



Chapter 4

Medicaid Provider Manual Claims Payments

December 2015

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4.1 CLAIM FORMS

The following claim forms are approved for filing claims for goods or services provided to Medicaid clients:

- CMS Form 1500
- Prescription Drug Claim Form 204
- Transportation Provider claim Form 208 for interisland air transportation by commercial carriers
- UB-04 for institutional services.
- ADA Form 2006 for dental services

Modified or proprietary forms will not be accepted.

4.1.1 Form Availability

Nationally developed forms such as the UB-04, CMS 1500 and ADA claim forms can be ordered from the U. S. Government Printing Office. In addition, forms can be obtained from vendors in Hawaii. Refer to Appendix 1 for the contact information and phone numbers.

4.1.2 Procedure and Diagnosis Code Sources

The procedure coding system recognized by the Center for Medicare & Medicaid Service's (CMS) Healthcare Common Procedure Coding System (HCPCS) as adopted by DHS. HCPCS consists of current year CPT-4 codes and HCFA alpha numeric codes. Diagnosis numerical coding is required based on the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). For acute inpatient claims, the surgical procedure codes listed in the ICD-9-CM Annotated Volume III are used in Form locator 74-74E of the UB-04 claim form to determine appropriate surgical versus medical classifications. For dates of service on and after October 1, 2015, ICD-10 CM must be used for diagnoses. For dates of service on and after October 1, 2015, acute inpatient hospital claims must use ICD-10 PCM codes to report acute inpatient procedures.

4.2 THIRD PARTY LIABILITIES

Federal regulations specify that all other readily available sources of medical insurance are primary to Medicaid. A third party liability (TPL) refers to another health coverage or responsible payor whose resources are available to the client in addition to Medicaid. Therefore, providers must bill the other insurance including Medicare and await payment or rejection notification before filing a claim for Medicaid payment.

4.2.1 Determining Third Party Resources

A provider or authorized staff should verify whether any other medical coverage is available to a client by asking the client. Providers may also use one of the eligibility verification modes offered by DHS, such as the Automated Voice Response System (AVRS), DHS Medicaid On-Line (DMO), Medicaid Fiscal Agent call center, or by asking the client. For more information on verifying a client's eligibility through AVRS and/or DMO, refer to the MQD website at www.med-quest.us at Provider section in the Quick References link. Information regarding third party coverage is required on all claims. It is the provider's responsibility to verify a client's TPL coverage and Medicaid eligibility. Accident claims must also provide the accident date and type of accident (work, auto-related, etc.). Claims are denied if this required information is not provided. Claims for services may be filed directly with the Medicaid Fiscal Agent if the liability of a third party is in question or cannot be determined within 30 days from the date of medical care.

4.2.2 Common Third Party Resources

a) Medical and Dental Health Insurance

Services must be billed to third parties for payment or rejection before being submitted to the Medicaid Program. The third party payment must be indicated on claims submitted to the Fiscal Agent as this amount is deducted from the Medicaid allowance in determining Medicaid payment.

- For the CMS 1500 form, enter the TPL information in the appropriate fields (FL 9, 9a, 9d, 11c-d). The corresponding payment or denial report from the third party carrier must be attached to the claim submittal.
- For the UB-04 form, enter the TPL information in the appropriate fields (FL 50- 55). Enter the TPL payment amount in the "Prior Payments" field (FL 54) on the applicable row identifying the TPL.
- For the ADA form, indicate TPL information in the appropriate fields (FL 31-37). Enter the TPL payment amount in the "Examination and treatment plans Deductible" field (FL 59). Claims for patients with third party coverage that do not indicate a third party payment or denial will be rejected to bill the third party.

If a third party payer denies a service that is normally covered, a rejection notice must be attached to the Medicaid claim showing the reason for the denial, e.g., pre-existing illness, TPL cancelled, patient ineligible, etc. Services that are known to be excluded under a patient's third party insurance, such as non-emergency transportation or dental services for a patient with only a basic medical insurance policy do not require denial notices. For these claims, a statement in the "Remarks" field on the claim regarding the non-covered status of the services rendered is sufficient.

b) Health Maintenance Organization (HMO)

Medicaid does not pay for a service if the patient is covered by an HMO or had pre-paid benefits but chose not to go to the designated provider for the services.

Medicaid pays only if the service is excluded from coverage under the HMO.

Medicaid does not pay for the services if the patient chose not to utilize the available HMO benefits and instead sought services elsewhere. Examples of HMO plans are HMSA-Health Plan Hawaii (HPH) Plan, Kaiser Health Plan and Veterans Administration (VA) (service connected disability).

c) No-Fault

If a Medicaid client has purchased private, no-fault auto insurance (TPL code 52), and was involved in an auto accident, was a passenger in a car insured with standard coverage, or was a pedestrian or bicyclist struck by a car with standard no-fault coverage, claims should be filed directly with the private no-fault insurance company. If a Medicaid client is involved in an auto accident as either a driver or passenger of a vehicle insured through the Hawaii Joint Underwriters Plan (HJUP), claims can be filed directly with Medicaid, as the Joint Underwriters Plan does not cover medical services. These claims must indicate the injuries were auto-related and include the date of the accident in the accident date field of the claim and a brief description of the accident.

d) TRICARE

TRICARE, formally known as CHAMPUS, is a medical benefits program to help pay for civilian medical care provided to active duty members and their families; retirees and their families; and survivors of all uniformed services who are not eligible for Medicare. Benefits are also available to the spouse or children of a veteran with a total, permanent service-connected disability, or the surviving spouse or children of a veteran who dies as a result of a service-connected disability. Since TRICARE is primary to Medicaid, claims must be filed with TRICARE first.

In addition to standard TRICARE coverage, two other alternative TRICARE plans are available: TRICARE Prime and TRICARE Extra. Members with TRICARE Prime must receive services from TRICARE Primary Care Providers. The person should be referred to the TRICARE Primary Care Provider for services. If a Medicaid client with TRICARE Prime coverage fails to utilize the services of a TRICARE Primary Care Provider then

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neither TRICARE nor the Medicaid Program will cover the services, including pharmacy services.

TRICARE Extra coverage applies when a standard TRICARE member goes to a TRICARE Primary Care Provider, resulting in a lower co-payment. Although it is preferred that a client with standard TRICARE coverage go to a Primary Care Provider, it is not mandatory and claims will not be denied by Medicaid for not utilizing the services of a Primary Care Provider. TRICARE members also have dental, drug and vision coverage.

e) Medicare

Clients who are age 65 or older, blind, have a disability, or are being treated for end-stage renal disease (ESRD) may have Medicare coverage. Clients age 65 or older qualifying for both Medicare and Medicaid coverages are automatically enrolled in Medicare Part B by their caseworkers. Part B premiums are paid by DHS on the client's behalf. Unless the service is not a Medicare benefit, all claims must first be filed with Medicare. If the service is not covered under Medicare, the provider may bill Medicaid using the applicable Medicaid claim form. To expedite processing, the provider must indicate the non-coverage status under Medicare and follow the claim procedures outlined in 4.2.2a regarding non-coverage indication of services.

Medicare coordinated claims for acute inpatient hospitalization and outpatient hospital services will be processed in accordance to the Medicaid Payment Methodology and applies to claims with dates of service after September 1, 2003 and billed on institutional claims (UB04 or 837I).

Effective July 1, 2008, all drugs submitted for services rendered in outpatient hospital emergency rooms and all prescription drugs covered by Medicare B and administered in the physician office that are not deemed appropriate for self-administration, must have NDC (National Drug Code) information—NDC eleven digit numbers, NCPDP (National Council for Prescription Drug Programs) billing units, and NCPDP quantity.. Failure to provide NDC information will result in denial or non-payment of the drug.

To view Hawaii approved Medicare HMO plans visit: www.medicare.gov/mppf/ and go to Hawaii's approved Medigap plans.

f) Other Insurance

Clients may not have the detailed health insurance information for all their known carriers. In these cases the caseworker may enter a TPL into HPMMIS that would show only "Other" or "Private Motor Vehicle". *An example would be a child in a single parent home whose absent parent or grandparent is able to provide health insurance. Although it is known that the child does have coverage, the policy number or even company may not be known.* For these situations the client is considered to have a viable TPL even though the exact nature of the coverage is

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unknown. It is the provider's responsibility to pursue all avenues of payment including clarification of unknown policies prior to submitting to Medicaid. Claims submitted to the Medicaid Fiscal Agent will pend to DHS for investigation of the TPL and possible relationship to the claim. Appropriate documentation attached to claims from these carriers (including explanation of benefits) when applicable will expedite the process.

g) Subrogation Report

A subrogation report is generated when a client notifies DHS of an accident that may result in injury. The report will only contain the date of the reported accident. The subrogation report is treated as TPL until the specifics of the accident and subsequent TPL information are completed with the caseworker. All claims submitted to the Medicaid Fiscal Agent will pend to DHS for investigation of possible relationship to the accident. This information is not available to the provider prior to the adjudication of the claim.

h) Subrogation Settlement

In certain cases a client may receive a settlement from the insurance company for the reported accident. The settlement represents reimbursement for related medical services as of the date of the accident. When the state is notified of the settlement the client's account is flagged and claims payment stops. Because the settlement is in fact a primary payment from TPL, the sum of claims related to the accident equaling the amount of the settlement becomes the responsibility of the client. Once the settlement sum is met the client updates their caseworker and the flag is removed from their account allowing for normal claims processing. Claims not related to the accident and subsequent settlement may be indicated in the remarks field as "Not Related to Accident." These claims will pend to the DHS TPL department for review before final determination.

i) Additional TPL Coverage Information

Services not covered by a client's other insurances may still be submitted to the Medicaid Fiscal Agent for payment. An explanation of benefits showing the denial of coverage attached to the claim will allow the claim to process. Services known to be non covered benefits may be indicated in the comments field of the claim form as "NOT A COVERED TPL" or "NOT RELATED TO TPL". This notation is acceptable for all insurances including Medicare, "Other", "Private Motor Vehicle", subrogation reports, and subrogation settlements. DHS may still pend the claim for review of the claim and insurance information prior to final adjudication. Accident claims known to have no related insurance may include in the remarks field "No TPL."

4.2.3 Medical Reimbursement

A Medicaid client may sometimes receive a check from his/her health insurance plan for services covered under that health plan. For example, if a client has an indemnified

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dental or vision plan, that plan's payment might be directed to the client. Or, in the case of HMSA, if you are not a participating provider with HMSA, payments are directed to the client. When providers bill the Medicaid Program, they may only bill Medicaid the reimbursable amount that remains after applying the other health plan's payment. This is true regardless of whether or not that payment is made directly to the provider.

4.3 CLAIMS SUBMISSION

Providers may submit hard copy or electronic claims to Medicaid for reimbursement. Pharmaceutical and vaccine claims should be submitted to the Medicaid Pharmacy Benefit Manager (PBM). Please refer to Chapter 19 Pharmacy.

4.3.1 Hard Copy Claims

A maximum of 25 lines may be included on a CMS 1500 form. A maximum of 99 lines may be billed on a UB-04 claim form. Claims that exceed 25 lines must be split billed. In addition, all services rendered on the same day should be billed on the same form. Hard copy claims must be mailed to the Medicaid Fiscal Agent. All hard copy claims must have a live ink signature. Printed or stamped signatures will not be accepted, this applies to all forms including UB-04 claims. The provider or authorized agent may sign a claim form. Refer to Appendix 1 for the mailing address

4.3.2 Electronic Claims

Submission of electronic claims will require ANSI ASC X12N Version 4010 for the UB04 and 1500 forms. Electronic claims must be submitted via virtual private network (VPN). Providers also have the option of electronically submitting claims utilizing WINASAP, a free software offered by Hawaii Medicaid. Claim submission through WINASAP is sent through a 56K fax modem. All providers that elect to submit electronic claims are required to participate in a testing and certification process and will receive a separate Electronic Media Claim (EMC) Manual. Refer to the EMC Manual for additional information regarding the electronic submission of claims. For questions or to begin sending claims electronically, contact the Fiscal Agent. See Appendix 1 for the phone numbers.

4.3.3 Medicaid Client Identification Numbers

The ten character client HAWI ID number (including leading zeros) will be required to submit a claim.

4.3.4 Provider Medicaid Numbers

Most providers are required to obtain a National Provider Identifier (NPI). All providers with an NPI are required to submit the NPI on the claim form. On the CMS-1500 form, the Servicing NPI should be submitted in field 24-J.

24. A.	B. DATE(S) OF SERVICE					C.	D. PROCEDURES SERVICES, CPT/ICD-9-CM/ICD-10-CM/ICD-9-CM/ICD-10-CM/ICD-9-CM/ICD-10-CM		E.	F.	G.	H.	I.	J.
From	To	PLACE OF SERVICE	EMC	(Explain Unusual Circumstances)	ICD-9-CM	ICD-10-CM	DIAGNOSIS POINTED	\$ CHARGES	UNITS	UNIT	QUAL	FENDERING PROVIDER ID. #		
1												NPI	000000001	

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The Group Payment NPI should be submitted in field 33-A.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	
SIGNED	DATE	a. NPI	b.	a. NPI	b. 0000000001

Claims submitted with a Servicing NPI in field 33-A will pay to the Servicing NPI rather than the Group NPI.

For UB-04 claims, the hospital NPI should be submitted in field 56.

PAGE OF		CREATION DATE		TOTALS			
50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0000000001

Do not submit the Group NPI.

The following provider types do not require an NPI:

A7 – Respite
H1 – DD/ID
01 – Group Payment ID
24 – Personal Care Attendant
25 – Group Home (Developmentally Disabled)
27 – Adult Day Health
28 – Non-emergency Transportation Providers
34 – Case Management Services
37 – Homemaker
38 – Developmentally Disabled Day Care
39 – Habilitation Provider
40 – Attendant Care
49 – Assisted Living Center
50 – Adult Foster Care
51 – Behavioral Health Counselor
52 – Mental Health Clinic
57 – Residential Treatment Facility
70 – Home Delivered Meals
75 – MHS Social Worker
80 – DHS MHS Provider
90 – QMB Only Provider
97 – Air Transportation
99 – EVS/Non-Service Provider

For provider types that do not require an NPI, the Medicaid provider number and the service location number must be submitted on the claim form as part of the provider ID number (PIN). On CMS 1500 forms, an ID Qualifier of 1D in the shaded portion of 24I plus the individual PIN should be submitted in the shaded portion of field 24-J and the group PIN should be submitted in field 33a.

4.3.4.1 Basic Medical Services Covered

Only Medicaid providers may be referring providers and when a referring provider is required to be indicated on a claim, the provider must indicate the referring provider's Medicaid number or NPI on the claim. Providers may not refer patients to themselves.

4.3.5 Filing Deadline

All claims for Medicaid services must be submitted to Medicaid for payment within 12 months of 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.

For cases involving retroactive eligibility for a client, the 12-month filing period will begin from the date that DHS approved the client's application. For example, a patient is admitted into a long term care facility on January 1, 2008 and applies for Medicaid benefits. The patient's application is approved on June 1, 2008 for eligibility beginning January 1, 2008. The facility has until June 1, 2009 to submit the Medicaid claim.

4.3.6 Waiver of Filing Deadline

If you are not able to submit your claim (including resubmissions) within the proper filing period, you must obtain a waiver of the 12 month filing deadline. Evidence must be provided showing that claims were previously submitted within the 12-month filing deadline. Claims without such documentation but with extenuating circumstances that may be considered for waiver of the filing deadline are:

- a) Claims with delays resulting from third party payments. Documentation of timely filing attempts with the third party must be indicated on the request.
- b) By a court order.
- c) By an administrative hearing determination.

Requests to waive the filing deadline for fee-for-service claims must be submitted to:

DHS/MQD/FO**1001 Kamokila Boulevard, Room 317
Kapolei, HI 96707**

You must list the names of the client, date(s) of service and Claim Record Numbers (CRNs) of previously submitted claims if applicable. Please include documentation and a description of the extenuating circumstances. If you have several claims for which you require a waiver, you may list these claims on a single request letter.

Providers will be notified by Med-QUEST of the waiver decision, and if approved, claims may be submitted to the Fiscal Agent for payment. The approval letter must be attached to the claim when submitted.

4.3.7 Prior Authorizations

Claims for services requiring prior authorizations do not require the prior authorization number to be recorded on the claim; however a prior authorization must still be obtained and will be verified by the claims processing system.

4.3.8 Additional Payment Requests

As per the Hawaii Administrative Rules § 17-1739.1-16 (amended May 5, 2005), you are allowed to file adjustments to claims up to *60 days* from the initial date of adjudication (payment or denial of the claim).

Routine requests for additional payment due to incorrect claim information such as dates, procedure codes, ID numbers, etc., may be sent to the Fiscal Agent. Medicaid will not reimburse late charges. Addresses can be located in Appendix 1. Refer to section 4.4.2.6 for more information on submitting adjustments to the Fiscal Agent.

Requests for payment reconsideration based on medical necessity or level of care reviews should be submitted as follows:

- a) Long term care stays lowered in post review by HSAG – The level of care letter should be sent back to HSAG with additional documentation to support the original level of care for the periods that the provider is contesting.
- b) Outlier claims down coded to a lower level of care – These claims typically deny because the medical reviewer considers the documentation to support a lower level of care. Facilities should attach a copy of the level of care change letter, the claim, and additional documentation supporting their position to a 240 request for reconsideration and forward to the Medicaid fiscal agent for processing.

- c) Acute inpatient hospital claims denied for prior authorization mismatch. These claims typically deny because the facility has a long term care level of care authorization on file, and did not attach documentation justifying the change to acute level of care. These claims should be resubmitted with the appropriate documentation to the Medicaid fiscal agent.

4.3.9. Special Claim Filing Procedures

a) Patients with Medicare Coverage

Claims should be submitted to Medicare for payment determination. As a general rule, Medicare will electronically transfer claim and payment information to Medicaid and report payment information to the provider. Notification of this electronic transfer is provided by Medicare. If Medicare does not transmit the claim information electronically to Medicaid, the provider should submit the explanation of Medicare benefit (EOMB) and a hard copy claim indicating Medicare payment to the Medicaid fiscal agent.

To ensure the accuracy of crossed-over claim information, providers submitting on an UB-04 or CMS 1500 claim form, must indicate Medicaid payer information.

If an electronic crossover does not appear as adjudicated on the provider's remittance advice within 30 days of Medicare's notification of crossover, the provider is encouraged to submit the claim in hard copy format for processing. Claims for Medicaid clients, who also have Medicare coverage, must be received by Medicaid within six months of the Medicare remittance advice date or within one year of the date of service, whichever is greater.

b) Spend-down Clients with Medicare Coverage

"Spend down" clients are not eligible for Medicaid coverage until their cost share has been paid. These patients may have a Medical Assistance Coupon (Coupon). The following procedures must be used when submitting a claim for spend down clients with Medicare/Medicaid coverage's:

- 1) Medicare must be billed first using the applicable claim form.
- 2) The patient's cost share must be applied to the co-insurance, deductible, or any Medicaid-only covered service remaining on the claim after Medicare payment.
- 3) A copy of the claim may be submitted to the Fiscal Agent if any portion of the coinsurance, deductible or Medicaid-only covered service remains after application of the Medicare payment and the patient's cost share. A copy of the Medicare payment summary (EOMB) must be attached to the claim and the patient's cost share deducted from the balance.
- 4) If there is no balance following Medicare payment and deduction of the cost share, do not file a claim with Medicaid.

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Claims for newborns must be submitted with the newborn's Medicaid identification number. Claims submitted with the mother's Medicaid identification number will be denied.

d) Inmates of Public Institutions

Although youths in the Hawaii Youth Correctional Facility and inmates in the Department of Public Safety's (DPS's) facilities not eligible for Medicaid, the Medicaid fiscal agent processes their medical claims. Services should be billed using existing approved Medicaid claim forms with appropriate procedure and diagnosis codes and submitted to either the Office of Youth Services (OYS) for youths in the Hawaii Youth Correctional Facility or to DPS. OYS/DPS will forward the claims to the Medicaid fiscal agent

For more information, please contact DPS or OYS:

Department of Public Safety (DPS) – 587-3379

Office of Youth Services (OYS) – 266-9525

e) Patients Covered by Another State's Medicaid Program

Claim filing procedures vary from state to state as individual States administer their own Medicaid Program following federal guidelines.

When treating a patient covered under another state's Medicaid Program, providers must verify the patient's coverage with a Medicaid card or document, which identifies the patient as Medicaid eligible. If unable to provide evidence of eligibility, the patient may be billed as a private patient.

If a patient provides evidence of coverage under Medicaid, a claim can be filed with the State Agency or fiscal agent for the Medicaid Program of the State where the patient resides. If the fiscal agent is not known, the patient may be billed with instructions to present the bill to the State's Medicaid fiscal agent upon returning home.

f) Qualified Medicare Beneficiaries (QMB) Plus Clients

Medicare is the primary insurer and therefore the claim should be submitted to Medicare first. Medicare assignment must continue to be accepted for the claim to automatically crossover to Medicaid.

The provider should make sure that Medicaid information is included on the claim form so that the claim will automatically "crossover" to the Medicaid fiscal agent for processing. Eligibility information sent to Medicare is also a determinant for claims to crossover.

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Most claims, which automatically “crossover” to Medicaid for processing will result in payment of the coinsurance and deductible for services covered under Medicare. Medicaid payment methodology is used for inpatient acute hospitalizations and hospital outpatient services. Generally, services not covered by Medicare, but covered under Medicaid are payable. A separate claim may need to be submitted to Medicaid for these non-covered Medicare services. Medicaid will coordinate payment up to the Medicaid fee schedule for in-patient services and up to the Medicare fee schedule for outpatient services.

g) QMB-Only Clients

A claim for services provided to a QMB-Only client should be submitted to Medicare as the primary insurer. For a QMB-Only client, Medicare assignment is optional. If assignment is accepted, claims submitted to Medicare fiscal intermediaries and carriers with crossover agreements with our fiscal agent will automatically “crossover” to Medicaid for payment of the coinsurance and any deductible. Since QMB-Only clients are not eligible for Medicaid, payment for services covered by the Medicaid program, and not covered by Medicare, will not be made.

h) Transplant Clients

Claims for clients that are approved for a tissue or organ transplant other than corneal or kidney transplants should be submitted to State of Hawaii Organ and Tissue Transplant (SHOTT) Program. Refer to Chapter 8 Transplant Services for more information.

4.4 CLAIMS PROCESSING

When a claim has been submitted and all required elements are included, the claim will be processed through the Hawaii Prepaid Medicaid Management Information System (HPMMIS). If the client has no other health insurance coverage, the claim will be paid based upon the Hawaii Medicaid payment methodology. If the client has other insurance coverage, the payment amount will be coordinated with the coverage from the primary payer.

Claims submitted with invalid, inconsistent or missing information will be denied. Claims will not be returned for the correction of the above reasons nor will turnaround documents (TADS) be generated and sent to the provider. Such claims will be denied and must be corrected and resubmitted for payment.

4.4.1 Medicaid Reimbursement with TPL Payments Other than Medicare

For claims coordinated with a third party resource except Medicare, Medicaid pays the difference, if any, between the Medicaid maximum allowance and the third party payment:

Example:

Claim Total \$255.00
 TPL Payment \$185.00
 Medicaid Allowance \$228.00
 Medicaid Payment \$43.00

24.	A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM FAMN Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		
	From MM DD YY	To MM DD YY																
1	01	01	08	01	01	08	99	A0001			1	255	00	1	NPI	000000001		
2															NPI			
3															NPI			
4															NPI			
5															NPI			
6															NPI			
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
						<input type="checkbox"/> <input type="checkbox"/>					<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 255.00		\$ 185.00		\$ 70.00	

\$228.00 (Medicaid Allowance) - \$185.00 (TPL Payment) = \$43.00 (Medicaid payment.)

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When the third party payment exceeds the Medicaid allowance, the provider is entitled to the amount paid by the third party; however, no Medicaid payment can be made:

Example:

Claim Total \$255.00 TPL Payment \$234.00

Medicaid Allowance \$228.00

Medicaid Payment \$ 0.00

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM FAMILY PLAN	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		
	From MM DD YY	To MM DD YY	MM	DD	YY	MM										DD	YY
1	01	01	08	01	01	08	99	A0001	1	255	00	1		NPI	000000001		
2														NPI			
3														NPI			
4														NPI			
5														NPI			
6														NPI			
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
						<input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 255.00		\$ 234.00		\$ 21.00	

\$228.00 (Medicaid Allowance) - \$228.00 (TPL Payment*) = 0.00

*Although the actual TPL payment is \$234.00, the TPL payment deduction is limited to the maximum Medicaid allowance (\$228.00).

4.4.2 Medicare Coordination of Benefits

4.4.2.1 Medicare Part A Coordination

Providers are required to supply Medicaid payer information on the UB-04 claim form (FL 5060). In addition, providers must indicate a patient's Medicare deductible (code 'A1') and coinsurance (code 'A2') in the "Value Codes" fields (FL 39). Claims submitted without applicable Medicare deductible or coinsurance amounts will be denied. Claims with this information will cross over to Medicaid once Medicare payment adjudication has been made.

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Medicare Part A coordinated claims for skilled nursing facilities (SNFs), Inpatient Rehabilitation Facilities, hospice services, and home health agency services are paid at applicable Medicare coinsurance plus deductible.

Medicare Part A coordinated claims for acute inpatient hospitalizations will pay either the Medicare coinsurance plus deductible, or the Medicaid allowed amount minus the Medicare paid amount, whichever is lesser

Example:

Claim Total: \$1000.00

Medicare Payment: \$250.00

Medicaid Allowed Amount: \$400.00

\$400.00 (Medicaid Allowed Amount) - \$250.00 (Medicare Payment) = \$150.00

Medicare Coinsurance + Deductible: \$100.00

38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0100 Room and Board				3	750.00		
2	0430 Emergency room				1	250.00		
50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO	53 ASG BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE
A Medicare		000000K000				250		56 NPI
B								OTHER
C								PRV ID

In this case the claim payment would be the coinsurance amount of \$100.00, because that is less than the \$150 (Medicaid allowed amount – Medicare payment).

Example:

Claim Total: \$1000.00

Medicare Payment: \$250.00

Medicaid Allowed Amount: \$300.00

\$300.00 (Medicaid Allowed Amount) - \$250.00 (Medicare Payment) = \$50.00

Medicare Coinsurance + Deductible: \$100.00

In this case the claim payment would be \$50.00, because that is less than the coinsurance + deductible.

CLAIMS PAYMENT

Example:

Claim Total: \$1000.00

Medicare Payment: \$350.00

Medicaid Allowed Amount: \$300.00

\$300.00 (Medicaid Allowed Amount) - \$350.00 (Medicare Payment*) = \$0.00

Medicare Coinsurance + Deductible: \$100.00

38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT			
a1	100	00							
b									
c									
d									
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
1 0100	Room and Board				3	750	00		1
2 0450	Emergency room				1	250	00		2
50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE		56 NPI	
A Medicare		0000001000			350			57 OTHER	A
B								PRV ID	B
C									C

In this case the claim payment would be \$0.00, because that is less than the coinsurance + deductible.

Medicare Part B coordinated claims for outpatient hospital services billed on UB04 claim forms are also paid at the lesser of Medicaid allowed amount minus Medicare payment or Medicare co-insurance plus deductible. For Medicare Part B coordinated claims for federally qualified health centers (FQHCs) and Rural Health Centers (RHCs), see Chapter 23.

Providers must separately bill for Medicare covered Skilled Nursing Facility (SNF) days and Medicare non-covered SNF days (FL 7 to 9). Providers must use the occurrence code 'A3', 'B3', 'C3', 'D3', or 'E3' (Benefits Exhausted) to identify SNF claims where Medicare covered days are exhausted. These claims will be processed according to Medicaid criteria.

Medicare Coordination

4.4.2.2 Medicare Part B coordination

DHS has negotiated with Medicare B for recipients with both Medicare and Medicaid coverage. Medicare is the primary insurance payer. Following Medicare payment determination, Medicaid will pay the deductible and co-insurance, as well as for any services not covered under Medicare, but which are benefits under Medicaid. For Medicare coordination of outpatient acute hospital services see 4.4.2.1 and for FQHC/RHC see Chapter 23. Medicaid will not pay any charges connected with services excluded from Medicaid coverage, such as treatment of tuberculosis or Hansen's disease.

4.4.2.3 Coordination Criteria

Medicaid may only pay on claims in which Medicare assignment was accepted by the provider. If assignment was not accepted because providers were unaware of a patient's Medicaid coverage, a claim may be submitted to Medicaid following Medicare payment, but the Assignment must be indicated and signed in the proper field of the claim form.

Medicaid also abides by the utilization decisions made on a claim by Medicare with the exception for durable medical equipment (DME).

4.4.2.4 Method of Coordination – Medical Services

Claims must first be submitted to Medicare for payment. When claims are processed for payment, Medicare will either electronically transfer claim and payment information to Medicaid for coordinated payment processing, or report payment information on a provider's Medicare payment report summary. This summary (EOMB) must be submitted with the hard copy claim to the Medicaid Fiscal Agent for coordinated processing.

4.4.2.5 Coordination Procedures – Electronic File Transfer (EFT)**a) Claim Submissions**

Claims should be submitted to Medicare for payment determination. When Medicare has made payment, claim and payment information will be electronically transferred to Medicaid using the Medicare Provider Identification number for coordinated payment of co-insurance and/or deductibles as appropriate. The provider must enroll with both Medicaid and Medicare for electronic crossovers. Notification of this transfer is provided by Medicare.

b) Multiple Payers

Medicare payment information transfer may be done only once per patient claim. If a patient has supplemental Medicare coverage, payment information will go directly to the supplemental coverage insurer if properly identified on the Medicare claim form

as a supplemental insurer. If there is a balance that may still be submitted to Medicaid, the hard copy claim must be submitted with the Medicare/Other Payers payment report attached.

c) Exception Situations

Medicare has expanded its coverage of preventive services to include yearly wellness examinations and certain screenings and testing. However, some services denied by Medicare as not related to an illness or injury will not be transferred. If the denied service is a benefit of the Medicaid program, a hardcopy claim must be submitted to Medicaid with an indication of the Medicare non-covered status.

4.4.2.6 Coordination Procedures – Hard Copy Claim Submittals

As with electronic transfer procedures, claims should be completed as normally done when submitting claims to Medicare for payment.

Following Medicare payment and proper claim form completion for Medicaid processing, claims may be submitted to the Fiscal Agent along with a copy of the Medicare payment summary. If a copy of the Medicare payment summary showing Medicare's payment summary lists more than one claim that is to be submitted to Medicaid, a separate copy of the applicable portion of the payment summary must be attached to each claim. The Medicare payment summary must be photocopied for provider records, as it will not be returned.

4.4.3 Durable Medical Equipment Filing Procedures

Coordination procedures apply only to DME items covered by Medicare. They do not apply when the patient is in a hospital, SNF or ICF; or when provided by Medicare participating home health agencies who should continue to bill Medicare Part A or B as applicable first.

4.4.4 Pricing and Payment Processing

As mandated by state law, non-institutional services will be paid using a fee schedule. All services that were paid on usual and customary charges will be paid on a fee schedule. This includes physician, diagnostic and therapy services. Outpatient hospital services that require a HCPCS or CPT code will also be subject to the fee schedule. The fee schedule does not apply to inpatient facility, hospice, and home health agencies, federally qualified health center/ rural health center, and ASC services. General excise tax will no longer be paid as a separate line item. The fee schedule reimbursement rates will be all inclusive. No balance billing is allowed.

4.4.5 Editing Process

The claims system attempts to apply all edits during a single processing cycle. This

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enables us to report all errors to the provider and avoid claims failing new edits after the provider has corrected and resubmitted the claim. However, if certain data are missing, incorrect or invalid, completion of the entire processing cycle may not be possible.

When a claim fails an edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed in the denied claims section of the Remittance Advice with an edit number, decimal point and a single digit that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice. See Appendix 1 for information on the Remittance Advice.

Examples of edit codes:

H001.1 – Service Provider ID – Field is Missing

H001.3 – Service Provider ID – Field is Not On File

L023.1 – Diagnosis Codes #1 – Invalid for Client Age & Gender

L023.2 – Diagnosis Codes #1 – Invalid for Client Age

L023.3 – Diagnosis Codes #1 – Invalid for Client Gender

If one or more edits fail during the editing process, there are two possible outcomes:

The claim may stop processing and “pend” for internal review when the error detected concerns data or procedures that may be resolved by MQD or the Fiscal Agent.

When a claim requires medical review, for example, it will pend internally until someone authorized by Medicaid reviews the services being billed.

Internally pended claims are generally handled without input from the provider.

The exception is when medical documentation is requested for a claim under review.

The claim may be denied if the data required for adjudication is complete but the service does not meet MQD policy requirements. For example, if a provider was not registered or if a client was not eligible on the date of service, payment would be denied.

MQD’s intention is to process all clean claims in a timely manner.

A Claim Reference Number (CRN) is assigned to all claims on initial submission to MQD. The first five characters of the CRN represent the Julian date the claim was

initially received by MQD. The remaining numbers make up the claim document number assigned by the claims processing system. The CRN does not change regardless of the number of times the claim is resubmitted or adjusted.

Below is an example CRN:

08	000	00	25	001	01	
						Line number
						Sequence number
						Batch number
						Receipt source
						Julian date

Calendar Year

The receipt sources are as follows:

00 – Paper claim

50 - Professional Electronic Claim

60 – Institutional Electronic Claim

80 – Medicare Crossover Electronic Claim

When submitting documentation (e.g., Medicare EOMB) subsequent to the submission of a claim, the CRN of that claim should be provided to enable MQD to link the documentation to the claim.

Providers also must provide the CRN when resubmitting, adjusting or voiding a claim. If a claim is resubmitted without the CRN, the claim will be treated as a first time submission and may not pass the appropriate filing deadline. The claim also may be denied as a duplicate of an existing claim.

4.4.6 Adjustments, Voids and Resubmissions of Claims

The claims processing system is designed to discourage erroneous payments by requiring edits through which all claims must pass prior to payment. Although much effort is made to prevent inaccuracies, they may occasionally result from incorrect procedure or eligibility data, post-payment reviews resulting in identification of a third party liability, or a retroactive denial of a service by the DHS Consultant.

4.4.6.1 Overpayments

Overpayments are recovered by Medicaid. If a post-payment review of a claim by the DHS Consultant results in an overpayment determination, notification is sent to the provider explaining the reason for the overpayment, the amount involved, and the action to be taken. The state reserves the right to either deduct the dollars from future provider payments, or request a refund to be received within 60 days.

Overpayments discovered by providers must be promptly reported to Medicaid for appropriate adjustments. Reimbursements received from an accident insurance, such as no-fault motor vehicle insurance, for a service already paid by the Medicaid Program, must be reported to Medicaid to initiate an adjustment, or refunded to the Program no later than 30 days from receipt of the insurance payment.

If a third party payment results in an overpayment for services already paid in full by Medicaid, the overpayment will be adjusted by the amount of the third party payment or the Medicaid allowance for the claim, whichever is lower? This conforms to Medicaid guidelines, which specify that Medicaid payment when coordinated with a third party payment is the difference between the calculated Medicaid allowance and the third party payment. Refer to Section 4.4.1 of this chapter.

Refund checks for claims paid by Hawaii Medicaid should be made payable to **Hawaii Medicaid** and mailed to Xerox, P.O. Box 1480, Honolulu, HI 96807-1480.

Refund checks for claims paid by Prescription Benefits Management should be made payable to **Xerox Prescription Benefits Management** and mailed to Xerox PBM-Refund Checks, PO Box 967, Henderson, NC 27536-0967. To comply with federal law addressing financial practice (Sarbanes-Oxley Act of 2002) the fiscal agent's Security Policy prohibits its employees from accepting provider refunds during provider visits. The refund check and supporting documentation must be mailed to the appropriate address listed above.

The check amount must agree to the dollar amount of the claim (or claims) being refunded.

Supporting documentation must provide the information needed to clearly identify the claim to be adjusted or voided. Please include the following:

- Client name
- Date of service
- HAWI identification number
- Specific reason for refund
- Amount of check
- Net amount of claim(s)

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- 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 Xerox CRN.
- If the claims were paid prior to October 31, 2002, please provide copies of the HMSA EOB.

Failure to provide required information will result in check being returned with a request for missing information.

4.4.6.2 Underpayments/Non-Payment

A provider may submit a request for payment or additional payment if records indicate a routine claim may have been denied or underpaid due to incorrect claim information such as service date, charge, procedure code, ID number, etc.

4.4.6.3 Claims Submittal

Providers may submit adjustments to previously submitted claims or void claims to correct previously submitted claims. Providers may also resubmit a denied claim. To ensure that processing of adjustment or void claims is being done correctly, please follow these submission guidelines:

When submitting an adjustment claim, or requesting that a claim be voided, please be sure to enter an "A" (for adjustment claim) or "V" (for void claim) in FL22 on the CMS 1500 claim form or FL2 on the ADA 2002 form. For the UB-04 use bill type XX6 for adjustments, and for a void claim use XX8. In addition, please provide the original 12-digit Claim Reference Number (CRN), found on your remittance advice in the applicable field.

The entire claim should be submitted exactly as originally billed, with any corrections circled, and deletions crossed out, etc. This will ensure that it is clear what you are requesting to be changed or voided. For a claim originally submitted with multiple lines, please submit all lines, even if only making an adjustment or void request for one line. Do not cross out lines that have already paid, unless you want them voided. To change the bill type on a UB-04 claim, resubmit the claim with bill type XX6, with a note in FL50 stating "Change bill type to XXX."

Any adjustment or voided claims where information is different than what was originally submitted, without indication that you wish to change that field, will be returned to you for clarification.

4.4.7 The Remittance Advice

The remittance advice (RA) accompanies the weekly Medicaid payment to providers and reports all processed claims whether they are paid, denied, pended or in process; as well as all claim adjustments. For samples of the remittance advice and the information included, please refer to Appendix 1.

The “Non-Facility” RA is forwarded to providers that submit CMS (formerly HCFA) 1500 forms. The “Facility” RA is forwarded to providers that submit UB-04 forms.

4.4.7.1 Remittance Advice Sections

Each RA is divided into five (5) sections: Paid Claims, Adjusted Claims, Denied Claims, Voided Claims and Claims in Process (includes claims reported on a previous RA and still in process). The last page of each RA contains processing notes. This page provides an alphabetical listing of denial reason codes and pricing explanation codes. For the CMS (formerly HCFA) 1500 claim form, if some of the lines on a single claim are paid and some of the lines are denied, the lines will be displayed in different sections on the RA. The paid lines will be listed in the Paid Claims section and the denied lines will be listed in the Denied Claims section.

a) Paid Claims

Paid claims are claims for which Medicaid has made payment, and are listed in the “Paid Claims” section of the RA. The allowed amount for each paid claim is listed first followed by any deductions to calculate the net amount paid for the claim.

b) Adjusted Claims

For each adjusted claim, the new allowed amount is listed first with the previous amount paid to the provider subtracted from the new allowed amount. A new net paid amount is then calculated which may result in additional payment to or a recoupment from the provider.

c) Denied Claims

Denied claims were not paid due to client eligibility, benefit limitations or claim submission reasons. Denied claims are listed in the “Denied Claims” section with the corresponding denial reason code(s). Denied claims will not be paid or returned to providers. The RA is the only notification of claim denial.

d) Voided Claims

The allowed amount is listed as a negative amount and any previous deductions will be added to the allowed amount. As a result, the net paid amount is the amount to be recouped from the provider.

e) Claims in Process

The RA will also list claims reported as in process and have not been adjusted.

4.4.7.2 Remittance Advice Sections

The RA is available to providers in an electronic format. Providers that receive electronic RA's will not receive hard copy RA's. To begin receiving an electronic RA, contact the Fiscal Agent. See Appendix 1 for the phone numbers.

4.4.8 Medicaid Payment Schedule

Medicaid payment checks are drawn on funds provided by the State. Checks for claims processed during the week are generally mailed the following week. To inquire about Electronic Fund Transfer options contact the Xerox Provider Inquiry Unit. See Appendix 1 for the phone numbers.

4.4.8.1 Expired or Stale-Dated Checks

Medicaid checks expire or become stale dated 180 days from date of issuance. To comply with CMS regulatory guidelines, the Fiscal Agent must void the paid claims in HPMMIS associated with a check, void the check in the payable system and remit the funds back to State. Providers must resubmit their claims to the Fiscal Agent for processing if they want to receive payment for the voided claims.

4.4.8.2 Lost Checks

All provider requests to stop payment and/or reissue checks must be submitted on letterhead (if available), with provider name, provider ID number, NPI number (if applicable), current address, check number, check date, check amount, authorized signature(s), and reason for request.

The request may be mailed to Xerox-Banking Department, PO Box 1480, Honolulu, HI 96807-1480 or faxed to (808) 952-5562.

4.5 CLAIMS INQUIRIES

Inquiries regarding claim information may be directed to the Fiscal Agent on weekdays from 7:30 a.m. to 5:00 p.m. Representatives are available to provide claim information and answer claims payment inquiries. Providers may also send claims inquiries. Claim status may also be checked using the DHS Medicaid Online website. Refer to Appendix 1 for phone numbers and address.

4.5.1 Information Limitations

The information the Fiscal Agent may furnish to a provider is limited by Federal restrictions regarding confidentiality.

4.5.1.1 Information Available from the Fiscal Agent

The fiscal agent is able to provide the following:

a) Claim Filing Procedures – Provide instruction on proper claim filing procedures and research unpaid claims.

b) Claims Payment Information – Furnish provider payment information through the weekly remittance advice and advise a provider on how a claim was processed.

c) Eligibility – Verify a patient's coverage under a Medicaid ID number as given by a provider.

4.5.1.2 Information Not Available from the Fiscal Agent

a) Client Information

Client Personal Data – Personal data such as addresses is not released. This information must be obtained from the patient.

b) Payment Information

The Fiscal Agent does not release payment information to unauthorized providers. This information is available only to the provider of service or his/her staff.

4.5.2 Common Inquiries and Required Information

Sufficient data from a provider is required for Medicaid to accurately respond to inquiries. The following are the most common types of inquiries and the required accompanying information.

a) Paid / Rejected Claim Inquiry

Required from provider: Provider name and number, patient's name, Medicaid ID number, FM code, service date, charge on claim, claim number, payment date, procedure in question.

b) Medicaid Reimbursement Determination

Required from Provider: Provider name and number, procedure, procedure code, charge for the procedure, service date, and diagnosis.

4.5.3 Outstanding Medicaid Claims Inquiry

Claims appearing as unpaid on a provider's records may have been paid or rejected to the provider. Medicaid provides a standardized inquiry service to aid providers in researching unpaid claims.

4.5.3.1 Method of Inquiry

All written inquiries to the Medicaid Program should be made on the Medicaid Correspondence Inquiry Form. A supply of this form may be obtained from the Fiscal Agent. See Appendix 1 for the contact information.

The Medicaid Correspondence Inquiry Form or Form 239 provides a standardized format in which to submit an inquiry and receive a response. This standardization reduces much of the response time. A clarifying letter or other documentation may be attached to the form when additional space is needed.

The Correspondence Inquiry Form may be used to request claim status research, inquire about claims filing procedures, or question payment amounts. In most cases, claim attachments are not necessary. If possible, internal methods are used to reprocess claims that are found to be outstanding more than 30 days from the date of the last submission. However, in cases where the data provided does not match data in the system at the point of research, providers are asked to resubmit a copy of the outstanding claim.

Outstanding claims submitted without a Correspondence Inquiry Form, letter, or other notification identifying the specific problem with a claim are sent through the processing system as routine claims. Representatives will not be able to identify the claim as one requiring special handling if documentation outlining a specific claim problem is not provided on an attached letter or Correspondence Inquiry Form.

The Medicaid Correspondence Inquiry Form is not appropriate for written inquiries regarding benefit information, policy determination, and coverage limitations.

4.5.3.2 Waiting Period for Claims Status Inquiries

Inquiries should be initiated for claims outstanding more than 30 days from the date of the last submission to Medicaid. Although most claims are paid within 30 days, additional processing time may be required if claims must be manually reviewed for medical necessity or to verify inconsistent claim information such as client TPL information or code pricing.

4.5.3.3 Inquiry Procedures

The Medicaid Correspondence Inquiry form is a three-part form consisting of an original copy, provider copy and Fiscal Agent copy. The form is divided into provider, inquiry and response sections and can accommodate up to three separate claim or informational inquiries. Please refer to Appendix 1 for a sample of the form and instructions for completion.

4.5.3.4 Inquiry Form Submittals

When inquiry forms are completed and prepared for submittal, the provider should make a copy for his/her files. The original form should be mailed to the Fiscal Agent (refer to Appendix 1 for the contact information).

The Fiscal Agent will research the inquiry and indicate the appropriate response on the form. A copy of the form will be returned to the provider. The Fiscal Agent will retain the original inquiry form for internal records.

Providers should review the response provided on the copy returned by the Fiscal Agent and take action as necessary. If a response is unclear or further information is desired, providers may call the Fiscal Agent. Phone numbers are listed in Appendix 1.

4.5.3.5 Research Limitations

Medicaid's claims research service is not a substitute for accurate claims accounting by the provider as staff limitations do not allow extensive research services on a routine basis. The following steps will be taken if a pattern of paid claims are submitted for research:

- a) If research shows a pattern of more than 50% of a batch of resubmitted claims were paid, only a 20% sampling of future batches will be researched.
- b) If more than half of the 20% sampling are paid, the claims will be returned with a request that the provider review his/her claims accountability system.
- c) Complete research on batches of unpaid claims will be resumed when a sampling shows that the problem in the provider's accountability system is resolved and the

resubmitted claims are indeed unpaid.

4.5.4 Procedure Code Inquiries

Effective November 1, 2002, the Med-QUEST Division (MQD) will not be accepting requests for Level I (Common Procedural Terminology [CPT]) codes and Level II (Healthcare Common Procedural Coding System [HCPCS]) codes on a routine basis. Providers should obtain these codes from published coding manuals. Failure to use the appropriate code will result in a delay in the processing of a request for authorization or claim.

4.6 PROVIDER BILLING - CLIENTS

4.6.1 Billing Limitations

Providers must accept the Medicaid Program’s established rates as payment in full. Providers may not bill or collect from Medicaid clients the difference between a provider’s charge and the total payments received from all sources including Medicaid.

A provider may bill and accept payment from a Medicaid client only for:

- a) TPL payments – A patient is responsible for turning over to the provider all payments received from a third party insurance carrier.
- b) Patient’s cost share – Spend-down patients with designated cost shares are responsible for paying a portion of their medical expense on a monthly basis. A provider may collect this cost share only if indicated on the patient’s coupon.

Example:

	Medicaid	Allowance
Claim Total	\$900.00	\$800.00
TPL Payment	-\$600.00	-\$600.00
Patient’s Share	-\$ 50.00	-\$ 50.00
Bal. Billed To Medicaid	\$250.00	\$150.00

MM	DD	YY	MM	DD	YY	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	GROUP OR UNITS	GROUP Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #		
11	01	08	01	01	08	99		A0001		1	900.00	1		NPI	0000000001		
														NPI			
														NPI			
														NPI			
														NPI			
														NPI			
														NPI			
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT’S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov’t claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
						<input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 900.00		\$ 650.00		\$ 250.00	

The provider may collect \$650 from the patient, representing the TPL payment and the patient’s cost share as long as it is less than the cost share amount noted on the coupon. If the cost share is less than the amount owed, the provider may collect up to the cost share amount and bill any difference to the Medicaid program. The difference of \$100 between the balance billed to Medicaid and the ultimate Medicaid payment cannot be billed to the patient.

4.6.2 Acceptable Billing Situations

Although patients covered under Medicaid are not responsible for amounts other than any third party payments or patient cost shares, a provider may bill a Medicaid patient under certain circumstances.

a) Patient did not present himself as a Medicaid client.

A Medicaid client must show his Medicaid ID card as proof of Medicaid coverage. If the patient presented himself as a private patient, or failed to identify himself as a Medicaid patient, a provider may treat and bill him for the services as a private patient. The Medicaid Program does not infringe on a provider's right to adjust compensation for services provided under a private agreement with his/her patient.

If a provider chooses to bill Medicaid for services rendered, no amounts other than third party payments or cost share amounts may be billed to the patient.

b) Patient requested non-covered service.

Ineligible services (e.g. immunizations for travel purposes) and procedures denied by the DHS Consultant on an applicable authorization form may be billed to the patient if the patient insists on the services even when informed that Medicaid would not pay for them. The patient is responsible for all charges made in connection with the ineligible service.

c) Patient failed to utilize prepaid health benefits from designated facilities.

All prepaid health insurance benefits must be utilized before Medicaid benefits are claimed. Medicaid does not pay claims for patients who chose not to seek services available to them at a pre-designated health center, such as HMSA's HPH Programs, Kaiser, or the Veterans Administration. Services rejected by Medicaid for this reason may be billed to the patient.

d) Patient received care from a non-designated provider.

"Lock-in" clients whose medical care is restricted by DHS must receive all medical care from their designated primary care physician. All non-emergency services provided by a provider other than the primary physician may be billed to the patient unless the patient was referred by the primary care physician.