Hawaii Medicaid Provider Bulletin

Volume 14, Issue 1

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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!

Med-QUEST Announces Quest Integration Contract Awards

Honolulu, HI – A request for proposals for QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals was issued in August 2019. The State of Hawai'i, Department of Human Services, Med-QUEST Division is grateful to have received a total of four proposals as noted below:

- AlohaCare
- HMSA
- 'Ohana Health Plan
- UnitedHealthCare Community Plan

On January 22, 2020, Med-QUEST extended awards to each of the plans who submitted a proposal. Hawaii Medical Services Association and UnitedHealthCare were awarded contracts to provide services statewide and 'Ohana Health Plan and AlohaCare were awarded contracts to provide services to the island of O'ahu only. These plans are scheduled to go into effect on July 1, 2020. More information of the contract award may be found here: https://medquest.hawaii.gov/en/about/recent-news/2020/Med-QUEST-Announces-Quest-Integration-Contract-Awards.html

1099 Form for year 2019

If a provider received payments from Hawaii Medicaid in the amount of $600 or greater during the 2019 calendar year, they will receive a 1099 Misc. Income form. These forms were mailed on January 31, 2020. Providers are also required to report this amount to the IRS. The 1099 Misc. Income forms have been mailed to the address on file with the Provider Enrollment Division of Med-Quest and Social Services.

To comply with IRS regulatory guidelines, the mailing address for the 1099 forms cannot be more than three lines and cannot contain more than 30 characters per line. In addition, the second address line must be a physical mailing address. The Post Office will not forward the 1099(s). Any non-deliverable mail will be returned to Conduent. If you need to change your mailing address for your 1099 Misc. Income form, you must submit the request in writing to Conduent Banking Department and forward the required forms to your respective Provider Enrollment Division.

Waiver of Filing Deadline

If the claim is being submitted more than 12 months from the date of service, a waiver approval for timely filing is required to adjudicate the claim. It is also best to check the patients eligibility. Per Chapter 4, if the patient's eligibility has been retro activated by the eligibility worker, the provider has an extension of 12 months from when the eligibility worker has modified enrollment date. No timely filing is waiver is needed if the patient's enrollment meets this exception. 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 the Finance Office.

Please send your letter to the following address:

DHS/MQD/FO
Attn: Timely Filing Waiver Request
PO Box 700190
Kapolei, HI 96709-0190

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 2013 Hawaii Medicaid Fee Schedule for FFS reimbursement which is located on the Med-QUEST Website at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html.

To confirm rate changes on a specific code, please contact our Provider hotline at 1-800-235-4378/ 1-808-952-5570 or email your inquiry to hi.providerrelations@conduent.com.
If you are inquiring for fee schedule on codes for a patient who is enrolled in the Quest Integration (QI) plans, please contact the health plan directly.

Transition of the State of Hawaii Provider Enrollment Sector Contractor

Koan Risk Solutions, Inc. is contracted to perform the processing of the DHS 1139 provider application form. For general questions, or concerns on your provider application, please contact Koan's customer service helpline at 808-692-8099.

EPSDT Forms Requests

The maximum amount for EPSDT form 8015 are a 100 sheets and EPSDT form 8016 are 25 sheets per week, per address. Please contact our call center agents to inquire on how to obtain additional forms per week. Amount subject to change without notice.

Call Center Reminders

- When calling into the call center, please have your NPI/PIN ready. No NPI/PIN is needed for general questions.
- Call center agents are only allowed to perform three inquiries per 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 for the RA to be received by email or post mail.

Guidelines for Submittal and Payment of Intentional Termination of Pregnancy (ITOP) Claims

ITOPs and services covered by Medicaid that are directly connected to the ITOP procedure for women in QUEST Integration and the Medicaid fee-for-service (FFS) program must be billed to Medicaid's fiscal agent, Conduent. All Claims for the ITOPs and ITOP related professional services must be submitted with the primary diagnosis (diagnoses # 1) in ICD-10 diagnoses table on Memo FFS-1512 on the Med-QUEST Website.

To expedite claims processing and to avoid denials of payment, the ITOP procedure 598xx and all ITOP related services performed by a provider should be submitted on the same claim.

Services not directly related to the ITOP should be submitted to the member's QUEST Integration health plan and not included in the ITOP claim. (Examples are birth control pills, implants, injectable contraceptives, intrauterine devices).

ITOPS IN THE INPATIENT SETTING– Place of Service 21

Codes 59850, 59851, 59852, 59855 and 59856 are induced ITOP codes that include hospital admission and visits. Thus, these must be performed in the inpatient hospital setting.
For additional information and specific details on how to bill for ITOP claims, please refer to Memo FFS-1512 on the Med-QUEST Website.

State Medicaid New ID Card Design

There are new changes in the design of our State Medicaid ID card that will go into effect April 1, 2020. The State will no longer be issuing out hard plastic Medicaid ID cards with the magnetic strip located on the back. The new Medicaid ID cards will be mailed out in a perforated fashion that can be punched out and folded. Individuals who are enrolled in QUEST Integration (QI) health plan will still receive a separate membership ID card from their health plan.

For more information of the ID cards please read memo QI-2005, CTF-2001, FFS 20-02 which is located on the MedQUEST website https://medquest.hawaii.gov/en/plans-providers/provider-memo.html.

WINASAP2003

The WINASAP2003 is a **free** electronic claims software. WINASAP2003 allows you to submit an unlimited number of claims electronically, multiple times a day, 24 hours a day, and seven days a week. It is an easy to use Windows based program that is capable of submitting HIPAA compliant electronic claims services rendered in an institution. It is ideal for use by providers who submit less than 300 claims per month. WINASAP2003 is available to all Medicaid providers at no cost with **free** installation and training services. Claims are entered and submitted through a computer via a toll free dial up number. WINASAP2003 is not a practice management system and does not interface with other practice management or billing systems. However, it has special capabilities that help save you time and money. Please contact our Provider Hotline at 1-800-235-4378/1-808-952-5570 and work with our EDI coordinator today about installation tools that is required.

Money Savings using WINASAP2003

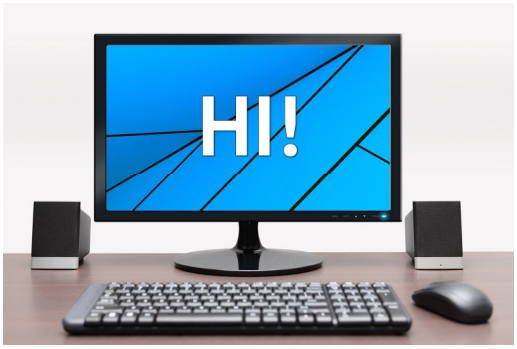
- WINASAP2003 and electronic claim submission are available for free.
- Electronic claims submission eliminates mail preparation and postage expenses.
- Claim submission to payment turnaround time is shorter.

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 system's 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!

✓ Ensure the USB WINASAP modem cord is directly from the PC to phone jack outlet.

✓ Having a phone jack splitter may interrupt and slow data transmission. It is best to have the WINASAP modem cord connected from the PC directly to the phone wall jack.

✓ We suggest a limit of two years' worth of claims kept in the database warehouse. It is best to perform purge clean up on a quarterly basis.

✓ The USB mini external modem (Zoom 3095) is inexpensive and is popular with the provider community.

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 field locator 9, 9a, 9d or 11c-d on the 1500 claim form and in field locator 50-55 on the UB04. 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

Billing Code Update Reminders

- **Patient Status 62** – not used by Medicaid Hawaii, use patient status 01
- **Patient Status 21–** not used by Medicaid Hawaii, use patient status 01
- **Locum Tenens –** modifier Q6 indicates services done by a locum tenen.
- **Code 80101 –** replaced with code G0431
- **Mod 76** – claims billed with codes using modifier 76 should NOT be billed as a separate claim from the original service. Please combine the claims and submit to Conduent.

Admission Types accepted by Medicaid Hawaii on the UB-04 claim form

1. Emergency
2. Urgent
3. Elective
4. Newborn
9. Info Not Available

Program Year 2019 is Open

The Hawaii Medicaid Promoting Interoperability (PI) Program Year 2019 opened on January 2, 2020. Providers who have previously attested in participation years one through five are eligible to attest for Program Year 2019. Go to https://hi.arraincentive.com to login and attest for Program Year 2019.

Providers are not required to attest consecutively, but please keep in mind that only three program years remain before the PI Program comes to an end in 2021.

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2013	First year Medicaid EP Qualifies to Receive Payment 2014	First year Medicaid EP Qualifies to Receive Payment 2015	First year Medicaid EP Qualifies to Receive Payment 2016
2013	$21,250	-	-	-
2014	$8,500	$21,250	-	-
2015	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$21,250
2017	$8,500	$8,500	$8,500	$8,500
2018	$8,500	$8,500	$8,500	$8,500
2019	-	$8,500	$8,500	$8,500
2020	-	-	$8,500	$8,500
2021	-	-	-	$8,500
TOTAL Possible Incentive Payments	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Maximum Incentive Payments for EPs

* Pediatricians with patient volume between 20-29% may qualify for a reduced payment amount totaling $42,500.

2015 Edition Certified Electronic Health Record Technology (CEHRT)

Beginning with the EHR reporting period in calendar year 2019, all participants in the Medicaid Promoting Interoperability Program are required to use 2015 Edition CEHRT. The 2015 Edition CEHRT **was not required** to be implemented on January 1, 2019. However, the functionality must be in place by the first day of the EHR reporting period and the product must be certified to the 2015 Edition criteria by the last day of the EHR reporting period.

eCQM Items to Note

First-time meaningful users must report on a 90-day Clinical Quality Measures (CQM) reporting period.
Returning meaningful users are required to report on the full 2019 calendar year.
EPs are required to report on any six eCQMs related to their scope of practice.
Medicaid EPs are required to report on at least one outcome measure. If no outcome measures are relevant to that EP, they must report on at least one 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 relevant measures.

The list of available eCQMs for EPs in 2019 can be found at https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms.

2019 EP CMS Promoting Interoperability Program Objectives and Measures

- Beginning in Program Year 2019, all providers are required to attest to Stage 3 Objectives and Measures.
- The EHR reporting period is any continuous 90-day period within calendar year 2019.
- There are a total of eight Objectives.
- The Security Risk Analysis must be completed in calendar year 2019.

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

Exclusion for Broadband Access

Several meaningful use objectives for program year 2019 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.

Resources

State Level Registry: https://hi.arraincentive.com/

Provider Outreach Page: http://hi.arraincentive.com/

Med-QUEST Division (MQD) Promoting Interoperability Program: https://medquest.hawaii.gov/en/plans-providers/provider-resources/electronic-health-record.html

CMS Promoting Interoperability Program: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

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.