Hawaii Medicaid Provider Bulletin

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Emergency Services Only

Recipients enrolled in Emergency Services only (EMGSVC) are covered for medical conditions with acute symptoms of sufficient severity such that the absence of immediate medical attention could result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to body functions, 3) serious dysfunction of a bodily organ or part, 4) harm during pregnancy including labor and delivery. Recipients eligible for this plan must have their eligibility authorized or the claims will be denied for AD120 "NO AUTH FOR EMERGENCY MEDICAL SERVICES."

The authorization will be specific to dates of service and providers based on information given to the recipient's eligibility worker. A medical reviewer for the eligibility office determines whether the services are acute in nature and issues an authorization. Upon completion, the authorization is forwarded to the Fiscal Agent. Claims are then processed based on the determination from the eligibility office medical reviewer.

Providers may call the Provider Relations Call Center to review the claim. The call center will research and advise providers on the specifics of the authorizations on file for the recipient's eligibility.

Medicare Pricing Logic

Effective November 8, 2007, the methodology used to reimburse Medicare coordinated claims for acute inpatient and outpatient hospital services processed for Medicaid Fee-For-Service (FFS) changed. The change affected claims with a date of service after September 1, 2003 per ACS Memo M07-23.

As of this change Medicaid will pay the difference of Medicare's payment up to Medicaid's allowable or the coinsurance plus the deductible, whichever is less.

Example

An outpatient claim with Medicare payment is sent to Medicaid for payment.

Claim Amount: $800.00

Medicare Payment: $350.00

Coinsurance: $75.00

Medicaid Allowable: $375.00

Medicaid Payment: $25.00

The payment is $25.00 in the example because Medicare's payment minus Medicaid's allowable is less than the coinsurance (375 - 350=25).

5010 Update

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each of those standards. HIPAA serves to:

•Create better access to health insurance

•Limit fraud and abuse

•Reduce administrative costs

Additional information will be included in future Provider Bulletins and a dedicated Provider Memo. HIPAA technical documents can be found on the Med-QUEST Division website http://www.med-quest.us/HIPAA/hipaatechnical.html.

DHS Pending PAs

All prior authorizations, except inpatient psych, require a valid HAWI ID number. If a patient is applying for Medicaid, a prior authorization should be sent after the HAWI ID number is obtained.

Approved DHS pending authorizations must be sent back to ACS once the HAWI ID number is obtained. Claims cannot be processed until the authorization is updated with the HAWI ID.

Limited Plan Outlier Payments

Inpatient acute stays that qualify for outlier payment for recipients who have limited coverage such as ACEFFS, QUEST ACE, or BHH FFS are still bound by the limitations of the plan. All the above plans allow only 10 inpatient days per calendar year. Claims billed with days exceeding this limitation cannot be paid as an outlier because of the limitation of the plan.

Claims submitted for recipients with these plans should take into account the total number of available days. The threshold claims (bill type 112) must also be accounted for prior to calculating the number of available outlier days.

Example: An ACEFFS recipient has an inpatient stay of 19 days. The recipient meets the threshold amount on the 4th day. The recipient is left with six days before the limitations of the plan are exhausted. The facility should then send a bill type 113 claim to represent the six days available to the recipient. In this way all 10 days of inpatient can be used (four on the 112 bill type claim and six on the next 113 bill type claim). The final nine days are not covered.

The Provider Relations Call Center can research the number of inpatient days a recipient has on file. The provider relations call center can be reached at: 808-952-5570 or toll free 800-235-4378.

1144 Submission Tips

- Both the supplier and physician section of the 1144 must be completed. The physician/ supplier name, provider number, etc. are all required fields. If it is the same provider you must indicate “same as above” or “same as below.” Provider name must match the NPI/provider # given.
- A signature is not required if marked “urgent.”
- Prior Authorizations must be submitted with legible writing.
- MRI Prior Authorization request supplier section should be filled out by the facility. If the MRI is authorized under one code and another is performed, the PA must be changed prior to billing.
- Inpatient psych authorizations must be submitted within five days of admission.

•Remember to sign all paper claims and authorization requests

Electronic Health Record (EHR) Incentive Program

Health care professionals in Hawai'i now have the opportunity to register for the Medicare and Medicaid EHR incentive programs. Those who meet the eligibility requirements could receive up to $44,000 over five years under the Medicare EHR Incentive Program or $63,750 over six years under Medicaid; eligible professionals cannot participate in both programs. Eligibility for the Medicaid Incentive Program includes the requirement that the professional has 30% Medicaid patient volume or 20% for pediatricians. Incentive payments are also available to eligible hospitals, some of which are able to participate in both programs. To receive the maximum incentive payment, providers must begin participating in the Medicare Incentive Program by 2012 or the Medicaid Incentive Program by 2016.

To qualify for incentive payments, eligible professionals and hospitals must use certified EHR technology, be a "Meaningful User" of that technology, and attest that they have demonstrated "Meaningful Use." The criteria for Meaningful Use will be updated in stages over the next five years, with increasing requirements in each successive stage. For Stage 1 (2011—2012) of Meaningful Use, eligible professionals must meet 20 objectives and six clinical quality measures. However, in the first year of participation in the Medicaid Incentive Program, eligible professionals and hospitals may also qualify for incentive payments if they adopt, implement, or upgrade an EHR; they must successfully demonstrate Meaningful Use for subsequent participation years.

A program called the Hawai'i Pacific Regional Extension Center (HPREC) has been established to help providers implement or upgrade certified EHR systems and meet the Meaningful Use requirements. The HPREC is specifically committed to providing assistance to providers in medically underserved settings where resources are limited. If you are a provider who is interested in implementing an EHR system and/or registering for the Incentive Programs, please contact Alan Ito, Project Director for the HPREC, at aito@hawaiihie.org or 808-441-1429 or visit www.hawaiihie.org/rec. Additional information about the EHR incentive programs is available at https://www.cms.gov/EHRIncentivePrograms.

Proper and Safe Use of Selzentry®

Hawaii State Law guarantees access to medication for HIV treatment for MQD program recipients. Many HIV medications require specific treatment regimens or special testing to ensure proper and safe use. The following are FDA-approved guidelines for Selzentry® (maraviro) and must be considered before initiating Selzentry® therapy:

Selzentry® (maraviro) is a CCR5 inhibitor used with other HIV medicines to treat CCR5-tropic HIV. Selzentry® is not recommended for patients with dual/mixed or CXCR4-tropic HIV. It is for adult patients with CCR-tropic HIV only. **A tropism test is needed before starting** Selzentry®. **Tropism testing must be conducted with a highly sensitive tropism assay that has demonstrated the ability to identify patients appropriate for Selzentry® use.** Outgrowth of pre-existing low-level CXCR4– or dual/mixed-tropic HIV-1 not detected by tropism testing at screening has been associated with virologic failure of Selzentry®. Selzentry® does not cure JHIV infection or AIDS and does not lower the risk of passing HIV to other people. People taking Selzentry® may still develop infections, including opportunistic infections or other conditions that happen with HIV infection. The long-term effects of Selzentry® are not known at this time.

Procedures for Financial Adjustments

Refunding overpayments due to non-coordination of benefits, other insurance payments, coding errors, etc. are handled by:

Submitting an adjustment claim form to ACS. The adjustment claim will be processed and the system will automatically apply the appropriate adjustments to the CRN and your PIN. These resubmissions can be submitted on hard copy claim forms or electronically to expedite the adjustment process.

OR

Submitting a refund check in the amount of the overpayment. When submitting refund checks, supporting documentation must accompany the refund check so the correct claim and provider number can be adjusted. Supporting documentation includes the CRN, Date of Service, reason for refund and the other insurance EOB if applicable.

When submitting a refund check in the amount of the overpayment:

Please be aware this process requires the adjustment to be handled manually to adjust the claims associated with the refund check. Failure to provide all information needed will delay processing of the adjustment .

This process requires a two-part reconciliation for the Remittance Advice (RA). When a claim is adjusted or voided as a result of a refund check, the recouped amount will be provided in the detail of the Adjusted or Voided Claims section of the RA. To offset this credit as a result of the adjustment or void, ACS posts a debit or C Invoice for the amount of the refund check. The C Invoice will be listed on the Financial Summary page of the RA.

Example of an Adjustment (refund a portion of a claim) to a Claim:

A provider (PIN 123456) submits a refund check in the amount of $25.00 to ACS, which was the overpayment amount they received on a claim that was paid on April 1, 2009 in the amount of $100.00. The patient had a primary insurance carrier but ACS had paid the claim with Medicaid as the primary insurance.

Medicaid's procedure is to adjust the claim according to the other insurance's documentation then credit the refund check amount.

RA Financial Impact Overview:

$75.00	Allowed Amount that should have been paid on 04/01/2009
-$100.00	Previously Paid Amount. ACS processes an adjustment to the CRN to recoup the entire original payment amount.
-$25.00	Net Paid Amount on PIN 123456
-$25.00	RA Net Paid Amount
$25.00	C Invoice, debit memo, for the refund check amount to offset the voided amount
$0.00	Financial impact on RA for provider 123456

Example of a Voided Claim:

A provider (PIN 123456) submits a refund check in the amount of $101.99 to ACS and requests to void a claim that was paid to the provider on April 1, 2010 because the recipient was not their patient. ACS will recoup the original payment.

RA Financial Impact Overview:

$101.99	Allowed Amount paid on 04/01/2010
-$101.99	Amount after claim is voided. (ACS voids the CRN, which recoups the original payment amount)
-$101.99	Net Paid Amount on PIN 123456
-$101.99	RA Net Paid Amount
$101.99	C Invoice, debit memo, for the refund check amount to offset the voided amount
$0.00	Financial impact on RA for provider 123456

A4358 Update

A4358 (urinary drainage bag, or leg or abdomen, vinyl, with or without tube, with straps, each) is a urinary collection bag that includes straps which hold the bag securely to the body.

Manufacturers of urinary collection bags have notified the Pricing, Data Analysis and Coding (PDAC) Contractor that some collection bags do not contain straps. While manufacturers may offer these products without straps, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers are reminded they MUST supply straps with the urinary drainage bag to the Medicare or Medicaid beneficiary.

Suppliers are reminded that A4358 includes both the drainage bag and straps. If the drainage bag from a particular manufacturer does not contain a leg strap, suppliers must provide a leg strap but should not bill Medicare or Medicaid using the miscellaneous code A4335 (incontinence supply; miscellaneous) and A5113 (leg strap; replacement only, per set) or A5114 (leg strap; foam or fabric, replacement only, per set).

Refer to the Local Coverage Determination (LCD) and Policy Article for Urological Supplies for coverage and HCPCS coding requirements.

Billing Tips

- Claims expected to require medical review should always be sent with documentation to support the services rendered. The inclusion of documentation will reduce the amount of time these claims spend in medical review.
- All claims sent to Medicaid Hawaii require an ink signature. Digitally signed, rubber stamped, or copied signatures are unacceptable unless initialed by a person. Faxed claims are not accepted.

Modifier 59 Usage

Modifier 59 is an important modifier; however, it is often used incorrectly. The modifier should be used to describe a procedure or surgery as a “distinct procedural service”, but it is frequently misused to describe the relationship of two or more procedures that have not adequately fulfilled the parameters for use of the modifier.

Edits define when two procedure HCPCS/CPT codes, which otherwise would not be allowed to be reported together, can be reported together under certain conditions. NCCI-associated Modifier 59 allows two procedure codes to be reported together if they are performed at different anatomic sites or on different patient encounters. Claims processing systems use the modifier to allow payment of both codes.

Modifier 59 may only be used to indicate the procedures were performed at separate anatomic sites or on different patient encounters. Modifier 59, as well as other modifiers, should NOT be used to bypass an edit unless the proper criteria for use has been met and documented in the patient medical record. Claims filed with Modifier 59 should have documentation attached showing justification for use of the modifier.

Recipient Eligibility Questions

Please remember providers should not advise recipients on health plan selections. Providers may advise recipients which Medicaid plan(s) they accept for payment. Recipient may call the Enrollment Services Section (number listed below) to choose their health plan. Eligibility offices cannot address health plan selection questions.

MQD Eligibility Office Locations & Telephone Numbers

Oahu (Honolulu)

Oahu Section

801 Dillingham Blvd, 3rd Floor

Honolulu, HI 96817-4582

Telephone: 587-3521 or 587-3540

Oahu (Leeward)

Kapolei Unit

Kakuhihewa State Office Building

601 Kamokila Blvd, Room 415

Kapolei, HI 96707-2021

Telephone: 692-7364

Hawaii East

East Hawaii Section

88 Kanoelehua Ave, Room 107

Hilo, HI 96720-4670

Telephone: 933-0339

Hawaii West

West Hawaii Sectoin

Lanihau Professional Center

75-5591 Palani Road, Suite 3004

Kailua-Kona, HI 96740-3633

Telephone: 327-4970

Maui

Maui Unit

Milyard Plaza

210 Imi Kala Street, Suite 101

Wailuku, HI 96793-1274

Telephone: 243-5780

Molokai

Molokai Unit

State Civic Center

65 Makaena Street, Room 110

Kaunakakai, HI 96748

Telephone: 553-1758

Lanai

Lanai Unit

730 Lanai Avenue

Lanai City, HI 96763

Telephone: 565-7102

Kauai

Kauai Unit

4473 Pahee Street, Suite A

Lihue, HI 96766-2037

Telephone: 241-3575

Medicaid Provider tools for checking recipient eligibility

Automated Voice Response System (AVRS)

1-800-882-4608

Must have provider ID and recipient ID available

DHS Medicaid Online (DMO)

https://
hiweb.statemedicaid.us

Must have provider DMO access. Provider can coduct search using HAWI or SSN or Name, DOB & Gender

Medicaid Provider Call Center

On Oahu

952-5570

Toll Free

1-800-235-4378

Enrollment Services Section (ESS)

Toll Free

1-800-316-8005

Option 7 Providers

Option 1 AVRS or

Option 4 Provider Hotline

Authorization Agreement for Electronic Funds Transfer (EFT)

Automatic Deposits/Payments

I (We) hereby authorize the Fiscal Agent for the State of Hawaii Med-QUEST Division to make deposits to my (our) checking or savings account and the depository bank indicated below, hereinafter called Depository, to credit the same to such account.

Depository Name_____ **Branch** _____

City _____ **State** _____ **Zip Code** _____

Bank Telephone _____

Bank Transit/ABA Number_____

Bank Account Number _____

Checking	**Savings**
□	□

This authority is to remain in effect as long as I (we) receive Medicaid payments or until we have received written notification from an authorized signer(s) to terminate this agreement. I understand that this electronic funds transfer deposit/payment will be from federal and state funds and that any falsification or concealment of a material fact involving the deposit may be prosecuted under federal and state laws.

Name on bank account _____

Provider name and telephone_____

Medicaid provider number_____

Date_____ **Signed** _____**Signed** _____

(The person(s) signing this form must be authorized to sign on this bank account.)
NOTE: Groups should enroll their group number only. Funds paid to individual numbers should not be deposited to group accounts. **You must attach a blank voided check or deposit slip to this form.**

Application Instructions

During weeks when there is a bank holiday, there will be a one-day delay in receipt of payments.

• **Depository Name** Enter the name of bank servicing your checking/savings account.

• **Branch** Enter the name of the bank branch.

• **City, State and Zip Code** Enter the name of the city, state and zip code where your branch is located.

• **Bank Transit ABA Number** Enter your bank's routing number. If you do not know this number, call your bank.

• **Provider Name & Telephone** Enter your provider name and telephone number.

• **Medicaid Provider Number** The Medicaid provider number will be added once it is assigned by the Medicaid fiscal agent.

• **Date/Signed** You must date and sign this form with an original signature. Copies or signature stamps will not be accepted.

• **Mail** this form and the account information to the following address:

Hawaii Medicaid Fiscal Agent, PO Box 1480, Honolulu, HI 96807-1480

***Please advise the fiscal agent immediately of any changes in the account, including additions, deletions, special instructions or addresses to avoid delays in payment.**

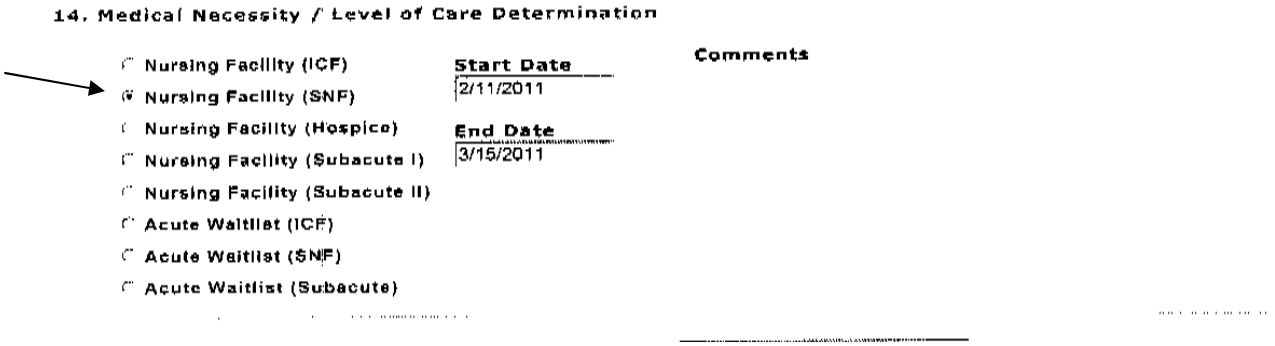
Electronic 1147 Submission

Approved long term care prior authorizations filed electronically with the Health Service Advisory Group (HSAG) through Hawaii Level of Care Evaluator (HILOC) are not automatically forwarded to ACS for entry. The fastest way to have claims associated with these authorizations cleared is to send a screen print of the authorization to ACS. The screen print can be either the recipient summary page showing the approved level of care, or the data entry screen showing fields 1-14 with the determination. The screen print can be attached to the claim or sent to ACS via fax. ACS' fax number is :

On Oahu 952-5595 or

Toll Free 1-800-246-8197

Field 14 Example including HSAG determination



Recipient Summary Page Example

Type	Elec?	Status	Status Date	MCP	Req. LOC	LOC Start	LOC End	Appr. LOC	LOC Start	LOC End
	☑	Complete	7/9/2011	N/A	Acute Waitlist (SNF)	6/28/2011	7/28/2011	Acute Waitlist (SNF)	6/28/2011	7/28/2011
	☑	Complete	7/21/2011	N/A	Nursing Facility (SNF)	7/5/2011	8/5/2011	Nursing Facility (SNF)	7/5/2011	8/5/2011

1147 1147e 1147a

ASC 24 Hour Billing

In the Medicaid Program, all outpatient surgical procedures performed in an acute care hospital, whether done in the distinct part of the facility called the ASC or in other operating rooms, are considered ASC services. Stays are generally less than twenty-four (24) hours.

Surgical Follow Up

Follow-up days used by the Medicaid Program are derived from the Medicare Standards for follow-up days.

If two or more procedures are performed during a surgical session, the follow-up days assigned will be the days associated with the procedure with the longest follow-up period.

Example: *Surgical follow-up period for procedure A is 90 days, follow-up period for procedure B is 45 days. The follow-up period is 90 days.*

When additional procedures are performed within the follow-up period for a previous procedure, the remaining days from the previous procedure or the follow-up period from the subsequent procedure, whichever is greater, will constitute the remaining follow-up period.

Example: *Follow-up period for procedure A is 45 days, follow-up period for procedure B is 45 days. Procedure B was performed 40 days after procedure A, the follow-up period is 45 days from the date procedure B was performed.*

Questions about the number of follow up days for a specific procedure can be answered by the Provider Relations Call Center.

MRO Document Requirements

Providers who are billing ACS for Medicaid Rehabilitation Option (MRO) behavioral health services for FFS clients that were previously receiving their services from either the Adult Mental Health Division (AMHD) or a QUEST health plan should attach the following documents with their claim :

1) AMHD SMI certification or psych evaluation
2) AMHD authorization for case management
3) AMHD denial with specific code and modifier*

**If AMHD was not billed then this attachment is not necessary.*

Remittance Advice Change

As of September 16, 2011 pended claims will only be reported on the remittance advice once. Subsequent remittance advices will not show these pended claims again. Claims will not appear in the remittance again until the status has changed. Providers wishing to inquire about a pended claim should contact the Provider Relations Call Center.

Call Center Reminders

- The call center is limited to three inquiries per call.
- A valid Hawaii provider ID or NPI, caller name, and phone number are required to receive PHI.
- Recipient eligibility inquiries must have the HAWI ID or SSN, name, and DOB.
- The call center can be reached toll free 1 (800) 235-4378 or on Oahu 952-5570.

Fraud and Abuse

The Office of Inspector General (OIG) for the U.S. Department of Health & Human Services has created educational materials to assist in teaching physicians about the Federal laws designed to protect the Medicare and Medicaid programs and program beneficiaries from fraud and abuse. The materials can be found at the following website:

http://oig.hhs.gov/compliance/physician-education/index.asp

Waiver of Timely Filing Address

The address to send requests for waivers of timely filing has changed. Please use the address below:

DHS/MQD/FO

1001 Kamokila Blvd, Rm 317

Kapolei, HI 96707

Timely Filing Policy

All claims for Medicaid services must be submitted to Medicaid for payment within 12 months of the date of service. This includes all claims submitted to the Fiscal Agent whether initial claims, resubmitted outstanding claims, or additional payment requests. When Medicare or any other Third Party Liability (TPL) are primary, providers must submit claims within (6) months from the date listed on the Explanation of Benefits (EOB) or 12 months from the date of service, whichever is greater.

Provider Manual Update

The Provider Manual has been updated in its entirety. In the future, when changes have to be made, a chapter will be temporarily pulled from the Med-Quest website and a notice "under revision" put in its place. The updated chapters can be found at; http://www.med-quest.us. If you have specific questions you need answered in a chapter being revise, please contact:

MQD Clinical Standards Office

1-808-692-8124

ACS

A xerox Company

Hawaii Medicaid Fiscal Agent

P.O. Box 1220

Honolulu, HI 96807-1220

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www.med-quest.us