Medicaid Provider Bulletin

Published for the Medical Providers of Hawaii
By the Department of Human Services, Med-QUEST Division

VOLUME I, Issue 4
August 2002

Hawaii Medicaid Automated Voice Response System

24/7 Free Access to Recipient Eligibility

In this issue:

The Med-Quest Division (MQD) in conjunction with Medifax EDI as a part of the HAPA (Hawaii Arizona PMMIS Alliance) project will be introducing the new Automated Voice Response System (AVRS). This enhancement to the eligibility verification process will offer all providers in Hawaii 24 hours a day, 7 days a week, real time access to recipient eligibility information through a toll free telephone number. No longer will providers need to wait to receive eligibility information!

How does the new AVRS work?

Providers will dial a toll free telephone number and be prompted through a series of voice response questions to search for a given recipient. The provider can search by Social Security Number (SSN) and Date of Birth, Recipient full name and date of birth or the recipient's HAWI ID. The system will also prompt the provider for the dates of service being verified.

The system will verify with the provider that the appropriate individual has been located in the system by responding back with recipient information.

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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.*

AVRS *continued from page 1*

The system will then prompt the provider through various options for checking eligibility.

What information will be available to the provider through the AVRS system?

Providers will have the ability to verify information regarding a recipient's eligibility. The provider will have access to:

- Medicaid eligibility for the dates of service entered by the provider
- Medicare information
- Third Party Liability (TPL) information
- Recipient's cost share amount and dates applicable
- Whether the recipient is/was in a nursing home and applicable dates
- Whether the recipient is subject to penalized nursing home benefits
- Whether the recipient has lock-in coverage and the lock-in provider name

Providers can complete 10 transactions per call and have the option to speak to a customer service representative if necessary. The system is user friendly: it has a quick response, allows for repeating speech, and allows for reentry on errors.

Providers must use their new HPMMIS provider ID numbers to access the AVRS. The new provider numbers will be mailed in September 2002.

Look out for this new functionality, which will be available September 24, 2002! ■

Have you received your Provider Verification Letter?

Providers should be receiving in the mail a letter from MQD requesting verification of information that Medicaid has on record to communicate with and pay providers. The letter includes the following information currently on file for the provider:

- Provider name
- Provider mailing address
- Each provider service address
- Pay-to information and address
- Tax identification numbers
- Licensing information

Please carefully review all of the information in the letter! This information will be used by the new claims system to adjudicate claims and make payments.

What to do with the Provider Verification Letter:

IF all provider demographic information is correct:

- There is no need to respond.

IF there are any corrections or updates to the provider demographic information:

- Make the changes on the letter and return to MQD as soon as possible. Updates will not be accepted over the phone.

Address: MQD-HCMB Provider Registration
P.O. Box 700190
Kapolei, HI 96709

Failure to correct the information could result in inaccurate payments or claims processing with the new claims system.

If you have not received a provider demographic verification letter please contact MQD at 692-8099 as soon as possible. ■

Coming soon…Check your mail for: New Provider Manuals and Provider Numbers

During September, MQD and ACS will be generating and distributing the new revised Provider Manual and Provider ID numbers for the new claims system.

The Provider Manual will be produced on a compact disc (CD) for your convenience. The new revised manual will have detailed information on the billing changes that will be implemented in conjunction with the new claims system.

The new Provider Medicaid ID Numbers will also be distributed with the new Provider Manuals.

- Most providers will be assigned a single new Medicaid provider number by the State.
- Providers will be assigned new two digit service location numbers.
- Providers will be required to use the new two-digit service location numbers on the claim forms to identify where the service was provided. ■

Key Dates to Remember

The HAPA claims project continues its progress towards the transition to the new claims system. Here are some key dates that will impact the various providers. Please mark your calendars.

Activity	*Target Date*	*Description*
1. Start issuing medical authorizations for a maximum 6 months	Now	• HMSA will begin issuing authorizations for a maximum of 6 months, except for incontinence supplies and level of care determinations (1147). This will assist with the transition to the new claims system. • Note, this is for the transition only to assist with the conversion to the new claims system.
2. Last deferrals issued on Prior Authorizations (PA)	9/13/02	• HMSA will issue deferrals on PAs to providers up to this date. These are the requests to providers for additional information. • From 9/16/02, HMSA will begin denying PAs that require additional information. Providers will need to resubmit their requests with the appropriate documentation • Note, this is for the transition only to assist with the conversion to the new claims system. *(continued on page 4)*
3. Final Turn - Around Documents (TAD) generated	9/13/02	• HMSA will generate the last TADS on this date. • From 9/16/02, HMSA will begin denying claims that would have previously pended for a TAD. • HMSA will also send providers a revised "TAD" that informs them that the claim has been denied.

Status of the 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.

Major project accomplishments to date include:

- Completion of system and integration testing
- Loading of reference tables for the HPMMIS system
- Beta testing with electronic claims submitters
- Development of the new fiscal agent policies and procedures

The HAPA team and ACS are currently busy conducting user acceptance testing, testing with third parties such as Medicare for crossover claims and preparing for provider education sessions. ■

Provider Focused Education Sessions

Our new Fiscal Agent, ACS, will begin Provider Training Sessions in mid-September. The Provider Trainings will focus on what will be new to you including, changes to prior authorization forms and billing procedures. This is also your opportunity to meet ACS. Look for more information coming soon! ■

Upcoming Changes to Claims Processing

- ✓ Pharmacy billing for non-drug items – **The 204 form will be discontinued.** Pharmacies are to bill using the HCFA 1500 form for medical supplies using CPT codes. 204 forms submitted after the cut over to the new system will be denied.
- ✓ Drug administration fees— Providers will no longer use J codes to get reimbursed for drug administration fees. The appropriate drug administration CPT codes are to be utilized for reimbursement of these services. ■

ECS Provider Surveys

If you completed your survey, further information will be distributed in September.

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.

Questions and Answers:

Question	Answer
Electronic Claims Submission	
1. What are the ramifications for not submitting the ECS survey.	The ECS survey responses will be used to schedule providers for re-certification. Current ECS submitters will not be able to submit claims electronically until after they are re-certified. After the transition to the new claims system, if you have not yet been re-certified you will need to submit hard copy claims. Please submit your ECS survey as soon as possible.
2. We currently file electronically for MEDICARE claims since UGS (fiscal intermediary for Medicare) provided the software to file electronic claims. Will the new fiscal intermediary for Medicaid provide the means to file electronic Medicaid claims?	MQD is currently coordinating with ACS for this service to be provided to providers. Further information will be provided through provider seminars and other communications.
3. 1: I urgently need the communication specifications. Can you email or fax to me? 2: Also, do you have more specific claim & remittance specifications? I have the file layout but there aren't field definitions for each. Are you using the standard NSF field definitions?	Providers that submitted a positive response to the ECS survey will be receiving additional information regarding transmission standards shortly. Standard NSF field definitions are used except where otherwise noted.
4. Clearing house wrote: Are each of our clients required to test with you or can we test with 1 client & once we/they pass, our other clients are o.k.?	Once you have successfully completed the certification process, you will be certified as a submitter for all of your clients. They will not need to individually test for EMC certification. Please note that you will be required to submit more than one provider's claims during the certification process.
5. I am a clearinghouse that sends to HI Medicaid and I was told to contact you in the summer to see if you are ready to test the new format that we will need to send to HI Medicaid starting in November. Are you ready for us to test yet?	If you have submitted a positive response to the ECS survey, you will be contacted shortly to begin the testing process.
6. We received a memo regarding the claims submission. We are already using national standard format, what else do we need to do?	Return the survey letter by fax to 692-7972. You will be contacted with further information for the certification process.
7. In record 22 there appears to be a required field "FORM LOCATOR 11 (UPPER)" to contain the Group Pay_To ID. What is this Group Pay –To ID? Is this required on Long	The ECS layout will be corrected. This field should be N/A and should be filled with blanks.

Question	Answer
Term Care/Nursing Home claims and Ancillary bills?	
Provider Identification Numbers	
8. Is the EMC Provider number that will be assigned by DHS/MQD for our whole group and the Provider Medicaid Number for each physician? Are you going to have multiple provider numbers per service location like DHS has now, or will it be a single number per provider of service? When will these numbers be given out or how do we go about applying for them?	EMC submitter IDs will be assigned to each entity that is submitting electronic claims. Individual provider numbers are assigned to each Medicaid provider. Generally, a physician group would be assigned a single submitter ID for EMC claims and each physician would be assigned a unique provider number. The provider numbers will be mailed in September 2002.
9. Will a different location number be required for each doctor a provider refers her patients to?	Location numbers are required for each servicing provider. Service location numbers are not required for referring providers on the claim forms.
General	
10. Medicaid Provider Bulletin, Volume 1 Issue 1 re page EPSDT Providers makes reference to EPSDT services that should be billed with appropriated E&M codes with the EP Modifier. Because EPSDT services include all of Medicaid's services (medical dental behavioral health, meds, laboratory, case management, etc) provided to individuals under age 21 years, does this mean that all services billed for individuals under age 21 years should have the EP modifier. Also what are the E&M codes?	Only preventive visits and catch-up visits for EPSDT services require the EP modifier. Note, the EP modifier should only be billed by EPSDT providers. E&M codes are a category of CPT codes that are billed for evaluation and management services.
11. Will ACS be taking over for entire Medicaid (standard) and Med-QUEST, or just Med-QUEST?	ACS will serve as the fiscal agent for the Medicaid Fee for Service program. The QUEST recipients will continue to be enrolled In managed care health plans.
12. When will the website be available?	MQD's is deploying two new web sites. The first will be available at the beginning of September. It will include provider information such as the provider manual, PA forms and other useful information. During November 2002, MQD will implement the second website which will provide recipient eligibility and claim status information.

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Question	Answer
HIPAA	
13. Who can my office contact if they have transaction and code set questions that may be related to HIPAA rules?	Your office can e-mail CMS at www.cms.hhs.gov/hipaa. Or if they would like to contact the Administrative Simplification Hotline, they can call (410) 786-4232 or e-mail: www.AskHIPAA@cms.hhs.gov.
14. I've heard that the revised HIPAA privacy regulations have gone to the office of the Federal Register for Display. Who can we contact if we have questions?	You can call the Office of Civil Rights (OCR) at 866-627-7748.

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