

Payment Error Rate Measurement (PERM) Review

The Centers for Medicare & Medicaid Services (CMS) is beginning their Payment Error Rate Measurement (PERM) review of Med-QUEST Fee-For-Service providers for services paid between July 1, 2019 to June 30, 2020.

Centers for Medicare & Medicaid Services uses contractors to perform the PERM review. CMS review contractor NCI, will be sending out requests for medical records and/or documentation.

Please respond to the medical record request letters within the timelines to avoid any errors. If a provider fails to submit all of the requested information, the claim will be considered an error and may result in an overpayment recouped by the State.

COVID-19 CLAIMS REIMBURSEMENT TO HEALTH CARE PROVIDERS AND FACILITIES FOR TESTING AND TREATMENT OF THE UNINSURED - Memorandum FFS 20-14

This memorandum is to notify providers that the federal government has funds available to pay providers for services provided to uninsured individuals with primary COVID-19 diagnosis. Providers who have conducted COVID-19 testing and / or provided treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, can file claims for reimbursement for testing and treating the uninsured individual regardless of citizenship or residency status. More information about the program is located at: hrsa.gov/coviduninsuredclaim.

Please submit a claim through the designated portal for reimbursement. Providers can access the portal at: coviduninsuredclaim.linkhealth.com.

Fraud Prevention and Contact Information

Medicaid fraud, waste or abuse depletes valuable public fund meant to provide healthcare and services to low-income and vulnerable citizens in Hawaii. Medicaid is funded by your Federal and State tax dollars. You can assist in fighting fraud, waste and abuse by reporting potential ling suspicious behavior or incidents. Med QUEST encourages anyone who observes instances of potential Medicaid fraud, waste, or abuse to contact one of the fraud hotlines for the QUEST health plans, or contact the Department of Human Services. To report fraud to a QUEST health plan, Medicaid Recipient Fraud, and Medicaid Provider Fraud, please review the article at /content/med-quest/en/members-applicants/fraud-prevention.html on the Med Quest website.

Additional Payment Requests

As per the Hawaii Administrative Rules 17-1739. 1-16, the providers are allowed to make adjustments to claims up to 60 days from the initial date of adjudication (payment or denial of the claim). Routine requests for additional payment(s) due to incorrect claim information such as dates, procedure codes, ID numbers, etc., may be sent to the Hawaii Medicaid Fiscal Agent. Medicaid will not reimburse late charges. Addresses can be located in Appendix 1. Refer to section 4.4.2.6 for more information on submitting adjustments to the Fiscal Agent. For more information regarding payments, please read chapter 4.3.8 of the Provider Manual on the MQD Website

https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/provider-manuals/PMChp04.pdf

WINASAP Claim Adjustments

Adjustment Claims using WINASAP
Adjustments on a 1500– Professional Claim form
When submitting an electronic claim via WINASAP, please use frequency type code 7 to replace or 8 to Void

Adjustments on a UB04– Institutional Claim form
When submitting an electronic claim via WINASAP, please change the Bill Date to TODAYS's date, and the Type of Bill will be changed to xx7 for Replacement and xx8 to void
Please use your WINASAP User Guide for details.

Points to Note When Submitting an Adjustment or a Void on a Hard Copy Claim

When submitting an adjustment or voided claim, follow these steps to ensure correct processing:

- To void a field: Strike a line through the unwanted claim detail line and circle it. This process will remove the line item from claim. Use resubmission code "A".
- To adjust: draw a circle around the claim line item with the change (**Only changes that are circled will be processed)**
- Adjustment claims are treated as replacement claims and will keep the original claim reference number (CRN)
- CMS 1500 form: write "Resubmission" on the top of the claim. In FL 22 enter an "A" to adjust or "V" to void along with the original CRN **(Entering "V" in FL 22 will void the entire claim)**
- UB04: write "Resubmission" in FL 2. In FL 4 enter bill type "XX6/XX7" to adjust or "XX8" to void. Enter the original CRN in FL 37A

Resubmitted claims must reflect the original number of claim lines. If the resubmission has less lines, Conduent will return the claim to provider (RTP).

WINASAP Maintenance Yearly Clean-Up

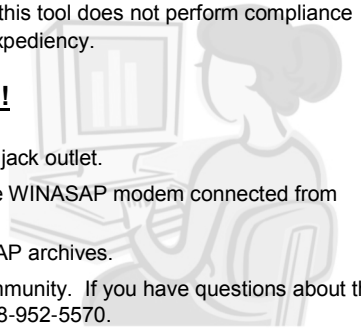
Database Backup: It is recommended that you back up the WINASAP5010 database weekly. Depending on the amount of information you enter in any given period of time, you may want to perform a backup more often.

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!

- Please have 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 to limit two years claims data to be kept in the WINASAP archives.
- The USB mini external modem (Zoom 3095) is inexpensive and is popular with the provider community. If you have questions about this modem, please contact our EDI helpdesk at 1-800-235-4378/ 1-808-952-5570.



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 stay as an inpatient in a hospital or nursing facility, facilities are urged to submit claims under his/her Medicaid FFS ID number.

Updates and Reminders

Pharmacy Benefit Manager (PBM) Claims Address Change

The PBM claims department have relocated. Please mail your claims to the new address:

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

In order for the agents to better serve you, it is best to have the following information ready:

- NPI/PIN ready. No NPI/PIN is needed for general questions.
- Call center agents are only allowed to perform three inquiries for phone call.
- All claims must be signed in ink on the original claim form. Stamped signatures are not allowed. Reproductions of the claim form are not acceptable.
- Remittance Advice (RA) may be requested by the provider community in a soft or hard copy form. Please allow 7 business days or the RA to be received by email or post mail.

Medicaid Provider Manual Billing Guidelines

Readmissions

A readmission is defined as the patient is readmitted to the same or different facility within twenty four (24) hours of discharge for the same spell of illness and for the same general diagnosis as the original admission is considered to be the same admission and must be billed as a single stay. When two different facilities are involved, the Department will make the determination whether to deny or make partial payments. Please review chapter 11.1.4.3 in the Medicaid Provider Manual for more information.

Cast Room and Treatment Room Service

Cast room and treatment room services are those services provided to outpatient who do not require emergency room services and / or receive services that do not result in an inpatient acute hospital admission. In chapter 11.2.5.2 Exclusion and Limitations in the Medicaid Provider Manual, treatment room, observation, casting and strapping, and other “treatments” (Revenue codes 076x, 070X, 094X, 095X) when part of a valid emergency room visit are not covered.

Hawaii Medicaid Promoting Interoperability (PI) Program

Program Year 2020

Program Year 2020 opened on December 1, 2020 and closes on March 15, 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 2020.
- All EPs must attest using a 2015 Edition CEHRT. The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2020. 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 2020 for all Medicaid EPs in Program Year 2020.
- Protected Health Information (PHI) should not be included in any documentation uploaded to the SLR.

2020 EP CMS Promoting Interoperability Program Objectives and Measures

Providers are required to complete all eight MU objectives. The 2020 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.

The Security Risk Analysis must be completed within calendar year 2020. EPs are required to attach documentation of the Security Risk Analysis to their attestations. We will accept the actual Security Risk Analysis document OR the SRA Tool Summary Report from Office of National Coordinator (ONC). EPs that are part of a large group do not need to include their individual provider information, i.e. name and NPI, on the Security Risk Analysis.

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 2020 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.