Medicaid Provider Bulletin

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MQD announces new fiscal agent:

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In this issue:

The Med-QUEST Division (MQD) is pleased to announce that effective November 2002, ACS will become the fiscal agent for the Hawaii Medicaid program. ACS will be responsible for:

- Claims Receipt and Data Entry
- Certification of Providers for Electronic Claims Submission
- Claims Adjudication, except medical reviews which will be the responsibility of MQD
- Payments to Providers and Remittance Advice Distribution
- Provider Training and Communications
- Third Party Liability Recovery and Coordination
- Provider Relations, including the Provider Call Center
- Issuing Recipient Identification Cards
- Printing and Distribution of Correspondence to Providers and Recipients

ACS also currently operates as the Pharmacy Benefit Manager for the Hawaii Medicaid Program. They have been processing Hawaii's pharmacy claims since August 2001. There will be no change in the manner in which pharmacy POS claims are processed.

Some functions currently performed by HMSA will be transferred to other parties. For example, provider registration and maintenance and medical authorization determination will be the responsibility of the MQD staff. Cost report audits and rate setting will be contracted during Summer 2002. MMIS system operations will be the responsibility of the Arizona Health Care Cost Containment System (AHCCCS).

ACS brings to Hawaii a depth of knowledge and experience in the Medicaid program. ACS currently serves as the Medicaid fiscal agent or facilities manager in 11 states and is currently implementing Medicaid fiscal agent contracts in three additional states, including Hawaii. Today, ACS processes well over two hundred fifty million Medicaid claims each year, representing multi-billion dollar payments to hundreds of thousands of health care providers. The company is currently in the process of securing office space in Honolulu and hiring local staff to support its fiscal agent operations.

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MQD recognizes that provider questions will arise as a result of the HAPA Claims Project. Future bulletins will provide more information and details. Please e-mail provider questions regarding the new medical claims system (HAPA) project to: ***hquestions@medicaid.dhs.state.hi.us.*** *or fax to "HAPA questions" at 692-8173.*

Electronic Claims Submission Survey

EFFECTIVE IN LATE OCTOBER 2002, the standards for electronic claims submission will change to NSF 4.0 for UB92 and NSF 2.0 for HCFA 1500. Survey letters were sent in late May to providers that currently submit electronic claims. The letters included detailed file layouts for the new electronic standards for both claim types and remittance advices. Providers that currently submit claims electronically will be required to be re-certified using the new electronic standards. Clearinghouses and billing services will need to be certified only once and will be applicable for all providers using that service. In addition, providers that receive an electronic remittance advice will no longer also receive a hard copy.

A new benefit to submitting claims electronically and receiving an electronic remittance advice is the ability to receive payment via electronic funds transfer.

If you want to continue submitting electronic claims, it is important that you return your survey response as soon as possible, the deadline was June 15. Providers that submit surveys after June 15 may have to wait until a later date to begin submitting electronic claims to the new system. If you have not received a survey and are currently submitting electronic claims, please contact hquestions@medicaid.dhs.state.hi.us or fax a request to 692-7972. ■

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"ACS is delighted to have been selected by the State of Hawaii. We have implemented more new Medicaid systems in the last five years than the rest of the industry combined," said Harvey V. Braswell, Group President of ACS Government Services. "We have had a thirty-year history of listening to our customers, ascertaining their business requirements, and implementing impressive solutions for the providers, recipients, and taxpayers of each of the 23 states we serve."

More information regarding the transition from HMSA to ACS, including timing and impacts will be provided in future bulletins. ■

Med-QUEST Division website to help providers stay informed

MQD wants providers to know that the wait for an up-to-date, easy access QUEST website is almost over.

MQD's multifaceted website, due to debut in July, will be accessible to the public and will host up-to-the-minute information about upcoming events, important information and news for the Hawaii Medicaid Provider community.

If you have any questions about MQD's upcoming website please call Elizabeth Ahana, QUEST Public Relations Officer at 692-8077. ■

This newsletter is published for Hawaii Medicaid Providers by the Med-QUEST Division of the State Department of Human Services. If you have any questions or comments about this publication, please call Elizabeth Ahana, Public Relations Officer at (808) 692-8077.

Status of the Claims Project

MQD has entered into an innovative partnership with the State of Arizona to share Medicaid data processing systems to replace Hawaii's current claims processing system. The new claims system will be called HPMMIS (Hawaii Prepaid Medical Management Information System). The HAPA project (Hawaii Arizona PMMIS Alliance) is a major endeavor involving thousands of man-hours for staff from MQD, AHCCCS (Arizona Health Care Cost Containment System), HMSA (current fiscal agent) and ACS (new fiscal agent). The project is currently scheduled for cut-over in October 2002 with the new claims system producing provider payments in early November 2002.

One of the goals of the project is to provide enhanced provider services. These will include:

- Free provider access, 24 hours a day, 7 days a week to an automated voice response system (AVRS) for recipient eligibility verification. The AVRS will also identify whether the client is enrolled in a QUEST health plan on the date of service and any third party liability information.
- Free provider access, 24 hours a day, 7 days a week to an internet web-based recipient eligibility verification and claim status system.
- An enhanced remittance advice will list all reasons that caused the claim to be denied. This information should assist providers in correcting and resubmitting denied claims. The remittance advice will also list pended claims (claims received but not yet paid or denied). This should reduce the need to follow-up on claim status and avoid re-billing claims that are pended.
- Medical authorization determination letters will be sent to both the rendering and referring physician for approvals and denials. This should assist providers in coordinating care.
- Electronic funds transfer will be available at a future date for all providers receiving an electronic remittance advice.
- Dental claim forms will be accepted electronically in late 2002/early 2003.

Additional information regarding each of these services will be made available in future provider bulletins. ■

Helpful Transition Preparation Tips

Providers should consider the following tips in preparing for the transition to the new claims system and new fiscal agent:

- Submit all unbilled claims on a timely basis. If you're behind in billing, catch up now. Claims submitted close to the cutover date to the new system may experience a delay in payment.
- Follow up on outstanding claims where considerable time has lapsed since submission. Do not rebill claims that have been submitted but not paid. Duplicate billings "clog" the payment process. Minimize duplicate billings by properly researching claims status prior to resubmitting an unpaid claim.
- Review remittance advice, denial reasons, and correct denied claims prior to resubmission.
- Reconcile and clean up credit balances. There is no timeliness deadline for returning any overpayments received.
- Return turnaround documents (TADs) in a timely manner. Claims with TADs that are not returned within 30 days will be denied. ■

Medicaid eligible recipients to receive new plastic ID cards

In Hawaii, Medicaid eligible recipients receive a paper Medicaid card in the mail monthly. Producing and mailing over 160,000 of these cards each month is expensive. In an effort to contain costs and improve customer service, MQD will be converting to plastic identification cards during October 2002.

Each eligible recipient will receive a card rather than one card per family. The card will have a magnetic stripe on the back for use in Point of Service (POS) devices just like a credit card. The card will include the recipient's name, HAWI number and date of birth. It will not contain eligibility dates since the recipient will keep this card throughout any changes in eligibility status.

Since eligibility information will not appear on the card, MQD will implement several new options for verifying eligibility. An Automated Voice Response System (AVRS) will enable providers to dial a toll-free phone number to verify eligibility 24 hours a day, 7 days a week. The response will be automated and the service will be completely free to the provider. Through the AVRS, providers will also have the option to lookup the recipient by a combination of name and other identifiers such as social security number or birth date. MQD will also be implementing an internet web-based eligibility verification system that will be a free service to the providers. Both of these options will require separate verification of each recipient. There are no batch capabilities with these options.

Providers have the option to contract with the eligibility vendor(s) that are currently providing eligibility verification services for Hawaii Medicaid. These vendors offer options to verify eligibility by swiping the card through a POS device, looking up eligibility through the Internet, or through software installed in the providers' computers and connected to the vendors' systems. Often, these services offer additional benefits such as linking to a claim entry and allowing batch processing.

From these queries, the provider will learn if the recipient is eligible for Medicaid on the date of service, if the recipient is enrolled in a health plan or fee-for-service, if the recipient has other insurance coverage (TPL), cost share and other information regarding eligibility. This information will be current and available 24 hours a day, 7 days a week from each of the options listed above.

Although there will be a learning curve for all involved with Medicaid, the benefits of moving to plastic cards will be well worth the effort. MQD will save money by producing the plastic cards versus the monthly paper cards and providers will have current information on the recipients' Medicaid eligibility status.

Expect to hear more on the subjects of plastic Medicaid cards and eligibility verification in the next several months. ■

NEW PROVIDER MANUALS MAILED

You should have received your new Provider Manual. They've been produced on a compact disc (CD) for your convenience. Please call 948-6444 if you need a hard copy.

If you have any questions or comments about the new Provider Manual, please call MedQUEST's Health Care Management Branch at 692-8085. ■

Attachment
Provider Q & A

Questions & Answers

MQD appreciates the effort by providers to prepare for the transition and to submit questions regarding the project. Following are responses to some of the questions we have received. You can continue to send questions to hquestions@medicaid.dhs.state.hi.us, and they will be answered in subsequent issues of the newsletter.

The effective date of the changes below will be provided in future newsletters.

Question	Response
General	
1. Why is MQD embarking on this project?	There are several reasons that MQD has undertaken this project: • The current MMIS system is not HIPAA compliant. Medicaid must be HIPAA compliant by October 2003 for electronic transaction standards. HPMMIS will be HIPAA compliant by October 2003. • The current MMIS is over 20 years old. Major changes to the system are difficult. Many of the edits are hard-coded. HPMMIS is a table-driven system with full audit capabilities.
2. What will not change?	MQD's policies related to recipient eligibility, service coverage, service limitations and payments will not change.
3. Will a revised provider manual and provider education be provided?	Yes, ACS will be issuing the revised provider manual and scheduling provider education sessions for late Summer 2002.
4. Will the new system process crossover claims from Medicare?	Yes, HPMMIS will electronically accept crossover claims from Medicare for Part A, Part B, DMERC and FQHC/RHC services.
Claims Standards	
5. Will it be necessary to include the leading zeros when using the recipient number on claims? Will the Medicaid recipient number be a max. of 10 characters?	Claims must be submitted with the leading zeros on the recipient number. The check digit is no longer required. The number on the claim form should be 10 characters.
6. For EPSDT, will the current forms be used?	EPSDT services should be billed on the HCFA 1500 using the appropriate CPT code with an EP modifier. The current EPSDT form will no longer be required.

7. What is meant by outlier claims required with condition code?	Hospitals submit outlier claims for acute facility patients that exceed a charge threshold. These claims must be submitted with a condition code of '61' to be eligible for outlier payment. Outlier claims without the condition code of '61' will be paid using the hospital's PPS rate. Hospitals can begin using '61' condition code immediately.
8. Do claims that reach the outlier threshold still need to be split billed?	Yes. The outlier claim should include the '61' condition code.
9. What is meant by the statement that late charges will be denied?	Late charges can only be billed on an adjustment claim or by voiding and submitting a new claim.
10. Since babies cannot be billed with the mother's HAWI ID number, how will providers know the baby's number?	Providers can call AVRS to obtain the baby's ID number. Providers can also call the provider call center for additional information. The phone number for the provider call center will be available in a future provider newsletter.
Provider Numbers	
11. Will all providers receive a new provider number?	Yes, all providers will receive a new 6-digit number with a two-digit service location code. The number will be issued in late Summer 2002.
12. Will the two-digit provider service location number be part of the Medicaid number? What will the service location identify?	All providers will be assigned a two-digit service location number for each physical location where services are provided. The service location must be submitted on the claim form as part of the provider number.
13. Will the current multiple provider numbers for different levels of long term care service be replaced with one provider number?	Yes, most providers will only have a single provider number.
14. If a provider submits a claim with the current provider number after the transition, will it be accepted?	The new claims system will store the current provider number and translate claims submitted to the new provider number for a limited timeframe after the transition.

Electronic Claims Submission	
15. When will electronic claims submission be effective?	New standards for electronic claims submission is effective in October 2002. A timetable with dates will be provided later.
16. When will testing for re-certification begin?	Testing to re-certify providers for electronic claims submission will begin in August 2002.
17. Would we be able to test one time or would all of our clients be required to test on the EMC submission?	Clearinghouses and billing services will need to be certified only once. The certification will be applicable for all providers using that service.
18. When will we receive specs for the EMC format as well as the HCFA 1500 claim form? Where can we get a copy of the NSF version 4.0 format for electronic submission?	Detailed specifications were provided to all current EMC providers in a letter mailed May 24th. If you didn't receive the letter, please fax a request to 692-7972.
19. How do we set up testing of EMC?	Basic information was provided in the EMC survey letter. Further information will be provided as part of the certification process.
20. When will the additional information for current EMC providers be available?	Survey letters were sent on May 24th.
21. Will MQD be working with clearinghouses to implement Medicaid's edits?	MQD does not plan to work with clearinghouses to implement Medicaid's edits.
22. General questions regarding the ECS standards: a. Are the filler and non-used areas of a record to be space-filled or zero-filled? b. Are optional records not required at all or required under certain circumstances? for c. Are records to be followed by a cr/lf? d. Are transmissions to be zipped?	a. Fill with spaces. b. Optional records are required under certain circumstances. For example, record 31 is required adjustments. c. No carriage return or line feed is needed. d. Yes, zip all transmissions. Further information regarding transmission standards will be provided to those participating in ECS.
23. Questions regarding specific records: a. Record '01' - Processing date field size seems too small.	a. This field has been changed to not applicable.

b. Record '01' - Please clarify the requirement for transmission number to be unique for each transmission.	b. Each transmission must have a unique number assigned. It is recommended that these be numbered from 000001, 000002, etc. If the same transmission number is sent on a subsequent file, then it will be rejected as a duplicate transmission. Within each transmission there can be multiple batches.
c. Record '30' – What are the codes for source payment code?	c. This field has been changed to not applicable.
d. Record '30' - What is the value for payor identification?	d. This field has been changed to not applicable.
e. Record '30' – How should the following fields be completed – insurance group name, group number, group name?	e. These fields have been changed to not applicable.
f. Record '60' – There are no modifier fields for hcpcs codes, is this an omission?	f. Yes, the record layout will be revised and sent to those participating in ECS.
g. Record '90' – There is a record type '91' qualifier but no record layout for record '91'.	g. This field has been changed to not applicable.
Fee Schedule	
24. When will the new fee schedule be available?	The fee schedule will be made available to providers late Summer 2002.
25. Who does the new fee schedule apply to?	All services currently paid on usual and customary charges will be paid on a fee schedule. This includes physician, diagnostic and therapy services. Outpatient hospital services that require a HCPCS or CPT code will also be subject to the new fee schedule. The new fee schedule does not apply to inpatient, dental and ASC services.

Fiscal Agent Transition	
26. When will HMSA stop processing claims? Will there be a lag time between HMSA and the new fiscal agent?	HMSA will stop processing claims in October 2002. MQD is currently working with both HMSA and ACS to plan a detailed timetable for the transition. All parties are hoping to minimize any lag time between HMSA and ACS.
27. There's a rumor that we'll need to send our claims to the mainland, is this true?	No. HMSA will be turning over the current P.O. Box to ACS. ACS will also be operating an office in Honolulu for those who choose to drop off claims.
28. What is the definitive timeline for the transition?	The transition will occur October 2002. MQD is currently working with both HMSA and ACS to plan a detailed timetable for the transition. Further information will be provided.
29. After the transition, can a claim paid by HMSA be adjusted?	Yes, MQD will be converting claims processed by HMSA.
Remittance Advice	
30. Will the new remittance advice show only one denial reason?	The remittance advice will list all applicable denial reasons.
31. If a provider receives an electronic remittance advice, can they also receive a hard copy?	No.
32. Will the denial codes and explanations be the same as the current RA?	No. New codes and explanations will be distributed to providers.