Hawaii Medicaid Provider Bulletin

Volume 13, Issue 2

July 2019

Inside this issue:

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

Conduent's New Office Location!

We have relocated! Our new office is now located in Bishop Square at 1001 Bishop St. Suite #575 Honolulu, HI 96813.

New Provider Management System

On March 1, 2020, the Division will launch it's new web based provider enrollment system. This is a change from the previously communicated implementation date of August 2019. This new system will allow providers to enroll, update, and make changes to their information quickly and easily online. This will reduce 'paper' processing and will save time for both the provider and state staff.

In the near future, Medicaid providers will be receiving an informational letter providing more details about this project and requesting their updated contact information (i.e. email, phone number). It is essential for the Division to have accurate contact information for all of our providers. This is in preparation for future informational notices that will focus on what providers will need to do to prepare for the implementation of the new system.

We anticipate starting provider community training prior to the launch in March 2020, and will have more specific training dates over the next few months.

For more information, please visit the MQD website at: https://medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html

Electronic Visit Verification (EVV)

The 21st Century Cures Act passed by Congress in December 2016 requires states to implement EVV for certain home and community-based services: personal care services (PCS) and home health care services (HHCS). This includes Self-directed/Consumer-directed services.

The EVV vendor kick-off meeting occurred the week of June 10 in Phoenix. The EVV vendor - Sandata, AHCCCS, and Med-QUEST met to review and ensure the details of the project and process are correct before work begins.

Additional EVV information can be found at the Med-QUEST website: www.medquest.hawaii.gov/EVV

1139 Revalidation Application Forms Processing

Please ensure you are submitting all required documents and following the proper instructions indicated on the 1139 instructional sheet. Also you will need to ensure all required signatures are in live ink. For any questions about your application, please contact the provider hotline at 1-808-952-5570. The application revalidation process is coordinated in processing phases and takes time to complete. It is imperative that the application is properly filed and completed accordingly.

Please contact us via Email!

Written Correspondence can be sent via email to hi.providerrelations@conduent.com. When inquiring about a claim, you may submit with a Claim Reference Number (CRN). If you are inquiring about a claim, it is best to submit your inquiry on a Form 239. The written correspondence form is available online on the Med-QUEST website DHS Medicaid Written Correspondence Form 239.

How to Properly Submit a Hard Copy Claim Adjustment

Adjustment claims may be submitted only within 12 months from the date of service. When the original claim is denied and you want to make a correction on the claim, simply submit a new claim. The adjudication time for new claims is much quicker than adjustment claims.

Here are tips on how to properly submit an adjustment claim:

- Circle actual changes only. i.e. if adding a line, circle entire line including total charges. If changing a code, replace with correct code and circle it.
- When deleting a line, strike through line item.
- On the top of the claim form, write the words “Resubmission”
- To make corrections on the UB04, in FL 04, please ensure you have the TOB of xx6 or xx7. Use TOB xx8 only to void the claim.
- If submitting an adjustment on the on the CMS 1500, please indicate “A” in FL 22 under resubmission code. Also notate the 12 digit CRN under Original Reference No. If voiding the claim, simply indicate “V” in FL 22 and notate the CRN.

If Conduent frequently returns your claims for the same reasons, we will contact your organization as additional training may be necessary.

How to submit an adjustment electronically 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 at http://edisolutionsmmis.portal.conduent.com/gcro/winasap

Refund Check Procedures

We are returning all your Financial Adjustments that are missing pertinent information. Supporting documentation must provide the information needed to clearly identify the claim to be adjusted or voided and must include the following:

- Client name and Patient Medicaid Identification Number
- Date of Service
- Claim Reference Number (CRN)
- Amount of the Check and Net Amount of Claim(s)
- Specific reason for refund
- For overpayments due to other insurance payment, a copy of the other insurer’s EOB must be included.
- For duplicate payments please provide copies of Remittance Advices or the CRN.
- Failure to provide required information will result in check being returned with a request for missing information.

Where on the claim to indicate Share of Cost amount on a UB04 and 1500 Claim Form?

The provider must use value code 23 along with the share of cost amount in box 39-40 when billing hard copy on a UB04 and FL field 29 on the 1500 claim form.

What is on the MQD Website?

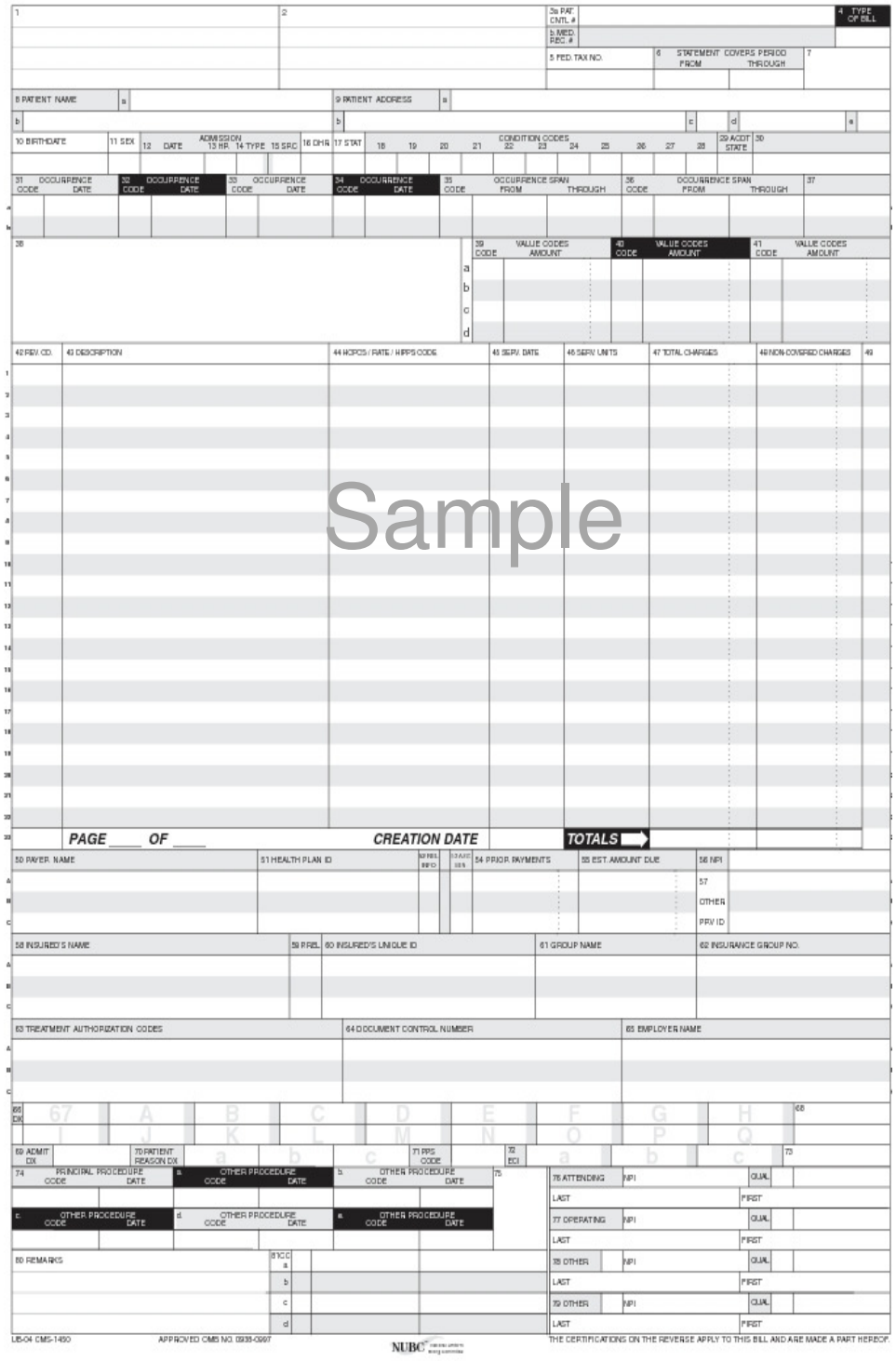
https://medquest.hawaii.gov/en.html
Please log on your PC and surf the new website! Links of interest to Medicaid Providers are in the ‘Plan and Providers’ menu, such as: Medicaid Provider Bulletins, Medicaid Provider Memos, Fee schedule, and the Provider 1139 Application with instructions. Please be up to date by reviewing the quarterly Provider Bulletin which gives you up to date policy and guideline changes.

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
1	Provider Name, Address, & Phone #	Required	Indicate the type of insurance coverage applicable to this claim by placing an "X" in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Required	Insured's ID number as shown on the Medicaid ID card (Medicaid ID #).
2	Patient's Name	Required	Patient's full name as it appears on the Medicaid ID card.
3	Patient's Birth Date, Sex	Required	Patient's birth date (MM/DD/YYYY). Enter an "X" in the appropriate box to indicate the sex of the patient.
5	Patient's Address	Required	Patient's street, city, state, zip code, area code and phone #.
6	Patient Relationship to Insured	Required	Enter an "X" in the correct box to indicate the patient's relationship to insured.
9	Other Insured's Name	Conditional	If FL11d is marked, complete fields 9, 9a, and 9d. Otherwise leave blank. When additional health coverage exists, enter the other insured's full name if it is different from that shown if FL2.
9a	Other Insured's Policy or Group	Conditional	Policy or group number of the other insured.
9d	Insurance Plan Name or Program	Conditional	Other insured's plan or program name.
10a-c	Is Patient's Condition Related to:	Required	Indicate whether the patient's condition is a result of an employment, auto, or other type of accident.
11	Insured's Policy, Group, or FECA Number	Conditional	If the patient has another TPL, indicate the TPL policy number. If FL4 is complete, this field should be completed.
11c	Insurance Plan Name or Program	Conditional	Insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?	Conditional	Enter an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	Patient's or Authorized Person's Signature	Required	Patient's or authorized person's signature releases any medical or other information necessary to process a claim. If the signature is on file, indicate "Signature on file" and date.
14	Date of Current Illness, Injury, Pregnancy	Conditional	Enter the first date of the present illness, injury, or pregnancy (MM/DD/YY).
17	Name of Referring Provider or Other Source	Conditional	Name and credentials of the referring physician are only required for consults (99241—99275). Leave blank if not a referral.

FL #	Field Name	Requirement	Information Required
17a	Other ID #	Conditional	Medicaid qualifier “1D” and the legacy number is required when referring physician is an atypical provider.
17b	NPI#	Conditional	Enter the NPI of the referring provider.
18	Hospitalization Dates Related to Current Services	Conditional	Required for hospitalizations only. Enter the admit date followed by the discharge date. If not discharged, leave discharge date blank (MM/DD/YY).
19	Reserved for Local Use	Conditional	If it is known that the TPL does not cover a certain service, a denial does not have to be obtained, but you must indicate “Not a (name of TPL) covered service”.
21	Diagnosis or Nature of illness or Injury ICD Indicator	Required	List up to 12 diagnosis codes. For dates of service on or after 10/01/15 only ICD-10 codes will be accepted. Use the highest level of specifity possible. Do no add provider narrative in this field. Relate the appropriate diagnosis code to the lines of service in FL24E using the appropriate alpha pointer. Use “0” for ICD-10 indicator.
22	Medicaid Resubmission	Conditional	Required for resubmissions only. Enter “A” (to adjust) or “V” (to void). Also enter the original 12-digit claim reference number.
23	Prior Authorization Number	Conditional	Waiver providers must indicate a “W”.
24A	Date(s) of Service [lines 1-6]	Required	Date(s) of service, from and to. If only one date of service, enter that date under “From”. Leave “To” blank or re-enter “From” date. **
24B	Place of Service [lines 1-6]	Required	Enter the 2-digit place of service. **
24C	EMG [lines 1-6]	Conditional	Required for emergency services. Enter “Y” for YES or leave blank if NO. **
24D	Procedures, Services, or Supplies [lines 1-6]	Required	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set on the date of service. **
24E	Diagnosis Pointer [lines 1-6]	Required	Enter the diagnosis reference letter (pointer) as shown in FL21 to relate the date of service and the procedures performed to the primary diagnosis. **
24F	$ Charges [lines 1-6]	Required	Do not add commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number. Symbols that denote no charge for service, such as ”N/C” and slashes or dashes are not a valid charges of service.
24G	Days or Units [lines 1-6]	Required	Enter the number of service units, visits or days applicable to each line. If field is left blank, the number is assumed to be 1. **
24H	EPSDT/Family Plan [lines 1-6]	Conditional	For Early & Periodic Screening, Diagnosis, and Treatment relates services. Enter a “E” only when requesting follow-ups for catch-up and preventative services. **
24I	ID Qualifier [lines 1-6]	Conditional	Enter qualifier “1D” if the provider number is the 6 or 8 digit Medicaid provider ID.
24J	Rendering Provider ID # [lines 1-6]	Required	Effective August 1, 2007 the NPI must be indicated in the un-shaded region. If an atypical provider, enter the legacy number in the shaded area.
25	Federal Tax ID Number	Required	Enter the provider of service or supplier’s Federal Tax ID (employer identification number) or Social Security Number. Enter an “X” in the appropriate box to indicate which number is being reported.
26	Patient Account No.	Conditional	Enter the provider patient reference or account number.
27	Accept Assignment	Required	Enter an “X” in the correct box. Only one can be marked. Medicaid requires YES to be checked.
28	Total Charge	Required	Sum of total line charges. (I.e., total of all charges in FL24F).
29	Amount Paid	Conditional	Enter total third party amount paid. Share of Cost information may also be listed here.
31	Signature of Physician or Supplier	Required	Signature of Physician or Supplier Including Degrees or Credentials.
32	Service Facility Location Information	Conditional	If the service was rendered in a Facility or Hospital, or if different from billing address, enter the name and address of the facility.
32a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the service facility.
32b	Other ID #	Conditional	Enter the Medicaid qualifier “1D” followed by the Legacy number (for atypical providers).
33	Billing Provider Info & Ph #	Required	Enter the provider’s or supplier’s billing name, address, and phone number.
33a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the billing provider.
33b	Other ID #	Conditional	Enter the Medicaid qualifier “1D” followed by the Legacy number (for atypical providers).
NOTE			** denotes that the information must be indicated in the un-shaded section of the field.

Medicaid Billing Required Fields for the UB04



FL #	Field Name	Requirement	Information Required
1	Provider Name, Address, & Phone #	Required	Enter the provider's name, and service address and ph. #.
2	Pay-to Name, Address, and Secondary ID	Conditional	Required when the pay-to name and address information is different than the Billing Provider information in FL1.
4	Type of Bill	Required	This is a 3-digit alphanumeric code that identifies the type of facility, type of care, and the billing sequencing.
5	Federal Tax #	Required	Enter the Provider's Tax ID#.
6	Statement Covers Period	Required	From and through dates for this billing period. (MM/DD/YY).
8b	Patient Name	Required	Medicaid Recipient's last name, first name and middle initial as it appears on their Medicaid ID card.
9	Patient Address	Required	Patient's street number and name of post office box, city, state and zip code.
10	Patient Birth Date	Required	Month, day and year of the recipient's birthday (MM/DD/YYY). This information must correspond with the birthday on the Medicaid ID card.
11	Patient Sex	Required	Enter "M" for male, "F" for female.
12	Admission Date	Conditional	Required if patient was admitted (01-24 hrs.).
13	Admission Hour	Conditional	Required if patient was admitted. (01-24 hrs.).
14	Type of Admission / Visit	Conditional	Required if patient was admitted. Enter the admission type code.
16	Discharge Hour	Conditional	Discharge hour is required if patient is discharged on end date of service. This field must be left blank if no discharge hour applies. "00" is not a valid entry (01-24 hrs.).
17	Patient Status	Conditional	Required if the patient was admitted. Enter patient status code.
18-28	Condition Codes	Conditional	Required if the patient was admitted. Enter patient condition code.

FL #	Field Name	Requirement	Information Required
31-34	Occurrence Code/Date	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
35-36	Occurrence Span Code/Date	Conditional	If occurrence code is billed, occurrence span date (both from and to date) is required (MM/DD/YY).
39-40	Value Codes	Conditional	When Medicare is the TPL, coinsurance/deductible amount must be indicated along with the corresponding value code. To report share of cost, use value code 23.
42	Revenue Code	Required	Enter the appropriate 4-digit revenue codes to identify specific accommodation and / or ancillary charges.
44	HCPCS/Rates	Conditional	Required for outpatient services (except for outpatient rev. codes 025x or 063x). Enter the HCPCS code for all services.
45	Created Date (line 23)	Required	Date of signature (MM/DD/YY).
46	Units of Service	Required	Required when billing with revenue codes.
47	Total Charges	Required	Sum charges. You will no longer be required to use revenue code 0001 to sum charges.
48	Non-covered Charges	Conditional	Non-covered charges must be indicated here.
50A-C	Payer Name	Required	Enter the names of the appropriate payers listed in order of primacy (primary payer on Line A, secondary on line B and tertiary on line C). Indicate “Medicaid” as the payer on the appropriate line.
54	Prior Payments	Conditional	Required when TPL applies. Enter the total amount paid by TPL on every line. If no payment was made, enter “0”.
56	NPI	Required	10-digit NPI
58	Insured’s Name	Conditional	On the same lettered line (A,B, or C) that corresponds to the line on which Medicaid payor information is shown in FLs 50-54, enter the patient’s name as shown on the Medicaid ID card.

FL #	Field Name	Requirement	Information Required
59	Patient’s Relationship to	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
60	Insured’s Unique ID	Required	On the same lettered line (A, B, or C) that corresponds to the line on which Medicaid Payor information is shown in FLs 50-54, enter the patient’s 10-digit Medicaid ID.
61	Insurance Group Name	Conditional	Indicate the insurance group name that coordinates with the insured indicated in FL58 A-C.
62	Insurance Group #	Conditional	Enter the ID#, control # or code assigned by the appropriate insurance carrier that corresponds to group FL61 A-C.
64	Document Control #	Conditional	Required for resubmission. The original 12-digit claim reference number must be indicated in FL64 A.
66	Diagnosis Code Indicator	Required	For dates of service 10/01/2015 going forward please enter “0” for ICD-10 CM diagnosis code.
67	Principal Diagnosis Code	Required	Enter the Principal Diagnosis Code.
67A-Q	Other Diagnosis Codes	Conditional	Hawaii Medicaid allows for the entry of up to 10 diagnosis codes. Provider may not duplicate the principal diagnosis listed in FL67.
69	Admitting Diagnosis Code	Conditional	Required if the patient was admitted.
74	Principal Procedure Code & date	Conditional	Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
76	Attending– NPI/Qual/ID	Required	Required when the claim contains any services other than non-scheduled transportation services.
80	Remarks	Conditional	Enter remarks needed to provider information that is not shown elsewhere on the bill but which is necessary for proper payment.)I.e. “Not a three day qualifying stay” or “Not a TPL/ Medicare covered benefit”).

Why are your claims being returned?

Our agents may advise that there are no claim(s) on file and it has been returned when inquiring. A reason for a returned claim is due to data entry errors on the claim processed 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. 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) and correction marks in its proper claim field

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 retroed back 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

Customer Service Branch for our Medicaid Recipients

Fiscal Agent Conduent Medicaid has been getting an abundance of calls from the Medicaid Recipient Community. Please discourage your patients from contacting the Provider Hotline. Instead, please have your patients contact the Customer Service Branch at 1-800-316-8005/1-808-524-3370, pressing option 2.

Program Year 2019 for the Hawaii Medicaid Promoting Interoperability Program

The last year for Eligible Professional (EPs) to begin participating in the CMS Medicaid Promoting Interoperability (PI) program was 2016. Those successfully attesting for six years have the opportunity to earn incentives totaling $63,750.00. Please note, EPs who attest successfully for Program Year 2019 can earn an incentive payment amount up to $8500.

EHR Reporting Period for Program Year 2019

For Program Year 2019, the EHR reporting period for Medicaid EPs is a minimum of any continuous 90 day period.

Certified Electronic Health Record Technology

Beginning in 2019, all EPs must attest using a 2015 edition CEHRT is to meet program requirements. The 2015 CEHRT must be used for the entirety of the 90 day EHR reporting period.

Clinical Quality Measure Requirements for Program Year 2019

Under the CMS Medicaid PI Program, all EPs in their first year of meaningful use have a Clinical Quality Measures (CQMs) reporting period of any continuous 90 day period.
Returning meaningful users are required to report on a full calendar year for CQMs.

Promoting Interoperability Program Objectives and Measures for Program Year 2019

Details for the Program Year 2019 Objectives and Measures may be found in the publication CMS Medicaid Promoting Interoperability Program Eligible Professionals Objectives and Measures for 2019.

Hawaii Outreach Coordinator

Heidi Miles is the Outreach Coordinator for the Hawaii Medicaid Promoting Interoperability Program, and is available to assist with your attestation. Have questions about how to attest or just want a little help with your attestation? Contact Heidi via email or telephone at Heidi.Miles@Conduent.com or (808) 561-2197.