NEIL ABERCROMBIE
GOVERNOR

P ATRICIA MCMANAMAN
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

March 29, 2011

MEMORANDUM

MEMO NO.
ACS – 1104

TO: Behavioral Health Providers

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

SUBJECT: BEHAVIORAL HEALTH PROVIDERS BILLING FOR MEDICAID REHABILITATION OPTION SERVICES

The Med-QUEST Division (MQD) and the Adult Mental Health Division (AMHD) are developing a process for Behavioral Health providers to bill Medicaid for Medicaid Rehabilitation Option (MRO) services (Attachment 1) when a Medical Assistance client is in the fee-for-service (FFS) program.

In order for Medicaid to be able to accept claims, Behavioral Health providers must submit a DHS 1139 (Attachment 2). If you are either a new provider or already a Medicaid provider, under box #5 (Specialty/Degree) please write MRO. If you are already a Medicaid provider and do not have any change in service location, then you can leave Section II blank. In #19, please submit your certification from AMHD to provide MRO services.

Prior to submitting your claims for MRO services, you need to call the Affiliated Computer Services (ACS) call center to verify that your provider application has been processed and the recipient's eligibility has been updated. Once you have verified both, you may start submitting claims to ACS. When you submit your claims to ACS, you must include a copy of the approved prior authorization from either AMHD or a QUEST health plan (i.e., AlohaCare, HMSA, or Kaiser Permanente) to allow the claim to process. ACS will review all MRO claims prior to processing them. If you have any problems with the processing of claims or to verify eligibility, please call ACS at 952-5570 from Oahu or (800) 235-4378 from all other islands.

Please contact Patti Bazin via e-mail at pbazin@medicaid.dhs.state.hi.us or call her at 692-8083 should you have any questions about services that are covered under the MRO or completing your provider application.

Attachments

ATTACHMENT I

Medicaid Rehabilitation Option Services
With MQD rates and HCPCS Codes

SPA	AMHD Service	HCPCS Code	Unit	MQD Rate	Comments
Biopsychosocial Rehabilitation	Psychosocial Rehabilitation	H2017	15 minutes	$ 3.30	Clubhouse not included
Intensive Outpatient Hospital Services	Intensive Outpatient Hospital Services	H0035	Daily	$250.00	
Therapeutic Living Supports	Community Based Specialized Residential	H0019	Daily	$236.14	Must be licensed, only treatment covered
Intensive Case Management/ Community Based Case Management	Intensive Case Management/Community Based Case Management, Face-to-Face Contact	H2015	15 minutes	$20.25	75% of Intensive Case Management/ Community Based Case Management claims must be face-to-face
	Intensive Case Management/Community Based Case Management, Case Assessment	H2015U1	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, Treatment Planning	H2015U2	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, Collateral Contact with No Consumer Contact	H2015U3	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, Telephone Treatment Planning with HSH, Kahi Mohala	H2OI5HT	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, Telephone Consultation with Consumer	H2015U5	15 minutes	$20.25	

STATE OF HAWAII
Department Of Human Services

ATTACHMENT 2

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

MEDICAID APPLICATION / CHANGE REQUEST FORM

(PART A)

☐ Group
☐ Individual

Please circle all that apply:

MEDICAID FEE-FOR SERVICE PROVIDER:	***(Y/N)***	***ELECTRONIC REMITTANCE ADVICE:***	***(Y/N)***
QMB ONLY PROVIDER:	***(Y/N)***	***ELECTRONIC PROVIDER MANUAL:***	***(Y/N)***
IS THIS A NEW MEDICAID APPLICATION	***(Y/N)***	***IS THIS A CHANGE REQUEST***	***(Y/N)***

SHADED FIELDS FOR MED-QUEST PROVIDER REGISTRATION STAFF ONLY ***Please Type or Print in Ink***

SECTION I

1) NATIONAL PROVIDER IDENTIFIER NUMBER *(Enter your 10-digit number, if applicable)*
— — — — — — — — — —

2) PROVIDER NAME *(Last Name/First Name/Middle Initial)*

3) PROVIDER'S REGISTERED BUSINESS NAME / DOING BUSINESS AS (d.b.a.) NAME

☐ SOLE PROPRIETORSHIP
☐ CORPORATION
☐ OTHER _____

4) SOCIAL SECURITY NUMBER
- -

5) SPECIALTY / DEGREE *(Attach Board Certificate or Ltr)*

6) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED
Month ____ Day ____ Year ____

DHS USE ONLY

PROVIDER MEDICAID ID NUMBER:

SECTION II ADDRESS INFORMATION

☐ INITIAL SERVICE ADDRESS *(IF NEW APPLICANT)*
☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

CORRESPONDENCE ADDRESS (C)

7) ATTENTION TO:
8) STREET LINE 1:
9) STREET LINE 2:
10) CITY/STATE/ZIP:
11) BUSINESS PHONE: ( ) –
12) FAX NUMBER: ( ) –

SERVICE ADDRESS (S)

DHS USE ONLY

7) ATTENTION TO:
8) STREET LINE 1:
9) STREET LINE 2:
10) CITY/STATE/ZIP:
11) BUSINESS PHONE: ( ) –
12) FAX NUMBER: ( ) –
13) BEGIN DATE: / /
14) END DATE: / /
15) CLIA NUMBER: *If Applicable*
16) NABP/NCPDP NO.: *If Applicable*

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO
E-MAIL ADDRESS:

PAY TO ADDRESS (P)

DHS USE ONLY

7) ATTENTION TO:
8) STREET LINE 1:
9) STREET LINE 2:
10) CITY/STATE/ZIP:
11) BUSINESS PHONE: ( ) –
12) FAX NUMBER: ( ) –
13) BEGIN DATE: / /
14) END DATE: / /
17) FEDERAL TAX ID NUMBER:
18) GENERAL EXCISE TAX NUMBER:

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO

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☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

SERVICE ADDRESS (S)		**DHS USE ONLY**
7) ATTENTION TO:		
8) STREET LINE 1:		
9) STREET LINE 2:		
10) CITY/STATE/ZIP:		____
11) BUSINESS PHONE: ( ) –	12) FAX NUMBER: ( ) –	
13) BEGIN DATE: / /	14) END DATE: / /	
15) CLIA NUMBER: *If Applicable*	16) NABP/NCPDP NO.: *If Applicable*	
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO	E-MAIL ADDRESS:	

PAY TO ADDRESS (P)		**DHS USE ONLY**
7) ATTENTION TO:		
8) STREET LINE 1:		
9) STREET LINE 2:		
10) CITY/STATE/ZIP:		____
11) BUSINESS PHONE: ( ) –	12) FAX NUMBER: ( ) –	
13) BEGIN DATE: / /	14) END DATE: / /	
17) FEDERAL TAX ID NUMBER:	18) GENERAL EXCISE TAX NUMBER:	
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO		

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

SERVICE ADDRESS (S)		**DHS USE ONLY**
7) ATTENTION TO:		
8) STREET LINE 1:		
9) STREET LINE 2:		
10) CITY/STATE/ZIP:		____
11) BUSINESS PHONE: ( ) –	12) FAX NUMBER: ( ) –	
13) BEGIN DATE: / /	14) END DATE: / /	
15) CLIA NUMBER: *If Applicable*	16) NABP / NCPDP NO.: *If Applicable*	
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO	E-MAIL ADDRESS:	

PAY TO ADDRESS (P)		**DHS USE ONLY**
7) ATTENTION TO:		
8) STREET LINE 1:		
9) STREET LINE 2:		
10) CITY/STATE/ZIP:		____
11) BUSINESS PHONE: ( ) –	12) FAX NUMBER: ( ) –	
13) BEGIN DATE: / /	14) END DATE: / /	
17) FEDERAL TAX ID NUMBER:	18) GENERAL EXCISE TAX NUMBER:	
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO		

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SECTION III ADDITIONAL INFORMATION

LICENSING AND CERTIFICATION

19) LICENSE / CERTIFICATE NUMBER	20) LICENSING/CERTIFYING AGENCY	21) ISSUE DATE (MM/DD/YYYY)	22) EXPIRATION DATE (MM/DD/YYYY)

* A **COPY** OF THE LICENSE AND/OR CERTIFICATION **MUST BE ATTACHED**

AUTHORIZED AGENTS

23) AGENT SIGNATURE	24) PRINT NAME	25) BEGIN DATE (MM/DD/YYYY)	26) END DATE (MM/DD/YYYY)

NOTE: THAT ALL SIGNATURES MUST BE ORIGINAL. ATTACHED A SEPARATE SHEET IF NEEDED.

GROUP BILLING AUTHORIZATION

27) GROUP NAME	28) ASSOCIATION BEGIN DATE (MM/DD/YYYY)	29) ASSOCIATION END DATE (MM/DD/YYYY)

MEDICARE INFORMATION *(Mandatory for all providers. If not a Medicare provider indicate by placing N/A in block #30)*

30) MEDICARE ID NUMBER	[redacted]

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I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

31) PROVIDER SIGNATURE *(ONLY)* _____ 32) DATE _____

33) PROVIDER NAME *(PLEASE TYPE OR PRINT* _____

FOR DHS USE ONLY - DETERMINATION

APPROVAL / DENIAL:

☐ FEE-FOR-SERVICE Provider ☐ QMB ONLY Provider *(Medicare Co-Payment / Deductible ONLY)*

☐ NEGOTIATED Provider *(Rates and/or Procedure Codes Attached)*

☐ APPROVED ____ ____ ____ (MM DD YY) ☐ DENIED ____ ____ ____ (MM DD YY) *REASON FOR DENIAL NOTATED BELOW*

REASON:: _____

MQD AUTHORIZED SIGNATURE _____ DATE _____

FOR DHS USE ONLY - VALIDATION

PROVIDER TYPE:		ENROLLMENT BEGIN DATE:				DATE COS ENTERED: *Per Attached*			
	CODE		MM	DD	YY		MM	DD	YY

MQD AUTHORIZED SIGNATURE _____ DATE _____

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PART B AND PART C

Read through the Provider Agreement and Condition of Participation.

HAWAII STATE MEDICAID PROGRAM
PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION
(PART B)

I/We, _____, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

1. I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R.) related to the Medical Assistance Program. Upon certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual.

2. I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L.94-135), and all the requirements issued pursuant to the respective title, section and/or act, as promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity of the service provider that is funded in its entirety or in part directly or indirectly by Federal Financial Assistance.

3. I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid recipients and to furnish the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, require as authorized by 42 C.F.R. §431.107(b)(2).

4. I/We agree to disclose full and complete information regarding ownership and business transactions (42 C.F.R. §455.105), information on persons convicted of crimes (42 C.F.R. §455.106) at the request of the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.

5. I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare and Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.

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6. I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment required by the Hawaii State Medicaid Program to be paid by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Services for services rendered under the Hawaii State Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.

7. I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such change will take effect within thirty (30) days of receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.

8. I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient except in accordance with Subtitle 12, Chapter 17-1702 of the Hawaii Administrative Rules; (2) Any information about Medicaid Providers and recipients shall be confidential and shall not be disclosed except in accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual; (3) The records of any person, including all communications or specific medical or epidemiological information contained therein, that indicates that a person has or has been tested for HIV/AIDS shall be strictly confidential and shall only be released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information regarding an individual's records and reports with respect to mental health and substance abuse services are confidential and may only be disclosed in accordance with Chapter 334-5, Hawaii Revised Statutes; (5) Any information pertaining to the provision of services related to pregnancy, family planning or venereal disease shall be treated as confidential and may be released in accordance with Chapter 577A-3, Hawaii Revised Statutes.

9. I/We shall comply with the provisions of the Federal Drug Free Act of 1988 (P.L. 100-690), Title V, Subtitle D, which requires that the provider maintain a drug-free workplace.

10. I/We shall comply with the provisions of HIPAA. In this, Agreement "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. PROVIDER is a "health care provider" under HIPAA. A "covered entity" is a health care provider that transmits information in a standard electronic transaction under 45 C.F.R. Parts 160 and 162. If PROVIDER is or becomes a "covered entity", then PROVIDER must comply with all of the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions and code sets, and national employer and provider identifiers. Refer to 45 C.F.R. Parts 160, 162 and 164.

(PART C)

I/We understand that I/We may be suspended or terminated from participation in the Hawaii State Medicaid Program for non-adherence to any of the preceding program requirements and for violation of any of the provisions of H.A.R. Subtitle 12, Chapter 17-1704 (Provider Fraud) and Chapter 17-1736 (Provider Provisions) which includes but is not limited to the following:

(1) Any provider's practice which is deemed harmful to public health, safety and welfare of Medicaid recipients; (2) Not providing full and accurate disclosure of the identify of any person or persons who has been convicted of a criminal offense relating to Medicaid or Medicare; (3) Fraud against the Hawaii State Medicaid Program including, but not limited to, the claiming and receipt of payment or payments for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payment than the amount entitled to; (4) Requiring and/or accepting any payment from a Medicaid recipient for services paid for by the Hawaii State Medicaid Program, except in cases where the Hawaii State Department of Human Services has identified a cost share to be paid by the recipient and where the recipient remits an amount equal to his or her cost share; (5) Requiring and receiving payment from a recipient to make up for the difference between the Hawaii State Department of Human Services' applicable fee schedule or rate and the provider's charges; (6) Revocation of the provider's license by the Hawaii State Department of Commerce and Consumer Affairs; (7) Withdrawal, expiration or termination of facility certification by the Hawaii State Department of Health; (8) Action taken by the provider's professional group or organization disapproving the provider's methods of treatment or care or a determination that care/services rendered by the provider are not in accordance with accepted practices of the profession or harmful to a recipient's health and safety; (9) Violation of the non-discrimination provisions; and (10) Notification from the Secretary of Health and Human Services, or person designated by him/her that an individual, hospital or nursing facility has withdrawn from participation in Medicare without refunding money it owes to Medicare or when the provider agreement has been terminated for defrauding Medicare.

IN THE CASE OF PROVIDERS WHO ARE INDIVIDUALS:

I agree that all services for which I make a claim against the Hawaii State Medicaid Program (Title XIX) will be personally rendered by me. Services such as administration of injections, immunizations, minimal dressings, and drawing of blood samples may be rendered by qualified support nursing staff.

I agree and understand that a qualified licensed psychiatrist or psychologist must provide all psychotherapeutic services, and qualified licensed clinical social worker or advance practice registered nurse shall be limited to behavioral health services.

IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSPITALS, CORPORATIONS OR OTHER ENTITIES:

(1) I/We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted; (2) If any real property or structure thereon is provided or improved either directly or indirectly by Federal

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Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

I/We agree that retroactive provider certification shall be limited to no more than twelve (12) months back to the date on which the application was received in the Hawaii State Department of Human Services/Med-QUEST Division/Health Coverage Management Branch office subject to the discretion of the Med-QUEST Division administration. The month in which the application was received shall be counted as the first month.

I/We have read all of the Provider Agreement and Condition of Participation in the Hawaii State Medicaid Program and fully understand and agree to its terms.

_____
Print Name of Provider / Authorized Business Agent

_____
Signature of Provider / Authorized Business Agent

_____
Date of Signature

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(PART D)

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROVIDER AGREEMENT

I, as a Primary Care Provider (PCP) agree to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in accordance with Title 17, Chapter 1737, Subchapter 6, Section 53 to 62 of the Hawaii Administrative Rules.

I HAVE READ AND UNDERSTAND PART D OF THE AGREEMENT:

_____ _____
(Full Signature of Provider) (Date)

(Leave Blank if New Provider)

_____ _____
(Print Provider's Name in Full) (Medicaid Provider No.)

EFFECTIVE DATE REQUESTED:

_____

FOR DHS OFFICIAL USE ONLY

APPROVED: _____ _____
Contract Specialist Date

EFFECTIVE DATE OF PROVIDER PARTICIPATION: _____
MONTH/DAY/YEAR

STATE OF HAWAII
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(PART E)

DISCLOSURE INFORMATION

As required by Hawaii Administrative Rules (§17-1736-20 & 17-1736-21) the following information must be submitted to the Med-QUEST Division prior to certification or renewal as a *provider* under Medicaid:

Information on Ownership and Control

1. List the names and addresses of each person who has an ownership or controlling interest in the disclosing entity (provider).

Name	Address	Title

2. List the name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

Name	Address	Title

3. List the names of any other disclosing entity in which a person has an ownership or controlling interest in the disclosing entity and also has an ownership or controlling interest in the other disclosing entity.

Name	Address

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Information Related to Business Transactions

1. List the ownership of any subcontractor (i.e., vendor) with whom your organization has had business transactions totaling more than $25,000 during the past 12-month period. (Attach list if necessary)

Describe Ownership (I.e., Corporation, Incorporated, etc.)	Dollar Amount of Transaction

2. List any significant business transactions between your organization and any wholly owned supplier or between your organization and any subcontractor during the past five-year period.

Name of Business	Type of Business Transaction

Information on Persons Convicted of Crime

1. List the names of any person who has ownership or controlling interest in the Provider, or is an agent, managing employee, or employee of the Provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Position

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I/We hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I/We understand that if I knowingly or willfully make or cause to make a false statement or representation on the statement, I/We may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in the Medicaid Program.

Further, the Provider shall, upon discovery of any information required by federal and state regulations, immediately notify the Med-QUEST Division in writing of the information required to be provided.

_____ _____

Date Signed

Print Name of Provider / Authorized Business Agent

_____

Signature of Provider / Authorized Business Agent