Medicaid

Provider Bulletin

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GUIDELINES FOR TIMELY FILING OF CLAIMS AND REQUEST FOR RECONSIDERATION OF PAYMENT (FORM 240)

The Med-QUEST Division would like to clarify the current rules for timely filing of claims and request for reconsideration of payment (Form 240).

These guidelines are outlined in Code of Federal Regulations (CFR) and Hawaii Administrative Rules (HAR) as referenced below:

42 CFR §447.45 (d): Timely processing of claims (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

Hawaii Administrative Rule §17-1739.1-16: Time limit for claims submittal and one year claim filing deadline waiver request.

(a) The provider shall submit all claims for payment within twelve months from providing care or services. No Medicaid payment shall be made for any claim submitted after this period except as allowed by subsection (c) and (d). Subsections (c) and (d) provide exceptions for payment after the 12-month period for delays caused by specific Medicare/TPL coverage issues and for waivers by DHS as a result of court orders, administrative hearings, or corrective action. Please refer to **http://hawaii.gov/dhs/main/har/har_current/1739.1.pdf** for further details on subsection (c) and (d).

(b) In cases where the provider disputes the department's allowance or claim adjudication, **a request for reconsideration of the payment amount or adjudication must be made within sixty days** of the Medicaid payment or claim adjudication date. The Medicaid payment or claim adjudication date is the date on the remittance advice or the date on the explanation of benefits (EOB).

Based on these guidelines, providers have one year from the date of service to submit, resubmit or adjust a claim. Any submission that exceeds the one year timely filing deadline will require a timely filing waiver.

If you dispute the Division's adjudication of a claim, you are able to submit a request for reconsideration via the 240 Form within sixty days from the Medicaid payment or claim adjudication date.

Please disseminate these guidelines to your billing offices to comply with the rules for timely filing and requests for reconsideration of payment.

In this edition...

Pass It On!

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

- ❑ Office Manager
- ❑ Billing Department
- ❑ Medical/Clinical Professionals

Provider Inquiry Agents are available to answer provider questions by calling 952-5570 from Oahu or (800) 235-4378 from the neighbor islands.

RADIOLOGY AND SLEEP STUDY CLAIMS

To ensure the proper processing of the professional component of a radiology or a sleep study claim that is performed in an inpatient or outpatient hospital setting (POS 21 or 22), please include the Service Facility Location (FL32) information on the claim form.

When billing these types of claims electronically, you will need to indicate the Service Facility on the "Claim Notes" section.

UPDATE:

ELIGIBILITY TERMINATES IN THE MIDDLE OF CONFINEMENT

When client eligibility terminates for Medicaid Fee For Service during an acute non-outlier inpatient stay, the claim should be billed accordingly.

- Type of Bill: 112
- Statement Covers Period: the through date should equal the end date of eligibility
- Patient Status: 30
- Condition Code: 61

PROCESSING CLAIMS WITH MEDI-GAP INSURANCE

To expedite processing of claims with Medi-Gap insurance, you **must** enter the Medi-Gap insurance plan / program name in FL 9d on the CMS 1500 form and FL 50 on the UB 04 form. Please be sure to also attach a copy of the EOB to the claim.

Some examples of Medi-Gap plans are:

- Aloha Care Advantage
- Aloha Care Advantage Plus
- HMSA 65C+
- Health Net: Pearl Option
- Humana: Gold Choice
- Kaiser Senior Advantage
- Sterling Life Insurance: Sterling Option II
- UniCare: Save Well– Plan I and II
- UniCare Life and Health Insurance: Security Choice Classic or Security Choice Enhanced
- United Healthcare: Medicare complete, Evercare or Secure Horizons
- WellCare: Summit, Duet or Concert

If a claim is received and it does not have the Medi-Gap insurance plan / program name on the claim form, and a EOB attached, your claim will be denied.

HAWAII MEDICAID CONTACT INFORMATION

Mailing addresses will be changed to the following:

Mail MQD Claims to:
Hawaii Medicaid Fiscal Agent
PO Box 1220
Honolulu, HI 96807-1220

Mail SSD Waiver Claims to:
Hawaii Medicaid Fiscal Agent
PO Box 1220
Honolulu, HI 96812-1220

Mail Prior Authorization requests to:
Hawaii Medicaid Fiscal Agent
PO Box 1220
Honolulu, HI 96804-1220

Mail returned checks to:
Hawaii Medicaid Fiscal Agent
PO Box 1480
Honolulu, HI 96807-1480

Provider Inquiry Unit
- Oahu: 952-5570
- Neighbor Islands:
- 1-800– 235-4378

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

Fax Provider inquiries to:
- 1-808-952-5595
- 1-800-246-8197

Fax urgent Prior Authorization requests to:
- 1-808-952-5562

EDI Helpdesk:
- 952-5583
- 1-888-333-5641
- Email: hi.ecstest@acs-inc.com

Email Provider inquiries to:
- Hi.providerrelations@acs-inc.com

Claims are not accepted via fax. Providers who submit hardcopy claims must ensure that the providers signature or signature stamp is on each claim with the inked initials of an authorized person.

UPDATE TO FEBRUARY 2007 BULLETIN

INPATIENT HOSPITAL STAY-SURGICAL CATEGORY OF SERVICE REIMBURSEMENT

Reimbursement correction to Provider Manual– Chapter 11, page 5 (11.1.3.3). Effective 10/18/2002, Surgical Category of Services are those stays that are not in the maternity category of service with a surgical ICD-9 procedure code and surgical date. (NOTE: only indicating an operating revenue code will not cause a claim to process as surgical). Valid operating room ICD-9 procedure codes are listed in the ICD-9 Professional for Hospital coding book.

MEDICARE PART B SERVICES SPLIT FROM AN INPATIENT CLAIM

In the event that a client has Medicare Part B and the charges are split from the rest of the inpatient claim, Medicaid will pay the inpatient claim and the Part B claim if the total for the coinsurance and deductible on the Part B claim are less than $100. Any amount greater than $100 will result in the Part B claim denying as a duplicate to the inpatient claim.

DHS MEDICAID ONLINE MASTER ACCOUNT CHANGE FORM

If you currently utilize the Department of Human Services (DHS) Medicaid Online verification system (DMO) and need to make changes to the Master Account, please follow these steps:

- Go to www.Med-QUEST.us
- Under "PROVIDER" click on "Quick References"
- Click on "DHS Medicaid Online User Manual"

Once you have completed the form on page 63, please fax it to (808) 952-5595. You will receive an email confirmation upon the completion of the request within 7 business days.

QUEST EXPANDED ACCESS (QExA)

To improve the health of seniors, 65 or older, and people of all ages with disabilities, the State of Hawaii Department of Human Services has created QExA, a Medicaid managed care program. Under QExA, clients receive medical services through their health plans and no longer have to navigate the Medicaid system alone.

Goals of QExA

- Improve the health of our Medicaid clients
- Connect Medicaid clients with a doctor who will be responsible for addressing their healthcare needs
- Support client independence, responsibility and choices for healthcare
- Provide quality health services in the homes and/or communities of clients, whenever possible

QExA Health Plans

Medicaid providers need to sign contracts with both QExA managed care health plans in order to bill for services provided on and after February 1, 2009. If you have not met with the two health plans, call them for contracting information. The health plan contact information for Evercare is (888) 846-4262 and for 'Ohana Health Plan it is (888) 980-8728.

Claim Filing Guides

- For services provided on or after February 1, 2009, claims must be billed to the client's QExA plan instead of to ACS.
- Only clients who were inpatient acute on or before February 1, 2009 should continue to have their claims billed to ACS as a continuous confinement, all other claims should be billed to the client's QExA plan. The acute patients are migrated to QExA as of their downgrade date.
- Crossover claims - all crossover claims with dates of service PRIOR to 11/01/2009 should be sent to ACS for processing. All crossover claims with dates of service 11/01/09 and after should be sent to the appropriate health plan for processing.

INTRA-ARTICULAR HYALURONIC ACID DERIVATIVE INJECTIONS

Effective January 1, 2008, the code used for Synvisc, J7319, has been discontinued and has been replaced by the following four codes:

- J7321 for Hyalgan
- J7322 for Synvisc
- J7323 for Euflexxa
- J7324 for Orthovisc

Please continue to submit J7319 on claims with dates of service prior to January 1, 2008.

BILLING FOR ADMINISTRATION OF VACCINES / TOXOIDS

- Providers must bill for the administration of the vaccines using procedure codes 90476-90749. While these codes are used to indicate the specific vaccine / toxoid product, Hawaii Medicaid also recognizes these codes for the administration of the vaccine.
- If the vaccine / toxoid is covered by the Vaccines for Children (VFC) Program, the reimbursement fee is part of the global EPSDT fee.
- If the vaccine is administered to an adult or is not covered through the VFC Program, please submit a 204 claim form using the NDC number on the vial to the Pharmacy Benefits Manager (PBM) Claims, PO Box 0967, Henderson, NC 27536-0967. For questions, call (877) 439-0803.
- Administration codes 90471-90474, G0008-G0010 and 90782 will be denied. Bill using 90476-90749 to receive reimbursement for the administration of the vaccine.

OCCURRENCE SPAN CODE 76 AND ICF / ICW LEVEL OF CARE

Occurrence span code 76 is used to indicate a non-covered period by Medicare, specifically intermediate care (ICF) or waitlisted intermediate care (ICW) level of care. Please verify the date range of the 76 occurrence span code on the Medicare claim matches the service dates on the ICF claim, or the dates of the 74 occurrence span code on the ICW claim. If the dates do not match, your claim will deny as a duplicate submission.

PREFERRED DRUG LIST (PDL) ENDING

The Med-Quest Division (MQD) has concluded the current Preferred Drug List (PDL) in the Fee-For-Service program effective January 1, 2010. With implementation of QUEST and QUEST Expanded Access (QExA), the remaining FFS population is quite small. Corresponding drug utilization will not produce sufficient revenue to fund the cost to administer the PDL.

GETTING A PRIOR AUTHORIZATION (PA) WHEN MEDICARE IS PRIMARY

If Medicare is primary and NOT making payment (i.e. benefits are exhausted or limits are exceeded, service not covered by Medicare), then:

- Provider should submit a PA and write Medicare benefits exhausted, Medicare limits exceeded or service not covered by Medicare on the PA

If Medicare is primary and WILL BE making payment:

- Provider should NOT submit a PA
- Submit the claim to ACS with the EOMB attached and ACS will pay the co-insurance / deductible

MEDICAID PRICING OF PROCEDURE CODE 01967 (NEURAXIAL LABOR ANALGESIA)

When billing procedure code 01967, please use the following table to determine your expected reimbursement from Medicaid.

Time in Minutes	Allowance $	Time in Minutes	Allowance $
1 to 30	114.00	165 to 209	250.80
31 to 45	136.80	210 to 269	273.60
46 to 74	159.60	270 to 329	296.40
75 to 104	182.40	330 to 389	319.20
105 to 134	205.20	390 or more	342.00
135 to 164	228.00		

Providers billing electronically or manually on the UB form, must limit the number of lines billed on a single claim to 99 lines. Claims received with more than 99 lines on a claim will be returned to provider (RTP'd).

BASIC HEALTH HAWAI'I

What is Basic Health Hawai'i?

Basic Health Hawai'I is a health insurance program. It is for non-pregnant adults, age 19 or older. Clients must live in Hawai'I. They must be an immigrant legally residing in the United States for less than five years or a non-immigrant. They must not be eligible for Federal Medicaid Programs.

Basic Health Hawai'I Benefits
Per Benefit Year

- 12 outpatient physician visits per year
  (6 of these visits can be used as mental health visits)
- 6 additional mental health visits per year
- 10 Inpatient hospital days per year
- 10 inpatient physician visits for medically necessary medical care, surgery, psychiatric care or substance abuse treatment.
- 4 prescriptions per month, either brand or generic to include insulin and chemotherapy, plus specific contraceptives and diabetes supplies.
- Emergency room services

Other Covered Services

- Dental Services only for emergencies to eliminate dental pain, infection and acute injuries

Who Will Pay The Claims

The BHH program will be administered through existing QUEST contract that MQD has with the following plans: AlohaCare, HMSA, and Kaiser Permanente. Clients will have a medical insurance card issued by one of these health plans.

To ask questions, call Med-QUEST Provider Hotline at (808) 692-8099.

Dialysis services are not covered by the BHH program. However, certain individuals who are not eligible for Medicaid because of their citizenship or duration of legal residency, including those enrolled in BHH, may receive coverage for outpatient dialysis under Emergency Medical Assistance through the Medicaid Fee-for-Service program. This dialysis coverage will also cover nephrology visits and certain medications that may be administered during dialysis, including epogen, iron, and a few commonly used antibiotics. Other medications administered during the dialysis that are not covered under Emergency Medical Assistance may be covered as part of the four prescriptions allowed per calendar month under BHH.

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Hawaii Medicaid

Look inside for these and other important updates:

Check us out on the web…
WWW.Med-QUEST.us

ACS
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