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MEMORANDUM

MEMO NO.
QI-2410
CCS-2406

TO: QUEST Integration Health Plans
Community Care Services (CCS) Behavioral Health

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: ZERO PAY ENCOUNTER SUBMISSIONS RELATED TO COORDINATION OF BENEFITS (COB) CLAIMS

The purpose of this memorandum is to inform the health plans of an expansion of guidance regarding the submission of zero pay encounters, focused on a coordination of benefits scenario where claims paid by another insurer or entity, such as Medicare cross-over claims, result in no financial liability for Medicaid. Section 7.2 of the HPMMIS Technical Guide has been updated to reflect the new guidance, and this policy will take effect for encounters with dates of service starting January 1, 2025.

Existing Policy and Background
Previous guidance for zero pay encounters in the HPMMIS Technical Guide (Section 7.2) and memo QI-2203/CCS-2202, considered two different zero pay scenarios:

Scenario 1: Plan-denied claims - A provider submits a claim for administrative or non-covered services, but the plan denies the claim.

Per HPMMIS Technical Guide – Encounters 7.2.1, this includes encounters that were denied for administrative reasons such as:

- Failure of the provider to obtain a required Prior Authorization (PA)
- Untimely submission of the claim to the Health Plan
- Provider billed units are in excess of Medicaid service benefit limits
- Provider's failure to supply required claim's supporting documentation

In short, services provided to Medicaid members were accurately reported in the corresponding claims, but the claims were denied due to Health Plan policy. Encounters representing these types of claims denials are to be submitted in the **.deny** file.

Scenario 2: Capitated Provider encounters - A plan capitates a provider, who sends an encounter to the plan. These encounters represent informational submissions by providers accurately reporting services provided to Medicaid members, where no further payment is warranted.

Per guidance in QI-2203/CCS-2202 and HPMMIS Technical Guide – Encounters 7.2.2, these encounters should be submitted in the **paid** encounter file

- CN101 CONTRACT INFORMATION should be '05' (Capitated)
- HP Allowed Amount should be set to a non-zero value
- HP Paid Amount would be set to zero

A third scenario has been identified that required additional clarification. This memo defines the new scenario (Scenario 3) and issues guidance on how to handle the submission of encounters from such claims.

Scenario 3: **Coordination of benefit claim** - Another payor (such as Medicare) has paid 100% of a coordination of benefits claim. The service is covered by Medicaid, but no payment is owed to the provider.

New Policy

Starting with dates of service of January 1, 2025, and later, Health Plans must submit Scenario 3 encounters in the .deny file. MQD has updated the HPMMIS Technical Guide Encounters 7.2.3 with this new policy.

Please contact mqd-encounters@dhs.hawaii.gov if you have any questions on this guidance.