Med-QUEST Division

Medicaid Provider Bulletin

Published for the Medicaid Providers of Hawaii.

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In This Issue

HIPAA Restricts E-mailing of Recipient Information

Because of the HIPAA Privacy Rule (effective April 14th, 2003) covered entities are no longer allowed to transmit protected health information (PHI) via e-mail unless it is encrypted. PHI is classified as information that can identify the recipient, e.g., recipient's name, HAWI ID number, SSN, etc.

Therefore, when e-mailing written inquiries to hi.providerrelations@acs-inc.com please do not include recipient protected health information. Similarly, ACS will not include PHI in e-mailed responses.

To simplify the inquiry process and comply with HIPAA requirements, please e-mail inquiries with a CRN and your internal patient account number only. You may include your internal patient account number as long as it does not include the recipient's name, or any references to the recipient's SSN, address, etc. Do not e-mail recipient names or HAWI ID numbers. Dates of service and amount paid are not necessary if you include an accurate CRN. If PHI is inadvertently included in a provider's e-mail, ACS will fax its response to the provider.

Thank you for helping to maintain the confidentiality of our recipient's personal information.

Important Contact Information

Provider Inquiry Unit (Call Center):
Oahu: 952-5570
Neighbor Islands: 1-800-235-4378

Eligibility Line (AVRS): 1-800-882-4608

Email Provider Inquiries to:
hi.providerrelations@acs-inc.com

Fax Provider Inquiries to: (808) 952-5595

Fax Urgent Prior Auth Requests to: (808) 952-5562
(Not Applicable to Medicaid Waiver Program)

Questions about HIPAA Transactions and Code Sets?
Contact us at: hipaatcs@medicaid.dhs.state.hi.us

Mail Prior Auth Requests to: *(Not Applicable to Medicaid Waiver Program)*
ACS
P.O. Box 2561
Honolulu, HI 96804-2561

Mail Returned Checks to:
ACS
P.O. Box 1206
Honolulu, HI 96807-1206

Mail MQD Claims to:
ACS
P.O. Box 1220
Honolulu, HI 96807-1220

Mail SSD Medicaid Waiver Claims to:
ACS
P.O. Box 4631
Honolulu, HI 96812-4631

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Ancillary waitlisted charges

When billing for ancillary waitlisted charges use occurrence **span** codes 74 and 75. These codes should be indicated in FL 36 on the UB-92.

Provider ID Number in the Proper Field of the UB-92

In FL 51 (Provider Number), please indicate the Medicaid Provider ID Number on the line that corresponds with the Medicaid Payer line. For example:

If "Medicaid" is in FL 50A, Medicaid PIN should be in FL 51A.

If "Medicaid" is in FL 50B, Medicaid PIN should be in FL 51B.

Medicare Coordinated Claims

For Medicare coordinated claims, Medicaid will cover 100% of the recipient's deductible and coinsurance amounts. MQD has reprocessed the Medicare electronic crossover claims and will be reprocessing the hard copy Medicare coordinated claims. If your Medicare crossover claim was not processed to pay these amounts, the claim can be reprocessed. Fax your affected claims to ACS at 952-5595 along with a note explaining why the claim needs to be reprocessed.

Modifier 32

MQD has determined that for CPT codes in the 9xxxx range, the facility and non-facility distinction for pricing will only apply to the following ranges of codes:

92500 – 92598	95830 - 95857
95970 – 95975	97000 - 97770

Facility and non-facility distinctions continue to apply to all other codes as indicated in the Medicare Provider Disclosure Report. If a service is performed in a setting other than a facility, please include a modifier 32 on your claims.

Claims Tips

Correction to Provider Manual

Prophylaxis and topical fluoride are covered two times per service year. In addition to code D1110 and D1205, code **D1204** is a valid code for children ages 15 through 20. For children from birth through age 14, code D1120, **D1201** and **D1203** are valid codes.

Anesthesia Units

Anesthesia units are rounded up to the nearest tenth of a unit if the amount is .05 or more. It is rounded down to the nearest tenth unit if the amount is less than .05.

One Year Filing Deadline Waivers

Providers are allowed one year from the date of service to file a claim with Medicaid. If the claim being submitted is more than one year old (from the service date), a waiver from the MQD Finance Office, TPL section is required. The MQD Finance Office, TPL section will primarily only approve waivers for TPL reasons (e.g., pursuing a third party payer). If a waiver is approved, the claim must be submitted with the waiver letter attached within 60 days of the date of the waiver letter. As a general rule, MQD will not approve subsequent waiver requests for the same claim.

Value Codes for Medicare and TPL Payments

On the UB-92, value codes A1 and A2 represent the deductible and coinsurance amounts for the payer indicated in FL 50A. It does not represent the deductible or coinsurance amounts if the claim is coordinated with Medicare Part A unless Medicare Part A is the payer in FL 50A. Similarly, value code B1 and B2 represent the deductible and coinsurance amounts for the payer indicated in FL 50B. It does not represent the deductible and coinsurance amounts if the claim is coordinated with Medicare Part B unless Part B is the payer in FL 50B.

Written Correspondence

When sending written correspondence to ACS, please use the Medicaid Correspondence Inquiry Form (on page 10). This will expedite your request and assist with a timely return. Please see cover story for guidelines when sending e-mailed inquiries to ACS.

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Behavioral Health Update

Effective immediately, prior authorization for Medicaid fee-for-service outpatient individual and group psychotherapy and inpatient psychotherapy is no longer required. The claims system will pay for 24 hours of outpatient psychotherapy services and 30 one-hour inpatient individual and group psychotherapy sessions per benefit year.

The CPT codes that do not require prior authorization are:

- Outpatient psychiatric therapeutic procedures – 90804, 90805, 90806, 90807, 90810, and 90811
- Other outpatient psychotherapy – 90847 and 90853
- Outpatient psychotherapy performed by the Department of Health's (DOH's) Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD) clinics
- Inpatient hospital psychotherapy services – 90817, 90819, 90822, 90824, 90827, and 90829. (These services are not covered in a partial hospital or residential care facility – outpatient psychiatric service procedure codes should be used.)

The following psychiatric services that did not require authorization in the past will continue to be provided without authorization:

- Psychiatric diagnostic or evaluative interview – 90801 and 90802 (Only one 90801 or 90802 is allowable per provider for each new hospitalization or new patient evaluation.)
- Other psychiatric services or procedures – 90862

All other outpatient behavioral health services require prior authorization. These services include, but are not limited to, neuropsychological testing, psychological testing, electroconvulsive therapy, and Clozaril case management.

Authorizations for inpatient hospitalization will continue to be required within 5 days of admission for acute psychiatric conditions.

Psychiatric services without medical evaluation and management services (90816, 90818, 90821, 90823, 90826, and 90828) are not covered in partial hospital or residential care facility settings - outpatient psychiatric service procedure codes should be used. Prior authorization for these services is required if performed in the acute inpatient hospital setting.

Hawaii Medicaid does not cover psychiatric therapy services performed in a nursing facility. The only instance in which Medicaid will make a payment for these services is for Medicare crossover claims.

Providers are strongly urged to refer their Seriously Mentally Ill (SMI) adult patients to the Med-QUEST contracted behavioral health program Community Care Services (CCS). CCS is available on all islands for both QUEST and Medicaid fee-for-service patients. CCS will provide your patients with intensive case management, unlimited medically necessary benefits beyond the 24 outpatient hours and 30 inpatient days.

If a provider's claim was denied because either the 24 outpatient hours or 30 inpatient days per year limits were exceeded but the Medicaid recipient had a medical need for services beyond the limit, the provider may ask for an adjustment. Attach a legible treatment plan with measurable goals and legible written justification of the recipient's medical needs to the resubmitted claim. Additionally, an exchange of two outpatient hours for one inpatient day may be requested by submitting a legible written request for this exchange along with the treatment plan and medical justification.

For those patients who are dually eligible for Medicare Part B and Medicaid, authorizations are not required for any behavioral health service covered by Medicare. Medicare requirements and limits must be followed and Medicare must be billed first.

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Home Health Services - Clarification

To expedite Home Health Agency authorizations (DHS Form 1144) please submit BOTH the revenue code(s) and related HCPCs code(s) on all requests.

1144 requests for recipients who have dual Medicare and Medicaid eligibility, but do not meet Medicare's homebound criteria, must clearly and specifically address the medical necessity for home health services. Home health service requests and supporting documentation requiring medical authorization may be dropped off at the ACS office or mailed to:

ACS
P.O. Box 2561
Honolulu, HI 96804-2561.

Urgent PA requests, such as requests for speech evaluation or speech therapy for recipients with dysphagia, may be faxed. Only urgent PAs may be faxed to the ACS urgent request fax line, (808) 952-5562. **Do not fax non-urgent PA requests.**

Notice to Physicians

The DHS Form 1144 (Request for Medical Authorization) is regarded as your prescription for services for the patient and treated the same way as any medication prescription that you sign. By signing the 1144 you are certifying that the supplies/DME/procedures being requested are **medically necessary** for a specific Medicaid recipient. We know that, as a service to you, the vendor may complete some of the information that should be provided by the physician and then forwards the form to the physician for signature. If you sign a blank or an incomplete 1144, return it to the vendor, and have the vendor fill in the blanks, you are legally responsible for the information that you as a physician should provide that supports the Medicaid recipient's medical need for the item because **your signature** is on it. As an analogy, this is similar to signing a blank medication prescription form and letting the pharmacist complete it for you. The same applies to the 1144.

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Medicaid Moving to CDT-4 Codes

Effective immediately please use the new CDT-4 codes listed below. A mapping of the CDT-3 codes to CDT-4 codes that are covered by Medicaid follows:

CDT-3 Codes	Description	CDT-4 Codes	Description
D2110	Amalgam - one surface, primary	D2140	Amalgam - one surface, primary or permanent
D2120	Amalgam - two surfaces, primary	D2150	Amalgam - two surfaces, primary or permanent
D2130	Amalgam - three surfaces, primary	D2160	Amalgam - three surfaces, primary or permanent
D2131	Amalgam - four or more surfaces, primary	D2161	Amalgam - four or more surfaces, primary or permanent
D7110	Extractions, single tooth	D7140*	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7120	Extractions, each additional tooth		
D7130	Extractions, root removal, exposed root		
D7430	Excision of benign tumor - lesion diameter up to 1.25 cm	D7410	Excision of benign lesion diameter up to 1.25 cm
D7431	Excision of benign tumor - lesion diameter greater than 1.25 cm	D7411	Excision of benign lesion greater that 1.25 cm

*Medicaid pays different amounts for code D7140 for primary versus permanent teeth. D7111 (coronal remnants - deciduous tooth) is a non-covered CDT-4 code. Please use code D7140 in its place.

DHS Medicaid Online

Q ***Can I set up master accounts for each of my service locations?***

A No. You are allowed one master account per provider root ID number (6-digits). Once a master account is created for the provider root ID only individual accounts can be created for that provider ID number. When registering, providers are required to enter the full 8-digit PIN. However, a master account can be created using any one of the 8-digit PINs.

Q ***Once I have registered for a master or individual account, how long do I have to authenticate the account?***

A You will have 30 days from the date the account was created to activate it.

Q ***Once I have registered for an individual account, how long will it take before I can log in?***

A Upon completion of the registration process, the master account holder for your provider ID number will receive an e-mail notifying him or her that there is an account waiting to be activated. The e-mail notification is automatically generated, so the amount of time it takes to activate the individual account is dependent upon the master account holder.

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Good to Know . . .

Resubmission Process

On the UB-92, enter "Resubmission" in FL 2. In FL 4, enter bill type "xx6" to adjust or "xx8" to void. Enter the original claim reference number (CRN) in FL 37A.

On the CMS-1500, write "Resubmission" on the upper right hand corner of the claim. In FL 22, enter "A" to adjust or "V" to void along with the original CRN (in FL 22A).

In the upper right hand corner of the ADA 1999 v. 2000, write "Resubmission." In FL 2 (under Prior Authorization #) enter "A" to adjust or "V" to void along with the original CRN.

On all claim forms, circle the changes and send the resubmission directly to the Claims P.O. Box: ACS, P.O. Box 1220, Honolulu, HI 96807-1220. All valid claim lines should be listed on the resubmission. The resubmitted claim will replace the old claim and adjustments will be made accordingly.

Outpatient Rehabilitation Therapy - Documentation

The CMS-700 and the CMS-701 forms are not required as long as:

a. The initial rehabilitation therapy evaluation is submitted with all initial requests, and
b. The re-evaluation and/or progress notes is/are submitted with 1144 requests for extended/continued therapy.

Please specify the anticipated frequency and duration of therapy in all 1144 requests.

Changes in Recipient Age

For Medicaid billing purposes, a recipient's age does not change until the first of the month following his/her birthday. For example, if a recipient's birthday is June 23rd, for billing purposes, the recipient's age will change in HPMMIS on July 1st. This is important to remember when billing age-specific CPT/HCPCS codes.

Please note the following changes when billing for surgical trays:

Tray	Coding	Description	Rate
Small tray	A4550	Suture removal, dressing change	$ 5.20
Medium tray	A4550, mod 52	Surgical procedures valued less than 10 surgical units or allowance less than $200	$ 20.80
Large tray	A 4550, mod 22	Surgical procedures valued at more than 10 surgical units or allowance greater than $200	$ 41.60

Trays are ONLY payable in non-facility settings.

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Top 4 Reasons Claims are Returned to Providers

Reason	Corrective action	Indicate in appropriate field locator		
		CMS-1500	UB-92	ADA 1999 v. 2000
Invalid provider ID number (PIN)	Use the 8-digit PIN, 6 base digits and a 2-digit location code separated by a dash, e.g. 123456-01.	FL 33	FL 51	FL 44
Signature is missing	Person authorized to sign for claims on behalf of the provider must sign all claims submitted to Medicaid. A rubber stamp may be used, but it must be initialed by the authorized party.	FL 31	FL 85	FL 62
Recipient HAWI ID number is missing	Use the recipient's complete and correct 10-digit HAWI ID number. Do not omit the leading zeros. Do not include the check digit. The correct HAWI ID format can be found on the recipient's plastic ID card.	FL 1a	FL 60	FL 13
Tax ID number is missing	All claims submitted to Medicaid must include the provider's tax ID number or Social Security number. This information must match the information (TIN or SSN) provided on the provider's enrollment form.	FL 25	FL 5	FL 45

Adjustment Claims

All adjustments must be filed through the proper resubmission process. Please do not send adjustment requests to the ACS Written Correspondence Associate. Examples of adjustments include correcting overpayments, increasing number of units, changing codes, etc. Please include the original claim reference number (CRN) on all resubmissions. See page 6 for complete resubmission process. Effective immediately, the Medicaid program will allow providers to file adjustments to claims up to six months from the date of payment. Please remember there are no time restrictions on repayments to the Medicaid program.

Good to know . . .

Outlier Claims

Effective immediately, Classification II and III acute care hospitals that submit outlier claims with Type of Bill 113 and 114 and that do not have arrangements with the Med-QUEST Division to conduct on-site medical record reviews must submit the following medical records with the claims.

1. Admission History and Physical
2. Discharge Summary
3. Physician and Nursing Progress Notes
4. Medication Administration Record
5. Intake and Output Records for the duration patient is on intravenous fluids

Progress notes, medication administration records and intake and output records should be from the date of admission through the final date of service on the claim.

Claims submitted without all of the above medical records will be denied.

Office Visits and Preventive Medicine Visits

Only one evaluation and management code will be paid per day. If a preventive medicine service (99381 to 99387, 99391 to 99397) is billed with another evaluation and management code, the preventive medicine service will be paid and the other evaluation and management service will be denied on prepayment or postpayment review. If Medicare (or other third party payor) has made reimbursement for the other evaluation and management service, the coinsurance for the other evaluation and management service will be paid and the preventive medicine service will be denied on postpayment review.

Procedures Done at One Session

All procedures done at one session should be billed as one claim. Multiple CMS-1500 forms should be used, if necessary, but there should only be one total charge.

Clarification on Refraction and Ophthalmology Separate Procedures

Claims for refraction (92015), gonioscopy (92020), sensorimotor examination (92060), and serial tonometry (92100) that are submitted with an evaluation and management code for the same date of service will be denied on prepayment or postpayment review as included in the evaluation and management service. Therefore, claims for these ophthalmology services should not be submitted if a claim for an evaluation and management service is being submitted or has been submitted for the same date of service. A claim for refraction should not be submitted to Medicaid if a claim for an evaluation and management service has been submitted to Medicare. Evaluation and management codes include office and other outpatient services, hospital inpatient services, outpatient and inpatient consultations, and general ophthalmological services (92002, 92004, 92012, 92014). This is a longstanding Medicaid policy.

Modifier 22- Unusual Procedural Service

Claims submitted for an evaluation and management service or procedural service with modifier 22 must include documentation that supports additional payment for the service. If documentation is not submitted or if documentation does not support additional payment, the claim will be paid at the usual allowance.

Modifer 62 – Two Surgeons

Claims submitted with modifier 62 should include the percentage of the total allowance that each surgeon will receive in form locator (FL) block 19 or 21 on the HCFA 1500 claim form. If no percentage is indicated, each surgeon will be paid 62.5%. An operative report and/or documentation supporting the necessity of two surgeons is required, unless the procedure is designated "2" in the Medicare Provider Disclosure Report and the two specialty requirement is met.

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Clarification of Add-on Procedures

Multiple surgery rules that apply to the primary procedure used in conjunction with an add-on code will be applied to the add-on code. For example, if the following CPT codes are billed:

64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level (primary code)
64476	lumbar or sacral, each additional level (add-on code)
64483	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level (primary code)
64484	lumbar or sacral, each additional level (add-on code)

The first procedure listed, 64475, and its add-on code, 64476, will be paid at 100% of the allowance. Multiple surgery rules will be applied to the second procedure, 64483, and its add-on code, 64484, and both will be paid at 50% of the allowance.

Thoracic Electrical Bioimpedance

The correct CPT code for cardiac monitoring by electrical bioimpedance is 93701.

Cardiac output measurement and related parameters by electrical bioimpedance is covered only in the following clinical circumstances:

1. Noninvasive diagnosis or monitoring of hemodynamic parameters in patients with suspected or known cardiovascular disease. This indication will be limited to the following specific clinical situations:

a. The patient with known cardiac disease who is about to undergo invasive cardiac/non-cardiac intervention and for whom the issue of left ventricular dysfunction is a key factor in that patient's potential morbidity and for whom there is no recent other cardiac output determination.

b. The patient with established but uncompensated heart failure in whom determination of cardiac output is needed to provide optimal therapy.

2. Differentiation of cardiogenenic from pulmonary causes of acute dyspnea.

3. Optimization of atrioventricular interval for a patient with an AV sequential cardiac pacemaker who has dyspnea, fatigue or suspected heart failure.

4. The patient with established heart failure for whom intravenous inotropic therapy is being considered.

5. The post-heart transplant patient requiring myocardial biopsy.

6. The critical care patient requiring optimal fluid management (in hospital settings).

Progress notes justifying the use of cardiac electrical bioimpedance must be submitted with the claim. The report of the bioimpedance test (hemodynamic status report) alone is not sufficient.

ACS State Healthcare
1440 Kapiolani Blvd., Ste. 1400
Honolulu, HI 96814-369

MEDICAID CORRESPONDENCE INQUIRY FORM

1. Date of Inquiry	2. Provider Name (Last, First, Middle Initial)		
3. Provider Number	4. Address ❑ Pay to Address ❑ Service Address		
5. Telephone Number	6. Name of Contact	7. Correspondence Number	
8. Claim Number (if applicable) Procedure	9. Purpose of Inquiry: ❑ Questionable Payment ❑ Adjustment/Correction ❑ Claims Status ❑ Claims Filing ❑ Other:		
10. Patient Name	11. Patient ID Number	12. FM Code	
13. Dates of Service	14. Payment Date	15. Charge	16. Allowance
17. Remarks			

18. Response to Provider: **(For Office Use Only)**

- ❑ Claim Paid on _____
- ❑ Denied on _____ Reason: _____
- ❑ Claim Reviewed, Maximum payment made.
- ❑ Adjustment claim initiated.
- ❑ Please submit claim with _____
- ❑ Patient name and ID # not in DHS files.
- ❑ Claim is in the processing system. Please allow additional processing time.
- ❑ Referred to DHS for determination and response directly to you.
- ❑ Unable to match above claim data with computer file data. Please submit copy of claim.

Comments: _____

A C S

State Healthcare
1440 Kapiolani Boulevard, Suite 1400 • Honolulu, HI 96814