Medicaid Provider Bulletin

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In this issue:

New system promises to enhance claim services to providers

THE MED-QUEST DIVISION (MQD) has begun the process of transferring its fiscal agent functions from the Hawaii Medical Service Association (HMSA) to a new fiscal agent to be named soon. The project is part of an overall conversion from the current Medicaid Management Information System (MMIS) to a new MMIS called the Hawaii Prepaid Medical Management Information System (HPMMIS).

MQD anticipates that the new system and related processes will result in enhanced provider services. This update is the first in a series to communicate vital information on the changes that will occur and the impact it will have on you and the services you provide. The new fiscal agent and system are slated to start in Fall 2002.

In 1999, MQD embarked on a joint information systems project with the Arizona's Medicaid agency known as the Arizona Health Care Cost Containment System (AHCCCS). The joint collaboration between the two states which allows Hawaii to use the AHCCCS information system is called the Hawaii Arizona PMMIS Alliance (HAPA) project. In Dec. 2000, Phase I of HAPA, the managed care component, was successfully implemented. Phase I of the HAPA project designed the system to track recipient eligibility, enroll recipients in health plans, and process encounters.

MQD has now begun Phase II of the project to incorporate claims processing. Phase II of the project includes claims processing and adjudication, prior authorization requests and determinations, registration of Medicaid providers, and generation of remittance advices and checks.

Once implemented, the fiscal agent functions currently performed by HMSA will be transferred to a combination of AHCCCS (for system operations), MQD, and a new fiscal agent for claims processing. ■

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.*

Be Prepared ...
HIPAA is coming!

You've been hearing about HIPAA coming for a few years now. Perhaps you thought it would go away. The implementation date for the Privacy Rule is April 2003, HIPAA compliance will become a way of life for you, your staff and your patients.

GET BACK TO BASICS

The way you do business now will have to change. Patient confidentiality will be priority one. Normal means of communication between your office and outside agencies or vendors will have to go under close scrutiny by the HIPAA compliance officers in your facilities.

Be careful how you disclose information. Check with your HIPAA compliance officer about ways to handle sensitive information. For example: speaking about a certain case in the elevator where it can be overheard is not compliant.

Each of you received a provider manual. Vital information about processes and compliance are part of this manual. Angie Payne, Health Care Management Branch Administrator for the QUEST program suggests that you utilize the provider manual on a regular basis; make it part of your day.

WHAT QUEST IS DOING TO BE HIPAA COMPLIANT

The Department of Human Services, Med-QUEST Division has been preparing for HIPAA since 1999.

The new claims System, HPMMIS will minimize the chances of compromising patient confidentiality. Internal policy and procedure modifications are also being implemented and the QUEST program anticipates to be HIPAA compliant by the 2003 effective date.

If you have questions about MQD's HIPAA initiatives or processes, please submit your questions to Lim Yong, HIPAA Project Manager at 692-8071. ■

NEW PROVIDER MANUALS COMING SOON

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 Med-QUEST's Health Care Management Branch at 692-8085. ■

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 early June 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.

HAPA's impact on you

Although MQD is striving to minimize the impact of the HAPA Claims Project to providers, changes will be necessary. Provided below are the impacts identified to date.

General Provider Impacts

- Provider Medicaid ID Numbers
  - Most providers will be assigned a single new Medicaid provider number by the State. Look for your new provider number information in the mail this summer.
  - Providers will be assigned new two digit service location numbers.
  - Providers will be required to indicate the location where the service was provided using the assigned service location number.
- Medicaid Recipient ID Numbers
  - Medicaid recipients will no longer be assigned a check digit at the end of the client number. Only the 10 character recipient HAWI ID number will be required to submit a claim.
  - Claims for newborns must be submitted with the newborn's Medicaid ID number. Claims submitted using the mother's ID number will be denied.
- Claims Submission
  - A maximum of 25 lines may be included on a HCFA 1500 claim form. Claims that exceed 25 lines should be split billed. All services rendered on the same day should be billed on the same form.
  - Third party liability payment amounts will be required to be entered in the "Reserved for Local Use" field (FL 24K) on the HCFA 1500. On the UB-92 it should continue to be entered in "Prior Payments" (FL54).
- Pricing and Payment Processing:
  - As mandated by state law, non-institutional services will be paid using a new fee schedule. Payment of usual and customary charges will be discontinued.
  - General excise tax will no longer be paid as a separate line item. The new fee schedule reimbursement rates will be all inclusive.
- Turnaround documents (TADs) will be discontinued. Claims that do not contain complete information for payment will be denied. You will need to correct and resubmit the claim for payment.
- Electronic Claims Submissions and Remittance Advice
  - Submission of electronic claims will require new electronic media claim (EMC) formats. The new formats are NSF version 4.0 for UB-92, NSF version 2.0 for 1500. Current EMC providers will be sent additional information regarding these standards. (Additional information can be found on page 4).

Continued on page 4

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. ■

From page 3

- In early 2003, dental providers will be allowed to submit claims electronically using ADA 1999-2000 version for dental.
- Electronic remittance advices will use a new format. Current ERA providers will be sent additional information regarding these standards.
- Providers that receive electronic remittance advices will no longer also receive hard copy remittance advices.
- All providers that submit electronic claims will be required to participate in a testing and certification process. Current EMC providers will need to test and be re-certified using the new submission formats.
- Current EMC providers will be given the first opportunity to be certified using the new formats. Providers currently not certified for EMC submission may request to participate as an electronic submitter afrter Nov. 2002.
- HMSA will discontinue certifying EMC providers using the current electronic claims submission format as of June 30, 2002.

Hospital Acute Inpatient Providers

- Medicaid outlier claims will be required to be submitted with a condition code of '61' and a bill type of '112', '113' or '114'. Claims submitted without the condition code of '61' will not be considered for outlier payment.

Dental Providers

- Dental claims will be required to be submitted on an ADA 1999 v. 2000 form. The Dentist's Treatment Plan and Report of Services Rendered Form should be submitted as a claims attachment when necessary.
- Dental services will be required to use CDT-3 codes.

Anesthesia Providers

- Claims for anesthesia services will be required to be submitted with American Society of Anesthesiologists (ASA) codes for service dates from Oct. 1 2002. Services prior to Oct. 1, 2002 should continue to be billed with CPT Codes with Anesthesia modifier. Anesthesia providers will receive additional information regarding these standards.

EPSDT Providers Only

- Claims for EPSDT services will be required to be submitted on a HCFA 1500 form.
- EPSDT services should be billed with appropriate E & M codes with the EP modifier to receive the appropriate payment rates.

Vision and Hearing Providers

- Claims for vision and hearing services will be required to be submitted on a UB-92 (surgical procedures) or HCFA 1500 (vision and hearing exams) form. ■