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DEPARTMENT OF HUMAN SERVICES
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Health Care Services Branch
P. O. Box 700190
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January 26, 2015

MEMORANDUM

MEMO NO.
CTR-1501

TO: Cyrca, Inc.

FROM: Kenneth S. Fink, MD, MGA, MPH
            Med-QUEST Division Administrator

SUBJECT: TRANSITION OF STATE OF HAWAII ORGAN AND TISSUE
            TRANSPLANT (SHOTT) PROGRAM CONTRACTOR

The Department of Human Services (DHS), Med-QUEST Division (MQD) is issuing this memorandum to communicate that effective April 1, 2015, Cyrca's contract with the DHS will terminate. Pursuant to the General Conditions and terms of the contract (RFP-MQD-2010-003), DHS has complete ownership of all material produced by Cyrca and all materials shall be delivered to DHS upon expiration or termination of the contract. In addition, Cyrca is required to cooperate with DHS to effect an orderly transition of services to members.

Cyrca shall provide DHS with the following documents/files by the dates identified below with formats provided by DHS as attachments. Please notify MQD if Cyrca has any fields in attachments 1 to 4 that you do not have access to information.

Requirement	Timeframe for submission to DHS
Claims processed from January 1, 2013 to December 31, 2014	February 2, 2015
Claims processed from January 1, 2015 to March 31, 2015	April 10, 2015
Demographics of all SHOTT beneficiaries who are receiving services as of February 28, 2015	March 4, 2015
Demographics of all SHOTT beneficiaries who are receiving services as of March 31, 2015	April 3, 2015
Prior Authorizations January 1, 2015 and later	February 20, 2015

Requirement	Timeframe for submission to DHS
Prior Authorizations from February 13, 2015 to March 31, 2015	April 4, 2015

Please direct any questions regarding this memo to Ms. Cori Woo at either cwoo@medicaid.dhs.state.hi.us or 808-692-7739.

Attachments

ATTACHMENT 1

<u>Member Demographics</u>

#	Field Name	Type	Description
1	Medicaid Client ID	text	As Assigned by DHS
2	Member Last Name	text	
3	Member First Name	text	
4	Member Middle Initial	text	If available
5	Member DOB	date	
6	Member Gender	text	
7	PCP NPI	text	NPI
8	PCP Last Name	text	
9	PCP First Name	text	
10	PCP Middle Initial	text	If available
11	PCP Specialty	text	
12	PCP Address 1	text	
13	PCP Address 2	text	
14	PCP City	text	
15	PCP State	text	
16	PCP Zip Code	text	
17	Medicare/TPL	Y/N	Yes/No
18	HIC/Medicare ID	text	
19	History of Transplant?	Y/N	Yes/No
20	Describe transplant	text	
21	Awaiting transplant?	Y/N	Yes/No
22	Describe transplant	text	

Specific Guidelines

(a.) Time frame: As of February 28, 2015 or March 31, 2015.

(b.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 2

Paid Medical Claims

#	Field Name		Description
1	HAWI Client ID	N	As Assigned by DHS
2	Claim ID	N	Cyrca's claim ID
3	Detail Claim ID	N	Cyrca's detail claim ID
4	Form Type	AN	Either HCFA or UB
5	Service Provider ID	AN	MQD Provider ID
6	Service Provider Last Name	A	If facility include name here
7	Service Provider First Name	A	
8	Service Provider Middle Initial	A	If available
9	Service Provider Address 1	AN	
10	Service Provider Address 2	AN	
11	Service Provider City	A	
12	Service Provider State	A	
13	Service Provider Zip Code	A	
14	Service from date	N	CCYYMMDD
15	Service to date	N	CCYYMMDD
16	Paid date	N	CCYYMMDD
17	Primary diagnosis	AN	no decimal
18	Diagnosis 2	AN	no decimal
19	Diagnosis 3	AN	no decimal
20	Diagnosis 4	AN	no decimal
21	Total $ Charged	N	Seven digits + decimal + two decimal places
22	Type of bill	N	UB claims only
23	Place of service	N	HCFA claims only
24	CPT/HCPCS	AN	
25	Modifer	AN	First modifier
26	Quantity	N	no comma, no decimal
27	Revenue code	AN	UB claims only

Specific Guidelines

(a.) The file will repeat records as many times as the claim has detail claim lines.

(e.g. One claim with 5 detail claim lines = 5 records)

(b.) This file will contain only paid medical claims; no denied claims.

(c.) Time frame: Service dates from January 1, 2013 to December 31, 2014 for submission on February 2, 2015.

Time frame: Service dates from January 1, 2015 to March 31, 2015 for submission on April 10, 2015.

(d.) Send latest version of a claim.

(e.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 3

Paid Pharmacy Claims

#	Field Name	Type	Description
1	HAWI Client ID	text	As Assigned by DHS
2	Claim ID	text	Cyrca's claim ID
3	Prescriber Provider ID	text	NPI
4	Prescriber Provider Last Name	text	If facility include name here
5	Prescriber Provider First Name	text	
6	Prescriber Provider Middle Initial	text	If available
7	Pharmacy Provider ID	text	NPI
8	Pharmacy Provider Name	text	If facility include name here
9	Dispense Date	date	
10	Total $ Submitted Cost	num	two decimal places
11	Total $ Allowed Cost	num	two decimal places
12	NDC	text	No dashes
13	Drug Name	text	
14	Quantity	num	no comma, no decimal

Specific Guidelines

(a.) The file will repeat records as many times as the claim has detail claim lines.
(e.g. One claim with 5 detail claim lines = 5 records)

(b.) This file will contain only paid medical claims; no denied claims.

(c.) Time frame: Service dates from January 1, 2013 to December 31, 2014 for February 2, 2014 submission.
Time frame: Service dates from January 1, 2015 to March 31, 2015 for April 10, 2015 submission.

(d.) Send latest version of a claim.

(e.) Send file as an Excel worksheet, version 2013 or lower.

ATTACHMENT 4

<u>Prior Authorizations</u>

#	Field Name	Type	Description
	Prior Authorization		
1	Medicaid Client ID	text	As Assigned by DHS
2	Primary diagnosis	text	no decimal
3	Start Date	date	
4	End Date	date	
5	Service Provider ID	text	NPI (preferred) or HI Medicaid Provider ID. If self-directed provider, include SD in this field.
6	Service Provider Last Name or Agency	text	If facility include name here
7	Service Provider First Name	text	
8	Service Provider Middle Initial	text	If available
9	Service Provider Address 1	text	
10	Service Provider Address 2	text	
12	Service Provider City	text	
13	Service Provider State	text	
14	Service Provider Zip Code	text	
15	CPT/HCPCS	text	If applicable
16	Allowed Units	num	no comma, no decimal
17	Used Units	num	no comma, no decimal
19	NDC	text	No dashes
20	Drug name	text	If applicable
21	Days Supply	num	If applicable
22	Quantity	num	If applicable. No commas, no decimals.
23	Acute Hospitalization	Y/N	Yes/No
24	If Yes, Hospital Name	text	Facility name
25	Date of admission	date	
26	Anticipated date of discharge, if unknown, leave blank	date	

Specific Guidelines

(a.) The file will repeat records as many times as the member has a Prior Authorization
(e.g. One client with 100 PAs = 100 records)

(b.) Time frame: Prior Authorizations open as of January 1, 2015 for February 20, 2015 file.

Time frame: Prior Authorizations open from February 13, 2015 to March 31, 2015 for April 4, 2015 file.

(c.) When sending subsequent PA files, exclude any PA that has previously been included unless modified.

(d.) Send file as an Excel worksheet, version 2013 or lower.