Medicaid

Provider Bulletin

Published for the Medicaid Providers of Hawaii

May 2007 **Volume 5 Issue 2**

NPI CONTINGENCY PLAN

Following the NPI Contingency Plan announcement by CMS on Monday, April 2, 2007, the Med-QUEST Division (MQD) began to develop options for the Hawaii Medicaid NPI Contingency Plan.

Based on concerns expressed by many providers regarding their preparedness, MQD has decided to implement its contingency plan.

Effective immediately MQD will implement its NPI contingency plan for Fee For Service (FFS) claims submitted to the Medicaid Fiscal Agent, ACS. This contingency plan will be in effect until **August 1, 2007.**

During the contingency plan period, providers can submit claims or prior authorization requests using either their NPI or Hawaii Medicaid provider number. Claims submitted without NPI during the contingency plan period will not be denied for NPI.

The contingency plan will also include the use of new claim forms. Providers can continue billing using the old claim forms, CMS 1500 (12-90) and UB-92, until **August 1, 2007**. Providers using the old forms must bill using only their Hawaii Medicaid provider number, as there is no option for NPI on the old forms.

If you have your NPI enumeration letter and have yet to submit it, you have the following options:

Mail: Department of Human Services
Med-QUEST Division-HCMB, Provider Relations
PO Box 700190
Kapolei, HI 96709-0190
FAX: (808) 692-8087
Email: NPIHI@acs-inc.com

In this edition...

NPI CONTINGENCY PLAN	1
NEW CLAIM FORMS	1
CMS 1500 CROSSWALK	2
CMS 1500 CLAIM EXAMPLE	3
CMS 1500 BILLING REQUIREMENTS	4-6
UB-92 TO UB-04 CROSSWALK	7
UB-04 CLAIM EXAMPLE	8
UB-04 BILLING REQUIREMENTS	9-11
SUBMITTING AN ADJUSTMENT OR VOID ON THE NEW CLAIM FORMS	12
MEDICARE CODE PR-49	12
ADDITIONAL INFORMATION FOR THE CMS 1500	12
DMO AND AVRS ACCESS	13
WINASAP UPGRADE	13

Pass It On!

Everyone needs to know the latest about Medicaid information. Be sure to route this to:

- ☐ Office Manager
- ☐ Billing Department
- ☐ Medical/Clinical Professionals
- ☐ Other Support Staff

CMS 1500 (12/90) TO CMS 1500 (08/05) CROSSWALK

Data Element	HCFA	CMS FL	Data Element	HCFA FL	CMS FL
Type of Health Insurance	1	1	Diagnosis or Nature of Illness or Injury	21	21
Insured's ID Number	1a	1a	Medicaid Resubmission	22	22
Patient's Name	2	2	Prior Authorization Number	23	23
Patient's Birth Date, Sex	3	3	Date(s) of Service [lines 1-6]	24A	24A
Insured's Name	4	4	Place of Service [lines 1-6]	24B	24B
Patient Address	5	5	Type of Service	24C	Deleted
Patient Relationship to Insured	6	6	EMG [lines 1-6]	24I	24C
Insured's Address	7	7	Procedures, Services, or Supplies [lines 1-6]	24D	24D
Patient Status	8	8	Diagnosis Pointer [lines 1-6]	24E	24E
Other Insured's Name	9	9	$ Charges [lines 1-6]	24F	24F
Other Insured's Policy or Group Number	9a	9a	Days or Units [lines 1-6]	24G	24G
Other Insured's Date of Birth, Sex	9b	9b	EPSDT/Family Plan [lines 1-6]	24H	24H
Employer's Name or School Name	9c	9c	COB	24J	24A Gray
Insurance Plan Name or Program Name	9d	9d	ID Qualifier [lines 1-6]	Unlabeled	24I
Is Patient's Condition Related to:	10a—10c	10a—10c	Rendering Provider ID# [lines 1-6]	Unlabeled	24J
Reserved for Local Use	10d	10d	Reserved for Local Use	24K	Deleted
Insured's Policy, Group, or FECA Number	11	11	Federal Tax ID Number	25	25
Insured's Date of Birth, Sex	11a	11a	Patient's Account Number	26	26
Insured's Employer's Name or School Name	11b	11b	Accept Assignment	27	27
Insurance Plan Name or Program Name	11c	11c	Total Charge	28	28
Is there another Health Benefit Plan?	11d	11d	Amount Paid	29	29
Patient's or Authorized Person's Signature	12	12	Balance Due	30	30
Insured's or Authorized Person's Signature	13	13	Signature of Physician or Supplier	31	31
Date of Current Illness, Injury, Pregnancy	14	14	Service Facility Location Information	32	32
If Patient Has Had Same or Similar Illness	15	15	NPI #	Unlabeled	32a
Dates Patient Unable to Work in Current Occupa-	16	16	Other ID #	Unlabeled	32b
Name of Referring Provider or Other Source	17	17	Billing Provider Info & Ph #	33	33
Other ID #	17a	17a	NPI #	Unlabeled	33a
NPI #	Unlabeled	17b	Other ID #	33	33b
Hospitalization Dates Related to Current Services	18	18			
Reserved for Local Use	19	19			
Outside Lab? $ Charges	20	20			

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. PATIENT STATUS — Single Married Other

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

Employed — Full-Time Student — Part-Time Student

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) — YES NO

a. INSURED'S DATE OF BIRTH MM | DD | YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY — SEX M F

b. AUTO ACCIDENT? — YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? — YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PATIENT AND INSURED INFORMATION

Sample

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM MM | DD | YY — TO MM | DD | YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM MM | DD | YY — TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
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) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED ____________ DATE ____________

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI — b.

33. BILLING PROVIDER INFO & PH # ( ) — a. NPI — b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
1	Provider Name, Address, & Phone #	Required	Indicate the type of insurance coverage applicable to this claim by placing an "X" in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Required	Insured's ID number as shown on the Medicaid ID card (HAWI ID #).
2	Patient's Name	Required	Patient's full name as it appears on the Medicaid ID card.
3	Patient's Birth Date, Sex	Required	Patient's birth date (MM/DD/YYYY). Enter an "X" in the appropriate box to indicate the sex of the patient.
5	Patient's Address	Required	Patient's street, city, state, zip code, area code and phone #.
6	Patient Relationship to Insured	Required	Enter an "X" in the correct box to indicate the patient's relationship to insured.
9	Other Insured's Name	Conditional	If FL11d is marked, complete fields 9, 9a, and 9d. Otherwise leave blank. When additional health coverage exists, enter the other insured's full name if it is different from that shown if FL2.
9a	Other Insured's Policy or Group Number	Conditional	Policy or group number of the other insured.
9d	Insurance Plan Name or Program Name	Conditional	Other insured's plan or program name.
10a-c	Is Patient's Condition Related to:	Required	Indicate whether the patient's condition is a result of an employment, auto, or other type of accident.
11	Insured's Policy, Group, or FECA Number	Conditional	If the patient has another TPL, indicate the TPL policy number. If FL4 is complete, this field should be completed.
11c	Insurance Plan Name or Program Name	Conditional	Insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?	Conditional	Enter an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	Patient's or Authorized Person's Signature	Required	Patient's or authorized person's signature releases any medical or other information necessary to process a claim. If the signature is on file, indicate "Signature on file" and date.
14	Date of Current Illness, Injury, Pregnancy	Conditional	Enter the first date of the present illness, injury, or pregnancy (MM/DD/YY).
17	Name of Referring Provider or Other Source	Conditional	Name and credentials of the referring physician are only required for consults (99241—99275). Leave blank if not a referral.

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
17a	Other ID #	Conditional	Medicaid qualifier "1D" and the legacy number is required when referring physician is an atypical provider.
17b	NPI#	Conditional	Enter the NPI of the referring provider.
18	Hospitalization Dates Related to Current Services	Conditional	Required for hospitalizations only. Enter the admit date followed by the discharge date. If not discharged, leave discharge date blank (MM/DD/YY).
19	Reserved for Local Use	Conditional	If it is known that the TPL does not cover a certain service, a denial does not have to be obtained, but you must indicate "Not a (name of TPL) covered service".
21	Diagnosis or Nature of Illness or Injury	Required	List up to 4 ICD-9 CM diagnosis codes. Relate lines 1, 2, 3, 4 to the lines of service in FL24E by line number. Use the highest level of specificity. Do not add provider narrative in this field.
22	Medicaid Resubmission	Conditional	Required for resubmissions only. Enter "A" (to adjust) or "V" (to void). Also enter the original 12-digit claim reference number.
23	Prior Authorization Number	Conditional	Waiver providers must indicate a "W".
24A	Date(s) of Service [lines 1-6]	Required	Date(s) of service, from and to. If only one date of service, enter that date under "From". Leave "To" blank or re-enter "From" date. **
24B	Place of Service [lines 1-6]	Required	Enter the 2-digit place of service. **
24C	EMG [lines 1-6]	Conditional	Required for emergency services. Enter "Y" for YES or leave blank if NO. **
24D	Procedures, Services, or Supplies [lines 1-6]	Required	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set on the date of service. **
24E	Diagnosis Pointer [lines 1-6]	Required	Enter the diagnosis reference number (pointer) as shown in FL21 to relate the date of service and the procedures performed to the primary diagnosis. **
24F	$ Charges [lines 1-6]	Required	Do not add commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number. Symbols that denote no charge for service, such as "N/C" and slashes or dashes are not a valid charges of service.

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
24G	Days or Units [lines 1-6]	Required	Enter the number of services, visits or days applicable to each line. If field is left blank, the number is assumed to be 1. **
24H	EPSDT/Family Plan [lines 1-6]	Conditional	For Early & Periodic Screening, Diagnosis, and Treatment relates services. Enter a "E" only when requesting follow-ups for catch-up and preventative services. **
24I	ID Qualifier [lines 1-6]	Conditional	Enter qualifier "1D" if the provider number is a non-NPI. **
24J	Rendering Provider ID # [lines 1-6]	Required	Effective August 1, 2007 the NPI must be indicated in the un-shaded region. If an atypical provider, enter the legacy number in the shaded area.
25	Federal Tax ID Number	Required	Enter the provider of service or supplier's Federal Tax ID (employer identification number) or Social Security Number. Enter an "X" in the appropriate box to indicate which number is being reported.
27	Accept Assignment	Required	Enter an "X" in the correct box. Only one can be marked. Medicaid requires YES to be checked.
28	Total Charge	Required	Sum of total line charges. (I.e., total of all charges in FL24F).
31	Signature of Physician or Supplier	Required	Signature of Physician or Supplier Including Degrees or Credentials.
32	Service Facility Location Information	Conditional	If the service was rendered in a Facility or Hospital, or if different from billing address, enter the name and address of the facility.
32a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the service facility.
32b	Other ID #	Conditional	Enter the Medicaid qualifier "1D" followed by the Legacy number (for atypical providers).
33	Billing Provider Info & Ph #	Required	Enter the provider's or supplier's billing name, address, and phone number.
33a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the billing provider.
33b	Other ID #	Conditional	Enter the Medicaid qualifier "1D" followed by the Legacy number (for atypical providers).
NOTE			** denotes that the information must be indicated in the un-shaded section of the field.

UB—92 TO UB—04 CROSSWALK

Data Element	UB-92 Field Locator	UB-04 Field Locator
Provider Name, Street, City, State, Zip & Phone	1	1
Paid-to-Name, Address, City, State, Zip	Unlabeled	2
Patient Control Number	3	3a
Type of Bill	4	4
Federal Tax Number	5	5
Statement Covers Period– From/Through	6	6
Admission Date	17	12
Admission Hour	18	13
Type of Admission/Visit	19	14
Source of Admission	20	15
Discharge Hour	21	16
Patient Status/Discharge Code	22	17
Medical Record Number	23	3b
Condition Codes	24—30	18—28
Occurrence Code/Date	32—35	31—34
Occurrence Span Code From/Through	36	35 & 36
ICN/DCN	37	64
Value Code/Amount	39—41	39—41
Revenue Code	42	42
Revenue Code Description	43	43
Page of	Unlabeled	43
HCPCS/Rates/HIPPS Rate Codes	44	44
Service Date	45	45
Creation Date	Unlabeled	45
Units of Service	46	46
Total Charges	47	47
Non-covered Charges	48	48
Payer– Primary, Secondary, Tertiary	50	50
Provider Number	51 (Provider Number)	51 (Health Plan ID)
Prior Payments– Primary, Secondary, Tertiary	54	54
NPI	Unlabeled	56
Other Provider ID– Primary, Secondary, Tertiary	Unlabeled	57
Insured's Name	58	58
Principal Diagnosis Code	67	67
Other Diagnosis	68—75	67
Admitting Diagnosis Code	76	69
Patient's Reason for Visit	76	70
Principal Procedure Code/Date	80	74
Other Procedure Code/Date	81	74
Attending Physician ID	82	76 (NPI/QUAL/ID)
Remarks (Reduced Field Size)	84	80
Signature	85	At the bottom of the form
Date	86	At the bottom of the form

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO. / 6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME a b

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | ADMISSION: 12 DATE, 13 HR, 14 TYPE, 15 SRC | 16 DHR | 17 STAT | CONDITION CODES: 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT (a, 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							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME (A, B, C) | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME (A, B, C) | 59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES (A, B, C) | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H / I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample

Medicaid Billing Required Fields for the UB—04

FL #	Field Name	Requirement	Information Required
1	Provider Name, Address & Ph #	Required	Enter the provider's name, and service address and ph #.
2	Pay-to Name, Address, and Secondary ID	Conditional	Required when the pay-to name and address information is different than the Billing Provider information in FL1.
4	Type of Bill	Required	This is a 3-digit alphanumeric code that identifies the type of facility, type of care, and the bill sequencing.
5	Federal Tax #	Required	Enter the Provider's Tax ID #.
6	Statement Covers Period	Required	From and through dates for this billing period (MM/DD/YY).
8b	Patient Name	Required	Medicaid Recipient's last name, first name and middle initial as it appears on their Medicaid ID card.
9	Patient Address	Required	Patient's street number and name or post office box, city, state and zip code.
10	Patient Birth Date	Required	Month, day and year of the recipient's birthday (MM/DD/YYYY). This information must correspond with the birthday on the Medicaid ID card.
11	Patient Sex	Required	Enter "M" for male, "F" for female.
12	Admission Date	Conditional	Required if patient was admitted (MM/DD/YY).
13	Admission Hour	Conditional	Required if patient was admitted. (01—24 hrs.).
14	Type of Admission / Visit	Conditional	Required if patient was admitted. Enter the admission type code.
16	Discharge Hour	Conditional	Discharge hour is required if patient is discharged on end date of service. This field must be left blank if no discharge hour applies. "00" is not a valid entry (01—24 hrs.).
17	Patient Status	Conditional	Required if the patient was admitted. Enter patient status code.
18-28	Condition Codes	Conditional	Enter condition codes that apply.

Medicaid Billing Required Fields for the UB—04

FL #	Field Name	Requirement	Information Required
31-34	Occurrence Code/Date	Conditional	If occurrence code is billed, a corresponding date must be billed (MM/DD/YY).
35-36	Occurrence Span Code/Date	Conditional	If occurrence code is billed, occurrence span date (both from and to date) is required (MM/DD/YY).
39-40	Value Codes	Conditional	When Medicare is the TPL, coinsurance/deductible amount must be indicated along with the corresponding value code.
42	Revenue Code	Required	Enter the appropriate 4-digit revenue codes to identify specific accommodation and / or ancillary charges.
44	HCPCS/Rates	Conditional	Required for outpatient services (except for outpatient rev. codes 025x or 063x). Enter the HCPCS code for all services.
45	Service Date [lines 1-22]	Conditional	Required for outpatient services. Each non-consecutive date should be billed on a new service line (MM/DD/YY).
45	Creation Date [line 23]	Required	Date of signature (MM/DD/YY).
46	Units of Service	Required	Required when billing with revenue codes.
47	Total Charges	Required	Sum of charges. You will no longer be required to use revenue code 0001 to sum charges.
48	Non-covered Charges	Conditional	Non-covered charges must be indicated here.
50A-C	Payer Name	Required	Enter the names of the appropriate payers listed in order of primacy (primary payer on line A, secondary on line B and tertiary on line C). Indicate “Medicaid” as the payer on the appropriate line.
54	Prior Payments	Conditional	Required when TPL applies. Enter the total amount paid by TPL on every line. If no payment was made, enter “0”.
56	NPI	Required	10-digit NPI required after August 1, 2007.

Medicaid Billing Required Fields for the UB—04

FL #	Field Name	Requirement	Information Required
58	Insured's Name	Conditional	On the same lettered line (A,B, or C) that corresponds to the line on which Medicaid payor information is shown in FLs 50-54, enter the patient's name as shown on the Medicaid ID card.
59	Patient's Relationship to Insured	Conditional	Required only if patient is covered by someone else's insurance.
60	Insured's Unique ID	Required	On the same lettered line (A,B, or C) that corresponds to the line on which Medicaid payor information is shown in FLs 50-54, enter the patient's 10-digit HAWI ID.
61	Insurance Group Name	Conditional	Indicate the insurance group name that coordinates with the insured indicated in FL58 A-C.
62	Insurance Group #	Conditional	Enter the ID #, control # or code assigned by the appropriate insurance carrier that corresponds to group FL61 A-C.
64	Document Control #	Conditional	Required for resubmission. The original 12-digit claim reference number must be indicated in FL64 A.
67	Principal Diagnosis Code	Required	Enter the Principal Diagnosis Code.
67A-Q	Other Diagnosis Codes	Conditional	Hawaii Medicaid allows for the entry of up to 10 diagnosis codes. Providers may not duplicate the principal diagnosis listed in FL67.
69	Admitting Diagnosis Code	Conditional	Required if the patient was admitted.
74	Principal Procedure Code & Date	Conditional	Required on inpatient claims when a procedure was performed. Not used on outpatient claims.
76	Attending– NPI/Qual/ID	Required	Required when the claim contains any services other than non-scheduled transportation services.
80	Remarks	Conditional	Enter remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. (I.e. "Not a three day qualifying stay" or "Not a TPL/Medicare covered benefit").
85/86	Provider Representative Signature/Date	Required	Enter the Signature and date at the bottom of the claim form.

N P I H E L P F U L H I N T S

SUBMITTING AN ADJUSTMENT OR VOID ON THE NEW CLAIM FORMS

Effective May 23, 2007, provider will be required to use the new UB 04 and the CMS 1500 claim forms when submitting an Adjustment or a Void. To ensure correct processing of the claims please be sure to do the following:

- To void: draw a line through the unwanted claim detail line
- To adjust: draw a circle around the claim detail line **(only changes that are circled will be processed)**
- Adjustment claims are treated as replacement claims
- CMS 1500: Write “Resubmission in the upper right hand corner of the claim. In FL22 enter an “A” to adjust or “V” to void along with the original CRN.
- UB04: Write “Resubmission” at the top of the claim form. In FL4 enter bill type “XX6” to adjust or “XX8” to void. Enter the original 12-digit CRN in FL64 A.

Resubmitted claims must reflect the original number of claim lines. If the resubmission has less line, ACS will return the claim to the provider (RTP).

MEDICARE REASON CODE PR-49

Med-QUEST has revised coverage guidelines for services denied by Medicare with reason code PR-49-non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

Lab services in the CPT procedure range 80000 to 89999 are not allowed when the only diagnosis present on the claim is VXX.

Medicare does not cover procedures 92002, 92004, 92012, 92014, 99381 to 99387, 99391 to 99397, G0141 and G0147 if the procedure is routine exam or a screening procedure. However Medicaid does cover these services. Providers may bill these claims to ACS within regular service limits with the Medicare EOMB attached.

ADDITIONAL INFORMATION FOR FORM LOCATOR 24 ON THE CMS 1500

Below are examples of how additional information is to be entered into the shaded region of FL24. These examples were referenced from the National Uniform Claim Committee Instruction Manual.

Anesthesia Services

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7Begin 1245 End 1415 Time 90 minutes															
10	01	05	10	01	05	22		00770	P2	134	875 00	90		NPI	0123456789

Miscellaneous Code

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker															
10	01	05	10	01	05	12		E1399		12	165 00	1		NPI	0123456789

NDC Code, Modifier and Units (NDC units must be indicated in the shaded region of FL24G)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400026064871 Immune Globulin Intravenous UN2													N	1B	12345678901
10	01	05	10	01	05	11		J1563		13	500 00	20	N	NPI	0123456789

DMO AND AVRS ACCESS

If you are a provider who is required to have an NPI, you will soon be required to have your NPI on file with MQD in order to access both the DMO website and the AVRS. Both applications have been ruled standard transactions, thus they are not exempt from the NPI requirement.

You will not be required to re-register to access the DMO website, however, if your NPI is not on file you will receive an error message and access will not be granted.

When accessing the AVRS, you will be provided an additional option for your NPI. If you are required to have an NPI, you would simply choose to search using your NPI rather than your legacy ID. If your NPI is not on file, access will not be granted.

WINASAP 2003 NPI UPGRADE

If you are required to have a National Provider Identifier (NPI) and currently bill using WINASAP 2003 version 5.9 or older, you must update your software immediately. Older versions of WINASAP 2003 will not accommodate the NPI field.

Before you begin, you will need to check what version of WINASAP 2003 you are using. To do this open the program and click HELP then ABOUT. The version of WINASP is located on the left side of the window under the green globe. If your version shows 5.10 then you do not need to run the upgrade. If your version shows 5.9 or older, please follow the upgrade instructions below:

WINASAP 2003 NPI UPGRADE (cont)

1. Download the newest version of WINASAP
   - log onto the internet and go to www.acs-gcro.com
   - click on the red link on the left side of the page
   - scroll to the bottom of the page and click on “Click Here to Download the WINASAP Software”
   - click on the WINASAP software icon to start
   - click on “Save” and save the program to your desktop
   - after the download is complete, click “Open”

2. Install the new version of WINASAP
   - follow the screen prompts (listed below) after the WINASAP Install Shield launches
     - click “Continue”
     - click “Next”
     - click “Yes”
     - enter your name and click “Next”
     - click “Next”
     - click “Next”
     - click “Yes” and save the backup to your desktop
     - Click “Yes” to replace the existing file
     - Click “Launch WINASAP 2003” and then “Finish”

3. Restore the Backup File to the new WINASAP
   - once WINASAP launches, enter your password
   - click “Ok” should any messages pop up
   - select the appropriate payor from the list (Hawaii Fee For Service or Hawaii Waiver) and click “Ok”
     - should you bill for both payers, choose one– both will be restored
   - click on TOOLS and then RESTORE DATABASE
   - click “Yes” to restore database from backup file
   - click “Yes” to include payor table
   - restore is now complete

4. Adding your NPI to your WINASAP profile
   - click on REFERENCE then PROVIDER
   - click on the provider name and click “Change”
   - choose “HCFA National Provider ID” from the Provider ID Type pull down list
   - enter your 10 digit NPI in the Provider ID field
   - click “Next Page”
   - select either “Employer Identification Number” or “Social Security Number” from Identification Type pull down list
   - enter your 9-digit Tax ID into the Identification Number field (do not include any dashes)
   - click “Save”

May 2007 Volume 5 Issue 2

Hawaii Medicaid

Look inside for these and other important updates:

Page 1 NPI Contingency Plan
Page 2 CMS—1500 Crosswalk
Page 3 CMS—1500 Required Fields
Page 7 UB—04 Crosswalk
Page 8 UB—04 Required Fields
Page 12 Additional Information for the CMS—1500
Page 13 DMO and AVRS Access

A C S®
State Healthcare
1440 Kapiolani Blvd, Suite 1400
Honolulu, HI 96814