Hawaii Medicaid Provider Bulletin

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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

Hawaii's Online Kahu Utility (HOKU)

For the past several months we have been announcing the Spring 2020 launch of our new HOKU system that will allow providers to:

- Enroll as a Med-QUEST Provider;
- Update address and general practice information online;
- Upload licenses, certifications and other necessary documents;
- Track the submission and status of an application or to request a change.

All online anytime of the day, without having to fax or call in or mail in information!

This automated process will significantly reduce the amount of time from application submission to approval allowing you to begin providing services and receiving compensation for your services in a shorter amount of time.

In preparation for HOKU's implementation it is important for you to provide us with your email address, as this will be how we will share HOKU registration information. If you have not done so, please be sure you report your most current email address to us. You can report your most current email address to us at: https://www.surveymonkey.com/r/HawaiiGov-PMSU-Survey. You may also report your current email address to our Fiscal Agent, Conduent, at 952-5570 or toll free from the neighbor islands at (800) 235-4378.

Finally, visit the dedicated HOKU website to get the latest updates on training and system roll-out: https://medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html

Electronic Visit Verification (EVV)

JULY

Reviewed the proposed HCPCS table for EVV services with the MCOs. EVV vendor (Sandata) held the Outreach and Training Kick-off meeting for MQD and established reoccurring meetings to build the communications plan.

AUGUST

Sandata held a software demo for MCOs to explain the functionality of the EVV solution. MQD hosted EVV kick-off meetings for the three provider groups representing the 90 agencies with over 150 participants. MQD met with the Sandata in a three-day working session to define program configuration requirements. Established reoccurring provider self-directed and financial intermediary meetings.

SEPTEMBER

Reviewed EVV configuration workbook with Sandata to progress toward a final configuration. Met with Sandata to clarify HCPCS codes and modifier functionality and determine how to implement them in the EVV solution. Engaged the provider agencies to discuss the proposed HCPCS codes and modifier use in the EVV solution to ensure alignment.

Please contact us via Email or by Mail!

Written Correspondence may be sent via email to hi.providerrelations@conduent.com. When inquiring about a claim via email, please submit the Claim Reference Number (CRN) along with your questions. If you do not have access to the internet, please request a form from the Call Center at 1-952-5570/1-800-235-4378. The form is available online on the Med-QUEST website https://medquest.hawaii.gov/. Please mail your 239 form to HMFA-Conduent PO BOX 1220 Honolulu, HI 96807-1220. You may also submit as an email attachment to hi.providerrelations@conduent.com or fax to 1-808-952-5595.

Points to note when submitting an adjustment or void

- When submitting an adjustment or void claim, follow these steps to ensure correct processing:
- To void: draw a line through the unwanted claim detail line
- To adjust: draw a circle around the claim change (**Only changes that are circled will be**
- **processed)**
- Adjustment claims are treated as replacement claims
- CMS 1500 form: write “Resubmission Adjustment” on the upper right hand corner of the claim. In FL 22 enter
- an “A” to adjust or “V” to void along with the original CRN
- UB04 form: 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, ACS will return the claim to provider (RTP).
- Resubmitted claim must reflect the same information on the original claim. For example, the patient account number should be the same on the resubmitted claim, otherwise will return it back.

Why your claims are always being returned!

When inquiring on your submitting claim, our agents have been advising that your claim has been returned. Some reasons are due to data entry errors on claims that have been done by your organizations billing department. To decrease payment delays and erroneous post mailing charges, we highly suggest your claim be reviewed carefully before submission. Our agents are available to answer simple billing criteria’s based on the instructional billing sheets on prior bulletins and are unable to advise what you should be billing. Claims may be returned for so many reasons. Here is a list of popular reasons why Conduent is returning your claims.

- Dental Claims should be sent to Hawaii Dental Services
- ICD-10 indicators are not indicated in box 66 on the UB04 and box 21 on the CMS 1500 Claim form
- Missing live ink signatures. Please sign on the bottom of the UB04 since there are no instructions of where to provide an authorized live ink signature
- Ensure the attached Explanation of Benefit is legible
- The patient’s Medicaid Identification consists of 10 digits
- Do not write the word “RESUBMISSION” on your claim unless it’s an adjustment claim. If you are submitting another claim because you have gotten no response, just submit a new claim.
- Adjustment Claims should have the original claim reference number (CRN) in its proper field on the claim and correction marks on the claim

1149a Document Appeals 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 Conduent Call Center and the agents will process and initiate your medical records on your behalf. Please work with an agent today!

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

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 is requested.

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. 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.

Diagnosis Codes on Claim

ICD-10 diagnosis codes should be seven digits. Please work with your biller to ensure your ICD-10 code is valid. DDD waiver providers are able to receive their ICD-10 diagnosis code by simply calling into the provider call center.

Are you ready for Program Year 2019?

Program Year 2019 is scheduled to open in early 2020. Here are some items to remember when attesting:

- EHR reporting period for all Medicaid EPs is a minimum of any continuous 90 day period.
- All EPs must attest using a 2015 edition CEHRT for the entirety of the 90 day EHR reporting period.
- All EPs are required to attest to the Stage 3 Measures and Objectives.
- EPs in their first year of meaningful use have a Clinical Quality Measures (CQM) reporting period of any continuous 90-day period. Returning meaningful users are required to report on the full 2019 calendar year.

2019 EP CMS Promoting Interoperability Program Objectives and Measures

The 2019 EP specification sheets are located here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_2019.pdf

Protect Patient Health Information Objective EPs must conduct or review a security risk analysis of CEHRT, including addressing encryption/security of data, implement updates as necessary at least once each calendar year, and attest to conducting the analysis or review. For Program Year 2019, the security risk analysis must be conducted or reviewed within calendar year 2019, between January 1st and December 31st.

The full scope of the Objective may be read here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEP_2019_Obj1.pdf

Public Health Measures

The Hawaii Immunization Registry (HIR) is currently down and going through restoration. The HIR is unable to accommodate new requests or receive any data exchange from providers. Because of this, providers may be able to claim an exclusion if any of the following apply:

- He or she practices in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- He or she practices in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period.

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.