Med-QUEST Division

Medicaid Provider Bulletin

Published for the Medicaid Providers of Hawaii.

Volume 2, Issue 4

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In This Issue

HIPAA Increases Information Available Online

DHS Medicaid Online provides online access to Medicaid information, claim status and eligibility verification. Additional information is now available online. New data elements include:

- Share of cost amount(s) for LTC recipients
- Share of cost begin and end date(s)
- Nursing home provider name
- Penalized nursing home indicator
- QMB dual eligibility indicator
- QMB dual eligibility begin and end date(s)
- Lock-in provider name(s)

In addition, error messages will now conform to the HIPAA compliant error messages. These changes will be outlined in the upcoming revision to the DHS Medicaid Online User Manual.

Future enhancements to *DHS Medicaid Online* include the availability of the 270/271 batch option. The batch option will allow users to check the status for a number of claims in a single transaction, as well as verify eligibility for more than one recipient at a time. Responses are returned to the provider on the following business day.

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)

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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Billing Clarifications

Medicare & Medicaid limitations

- Medicaid covers the co-insurance and deductible amounts for Medicare primary claims. This applies even if the recipient has exceeded Medicaid limitations (e.g. psychotherapy services).
- Medicaid limitations apply only when Medicaid is the primary payer.
- If a claim was denied for exceeding Medicaid limitations, and Medicare is the primary payer, contact the ACS Provider Inquiry Unit to have the claim reprocessed.
- If the service is not a Medicare covered service, Medicaid may provide reimbursement if the service/item is medically appropriate and covered by Medicaid. However, if the recipient is a "Qualified Medicare Beneficiary (QMB) only" recipient, Medicaid will only pay Medicare coinsurance and deductibles.

Medicare Value Codes A2 and 09

- 09 and A2 value codes are used to represent the Medicare coinsurance amount.
- Providers should not bill both 09 and A2 value codes on a single claim. Only one of these value codes can be indicated on a single claim form.
- Billing both 09 and A2 on the same claim form will cause overpayment. Medicaid is required to recover all overpayments. If you have received overpayments because you used both 09 and A2 on the same claim form and recovery has not taken place, please contact ACS to report the overpayment.

Billing for ESRD Related Services

- Use CPT codes 90922 - 90925 for End Stage Renal Disease (ESRD) related services when billing for less than a full month of services.These codes have a maximum of 29 units per month.
- Use CPT codes 90919 - 90921 to bill over 29 units.

FQHC Billing Update

- Updated billing instructions were sent to all FQHCs on November 20, 2003. In order to be paid correctly at the PPS rate, FQHCs must follow these instructions.

Instructions for Submission of Adjustment Claims

- Resubmissions must include the original claim reference number. On the CMS-1500 and ADA 1999 v. 2000, note a Medicaid resubmission code (A or V). UB-92 resubmissions should be indicated with an appropriate bill type; xx6 to adjust or xx8 to void.
- Include all the lines billed on the original claim. Identify the portion of the claim that should be adjusted by circling the change. If a change is not circled, the claim will be returned to the provider (RTP).

Resubmitting Denied Claims

- If an original claim was denied, resubmit the claim again as a brand new claim. Do not submit it as an adjustment. Using the instructions for submitting adjustments described above may delay the processing of a denied claim.
- **Denied claims should only be resubmitted when the dates of service are still within the filing deadline and all lines on the claim were denied.** If a claim is resubmitted past the filing deadline as a new claim, it will be denied unless a waiver of the filing deadline has been obtained and is attached to the claim.
- If a claim is partially denied (some lines paid), providers must use the resubmission process.

Reporting Voluntary Payments

- List the contribution amount as a TPL payment and enter "Voluntary Contribution" under the payer field.
- The voluntary contribution will be deducted from the Medicaid payment amount.

Billing with Revenue Code 450

- Revenue code 450 is allowed once a day for emergency room services with HCPCS 99281 - 99285. Appropriate HCPCS codes for this revenue code are 99281 - 99285 or 99291. Other revenue codes should be used to expedite the review of services/items submitted on the same day that may be separately reimbursed.

Correction to February Provider Bulletin

Procedure codes 90476 - **90749** are valid when billing for the administration of vaccines.

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Clarification of Reporting Overpayment
- Overpayments should be reported to the Medicaid Fiscal Agent, ACS Provider Inquiry Unit.

Billing for D0230
- When billing multiple units of D0230, bill all units on a single line. D0230 is limited to four units per day.

Certain DME Under $50 Require PA
- Certain durable medical equipment (DME) and supplies under $50 per line item (e.g. custom wheelchair accessories, diapers, underpads, gloves, and miscellaneous supplies/ equipment) require PAs. The "under $50 exclusion from PA" applies to the provider's billed charges for DME/ supplies covered by Medicaid.

Remittance Advice (Credit & Debit Invoices):
- When manual adjustments are made invoice numbers that begin with the letter "B" or "C" will appear on the financial summary page of the RA (page 2).
- "B" and "C" invoices are commonly seen when transferring money from one provider account to another.
- For example, a physician is paid $100 for services that his facility should receive payment for. A manual transfer of funds is required to correct the accounts. A "B" invoice will deduct $50 from the physician's account. A "C" invoice for $50 will appear on the facility's RA.

Make refund checks payable to:
- "Hawaii Medicaid"
- Send to:

  ACS
  P.O. Box 1206
  Honolulu, HI 96807-1206

Waiver Service Providers Only

Always enter "Not a covered TPL/Medicare service" in FL19 and a "$0" in FL 24k for each line item billed. These steps should be taken on all claims regardless of whether a recipient has a TPL or not because TPL and Medicare do not cover waiver services.

THE TOOL BAR

Automated Voice Response System

☎ ***AVRS is an information line available to providers 24 hours a day. Call 1-800-882-4608 to verify recipient's eligibility, TPL, & cost share amounts.***

- If you are getting a busy signal when calling the *Automated Voice Response System (AVRS)*, please report this problem to the Medifax Customer Service Center at 1-800-333-0263.
- To report a problem after hours, leave a message and an on-call Medifax representative will contact you.
- If you need other assistance with *AVRS*, please call Joyce Lignell, the Hawaii District Sales Manager for Medifax, at 1-800-444-4336, ext. 2455.

DHS Medicaid Online (DMO)

💻 ***DMO provides access to Medicaid information, claim status, and eligibility verification via an internet website, https://hiweb.statemedicaid.us.***

Verification Screen
- Providers using *DHS Medicaid Online* are encouraged to keep a record of their username, password, and account details.
- When creating a new username, print a copy of your entries under the "Create a Profile" section and the "Account Created" section. Keep a copy on file for easy reference for your password & account details.

ACS Provider Inquiry Unit

✆ ***The customer service line is available to answer provider's questions on claim status, prior authorization, remittance advices, payment, and Medicaid policy.***

News for New Medicaid Providers
- Call the ACS Provider Inquiry Unit to schedule an orientation meeting with an ACS Field Representative. ACS will also provide re-orientation sessions for providers upon request.

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Reasons for Returned Prior Authorization Requests

1. Supplier name and provider ID number are missing
2. Invalid recipient number
3. Procedure code is invalid or missing
4. Referring provider signature or ID number is missing
5. Duplicate submission
6. Medicare recipient - no prior auth needed
7. Outpatient psychiatric service - no prior auth needed
8. Pharmaceutical request - send to PBM
9. Request submitted under the group payment ID

Top Reasons Claims are Returned To Providers

1. Invalid HAW ID number
2. Invalid provider ID number
3. Invalid tax ID number
4. Missing or invalid date of service
5. Explanation of Benefits is missing
6. Explanation of Benefits does not match the claim
7. HAW ID number does not match the name
8. Changes on resubmission claims are not circled

If claims are returned with a Return To Provider (RTP) coversheet, make the corrections necessary and submit it as a brand new claim **Do not use the resubmission process.**

Payment of Medicare Crossover Claims

We have experienced a problem with the processing of Medicare crossover claims. This problem stems from the mapping of the provider identification number (PIN) on your Medicare claim to your Medicaid PIN. When a PIN is not mapped correctly, the result is a Medicaid payment to the wrong PIN or HPMMIS not being able to link the claim to any Medicaid PIN. We hope to have this problem resolved soon.

New Medicaid Correspondence Inquiry Form

Effective immediately, please use the new full page Form 239 Medicaid Correspondence Inquiry Form. Make copies of the form on the following page for use on all future inquiries. Do not use this form for claim adjustments. All adjustments and voids should be sent directly to ACS Claims PO Box 1220, Honolulu, HI 96807-1220.

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

FORM 239
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. Claim Number (if applicable)	8. Purpose of Inquiry: ❑ Questionable Payment ❑ Claims Status ❑ Claims Filing Procedure ❑ Other: *** Do <u>not</u> use this form for claim adjustments. Send resubmissions to the appropriate ACS Claims PO Box.**		
9. Patient Name	10. Patient ID Number		
13. Dates of Service	14. Payment Date	15. Charge	16. Allowance
17. Remarks			

18. Response to Provider: (**For Office Use Only**) Completed by _____ Date _____

- ❑ Claim Paid on _____ Amount _____
- ❑ Denied on _____ Reason: _____
- ❑ Claim sent to Claims Dept. for reprocessing. _____
- ❑ Patient name and ID # not in DHS files. _____
- ❑ Claim is in the processing system. Please allow additional processing time. _____
- ❑ Claim is being researched. (We are currently working to resolve this issue.) _____
- ❑ Unable to match above claim data with computer file data. _____

- ❑ Please submit claim with
  - ❑ Medicare/TPL EOMB
  - ❑ Approved waiver of filing deadline
  - ❑ Other
- ❑ Claim date exceeds one year filing deadline

- ❑ Submit copy of FFS claim to:
  ACS Claims P.O. Box 1220, Honolulu, HI 96807-1220
- ❑ Submit copy of Waiver Services claim to:
  ACS Claims P.O. Box 4631, Honolulu, HI 96812-4631
- ❑ Submit filing waiver request letter to:
  MQD/FO/TPL, 1001 Kamokila Blvd., Ste. 317,
  Kapolei, HI 96707

Comments: _____

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