Medicaid

Provider Bulletin

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DO YOU HAVE YOUR NPI NUMBER YET?

The National Provider Identifier (NPI) is a federally mandated identification number issued to health care providers by the National Plan and Provider Enumeration System (NPPES). Enrollment is currently underway and must by completed by **May 23, 2007**.

The Med-QUEST Division (MQD) will **require** the use of the NPI on claim submissions (both paper and electronic) **effective May 23, 2007** for those providers required to obtain a NPI. Do not submit clams with your NPI until instructed to do so by MQD.

If you only submit non-medical waiver claims, then you may not be required to obtain a NPI.

Certain Social Service Division (SSD) claims, primarily those for DME suppliers, will require the use of NPI as well.

For more information on how to obtain your NPI, please use the following resources:

Phone 1-800-465-3203 (NPI Toll-Free)
Phone 1-800-692-2326 (NPI TTY)
Email customerservice@npienumerator.com

Regardless of how you obtain your NPI, it is important that you **retain the notification documentation** that NPPES sends you containing your NPI. You will need to forward this information to MQD so your provider profile can be updated. Failure to forward your notification document will lead to the denial of your claims.

You may submit your NPI information the following ways:

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

Please look for additional information in upcoming inserts and flyers.

IN THIS EDITION

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

The ACS Inquiry Unit is a direct line to help providers with questions and concerns. The unit averages about 500 calls every day. Due to this high volume of calls, we ask providers to please limit themselves to 3 inquiries per call.

POINTS TO NOTE WHEN SUBMITTING AN ADJUSTMENT OR VOID

When submitting an adjustment or void claim, follow these steps to ensure correct processing:

- To void: draw a line through the unwanted claim detail line
- To adjust: draw a circle around the claim change (**Only changes that are circled will be processed)**
- Adjustment claims are treated as replacement claims
- CMS 1500 form: write "Resubmission" on the upper right hand corner of the claim. In FL 22 enter an "A" to adjust or "V" to void along with the original CRN
- ADA 1999 v. 2000: write "Resubmission" in FL 2 and enter an "A" to adjust or "V" to void along with the original CRN
- UB92: write "Resubmission" in FL 2. In FL 4 enter bill type "XX6" to adjust or "XX8" to void. Enter the original CRN in FL 37A

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

BILLING LONG TERM CARE CLAIMS SPANNING TWO FISCAL YEARS

In order to receive payment at the correct fiscal year rate, the claim must be split.

Example:
Admit Date: 06/01/2006
Discharge Date: 07/31/2006

1st claim: Service Covers Period (FL 06) From 06/01/2006 Through 06/30/2006
2nd claim: Service Covers Period (FL 06) From 07/01/2006 Through 07/31/2006

Claims that have already been submitted and paid the incorrect rate must be split into two claims with the appropriate Service Cover Period (FL 06). If the date of service for the claim(s) is past the 12 month timely filing deadline, or adjustment period, then a waiver must be attached to the claim.

CLARIFICATION AND CHANGES IN PRIOR AUTHORIZATION REQUIREMENTS

As of November 15, 2006 there have been changes in prior authorization requirements. Please reference memo: ACS M06-18.

MEDICARE HMO CLAIMS

If the Medicaid recipient has Medicare coverage with Medicare Complete, Evercare or Secure Horizons, follow these steps to ensure payment:

- If billing on the HCFA form, put the carrier name in FL 9D (e.g. United Healthcare / Medicare Complete)
- If billing on the UB92, put the carrier name in FL 50 or 84
- Attach the EOMB to the claim

If Medicare Complete, Evercare or Secure Horizons is present on the claim, ACS will process the EOB as a Medicare EOB by keying in the deductible, co-insurance and payment. ACS will then pay the claim in accordance to the individual plan.

Admission code type 05 is not valid for Hawaii Medicaid. Any claim that is submitted with this admission type will be returned to provider to be adjusted or corrected

WINASAP 2003

WINASAP is a free data entry software provided by ACS that allows providers to submit HIPAA compliant claims electronically. The claims are submitted from a personal computer to the ACS EDI Gateway through a secure 800 number (no internet connection required).

Benefits:

- **(NEW)** Share of cost may be billed
- No charge claims submission 24 hours a day, 7 days a week
- No charge software, training, installation and technical support
- Saves money by eliminating the expense of paper processing and postage
- Reduces claims processing time and expedites claim payment

Requirements:

- Windows 98 (2nd Edition), 2000, XP, NT or higher operating system
- Pentium or equivalent processor
- CD-ROM Drive
- 25 Megabytes of free disk space
- Hayes compatible 9600-baud asynchronous (dial up) modem
- Telephone or facsimile line

Enrollment:

Call the ACS Provider Inquiry Unit at (808) 952-4378. An ACS Provider Field Representative will contact you and send the EDI Agreement form via facsimile or US Mail. This form must be completed and signed. You may fax the EDI Agreement to (808) 952-5595.

Once we receive your EDI Agreement enrollment form, the ACS EDI Department will process it for validity and assign a Trading Partner number along with a unique username and password.

An ACS Field Representative will then contact you to schedule the install and training.

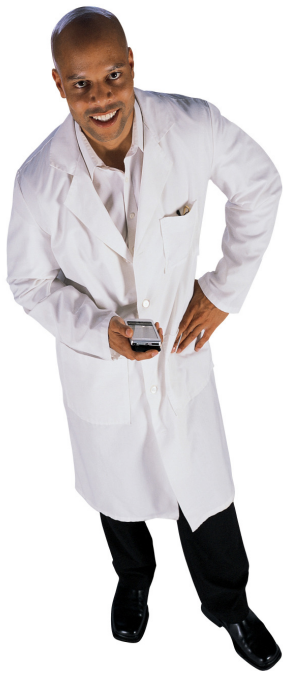
H E L P F U L H I N T S

PROVIDER INQUIRIES

ACS recommends that before calling the Provider Inquiry Unit please be prepared with the following:

- Provider ID number
- Phone number
- Recipients ID number

By having these things prepared in advance you can help ACS decrease call wait times.



MEDICARE CLAIM LINES DENYING FOR DUPLICATE

Charges for Medicare primary hard copy claims that have multiple lines for the same date of service and the same procedure code should be combined into one line.

Example:

The Medicare EOMB has four lines for procedure code 99232 on date of service 05/15/2006, one unit each. Combine the charges into one line for four units and bill to Medicaid.

Thank you for being a Medicaid Provider. You make a difference.

REQUEST FOR RECONSIDERATION FORM 240 REQUIRED / CONDITIONAL FIELDS

Providers are able to submit a Form 240 if a claim issue has been reviewed by the ACS Provider Relations Department and you would like to challenge either a MQD policy or decision. Form 240 must follow the requirements listed below. If it does not follow the requirements it will be returned to you for the appropriate information.

Field Name	Required / Conditional	Comments
Date of Request	Conditional	
Provider Name	Required	Provider Name must match Provider ID # and Claim Reference Number fields.
Contact Name	Required	Provider relations will attention responses back to the person indicated in this field.
Provider ID #	Required	Provider ID must match Provider Name and Claim Reference Number fields.
Provider Phone #	Conditional	Telephone number is used when Provider Relations needs to ask for additional clarification on the 240 form.
Provider FAX #	Conditional	
Provider Address	Required	The response will be returned to the address located in this section.
Provider Email	Conditional	
Claim Reference Number	Required	When requesting for reconsideration a valid CRN is required. CRN must match Provider ID, Provider Name, HAWI ID #, and Date of Service.
HAWI ID #	Required	HAWI ID # must be the same on the form and the claim.
Date(s) of Service	Required	Date(s) of Service must match the claim.
Justification	Required	Please indicate why you are sending a Request for Reconsideration. A letter of receipt will be sent to you within 7 business days.

DME CODES THAT REQUIRE DESCRIPTIONS

The following DME codes require a description when billing Medicaid:

- A6260
- E1399
- A4649
- V2799
- V5267
- K0108

ELECTRONIC FUNDS TRANSFER

EFT allows providers to get Medicaid payments transferred directly from ACS to their checking or savings account.

Benefits:

- Eliminates prolonged waits for the US mail to deliver your check
- No lost checks
- Funds are deposited directly into your bank account on Fridays
- Eliminates traveling to pick up checks

When stating voluntary contribution on a UB92 claim, please indicate “Voluntary Contribution” in FL 50 and the dollar amount in FL 54.

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 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.

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

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Hawaii Medicaid

Look inside for these and other important updates:

A C S®
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