Medicaid Provider Bulletin

Published for the Medicaid Providers of Hawaii

VOLUME 1, Issue 7
Dec. 2002 / Jan. 2003

ACS Commitment

In This Issue

Effective November 1, 2002, the Med-QUEST Division (MQD) transitioned from the HMSA claims processing to a new Medicaid claims processing system.

As your new Medicaid fiscal agent, we, the staff at Affiliated Computer Services (ACS) extend this commitment to each member of the provider community: 1) to explain how new billing requirements are affecting your claim payments; 2) to help review your Remittance Advice in order to determine which claims have not paid due to system errors, more stringent edit criteria, keying errors, missing data, or billing errors; 3) to work with you to determine what must be corrected on your claim form/ECS record; 4) to expedite the correction of billing or keying errors; 5) to work diligently with MQD and SSD to fix payment problems.

–Sharon N. Foster

Account Manager – ACS Hawaii
Medicaid Med-QUEST Fiscal Agent

Important Contact Information

Provider Inquiry Unit (Call Center):
Oahu: 952-5570
Neighbor Islands: 1-800-235-4378

Eligibility Line (AVRS): 1-800-882-4608

Email Provider Inquiries to:
hi.providerrelations@acs-inc.com

Fax Provider Inquiries to: (808) 952-5595

Fax Urgent Prior Auth Requests to: (808) 952-5562
(Not Applicable To Medicaid Waiver Program)

Med-QUEST Website
The Med-QUEST website is unexpectedly down. A new website will be coming soon, we will keep you informed.

Mail Prior Auth Requests to: *(Not Applicable to Medicaid Waiver Program)*
ACS
P.O. Box 2561
Honolulu, HI 96804-2561

Mail Returned Checks to:
ACS
P.O. Box 1206
Honolulu, HI 96807-1206

Mail MQD Claims to: ACS
P.O. Box 1220
Honolulu, HI 96807-1220

Mail Medicaid SSD Waiver Claims to:
ACS
P.O. Box 4631
Honolulu, HI 96812-4631

Claims Tips

Group Provider ID Number (PIN) vs. Individual Provider ID Number: What to Use When Billing?

- Never use your group provider ID for claims submission. Use hospital provider ID number to bill facility charges, i.e. room & board. Use individual PIN for other charges, such as professional fees.
- Reminder: Please use your new eight digit provider ID # to prevent the delay of your claims from being processed.

Coupons

- When resubmitting a claim that originally required a coupon, attach a copy of the eligibility coupon.

HCPCS Modifiers

- Providers must use valid 2 character HCPCS modifiers.
- Like Medicare, the Medicaid fee schedule has two distinct rates for certain procedures: (1) when performed in facility settings and (2) when performed in settings other than facilities. Codes subject to rates applicable when performed in facilities are identified in the Medicare fee schedule with an asterisk (*). To expedite claims processing for these asterisked procedures, please enter the modifier -32 when asterisked procedures are performed in non-facility settings.

UB-92

- Do not submit claim with a tax line (RC 091). Including a tax line will result in denial of your entire claim.
- The total amount paid by the TPL must be entered in FL 54. If the recipient has more than one TPL, the amount paid by each TPL must be indicated on each line. If the TPL denied the claim, then indicate $0 on every line where no TPL payment was received.

Dental

- Remember to submit claims using CDT-3 procedure codes. All of these codes have a leading “D” which is required on your claims.
- Dental claims must be submitted on the ADA 1999 version 2000 dental claim form or a claim form in identical format.
- Enter the rendering provider’s ID number in block 44. If the visit was the result of a referral, enter the referring provider’s ID number in block 47.
- If a procedure requires a tooth number, you must submit a double digit number for permanent teeth, i.e. 08. Single characters are accepted only for primary teeth.

Billing for Room Charges and Ancillary Charges

- Long Term Care ancillary charges that are reimbursed in addition to the PPS rate should be submitted on a separate claim form.
- Use the appropriate level of care bill type for room and board charges. The bill type for ancillary services should be the same. Use appropriate HCPCS for ancillary services.

Continued Page 3

Billing for Room Charges and Ancillary Charges (Continued)

Level Of Care	Bill Type	Room & Board Rev Code
Subacute	17X or 27X	19X
ICF	61X	1XX
ICF MR	65X	1XX
SNF	21X	1XX
Swing Bed SNF	28X	1XX
Swing Bed ICF	68X	1XX
Waitlisted subacute	17X	19X
Waitlisted ICF	11X or 21X	11X (w/occurrence span code 74)
Waitlisted SNF	11X	11X (w/occurrence span code 75)

Electronic Claims Submission

- After successfully passing the ECS process, remember to change your Transmission Indicator from test to production.
- For HAWI ID's (a.k.a. recipient ID's), submit with full 10 characters (include leading zeros). Do not submit with check digits. If the HAWI ID number is submitted without leading zeros, the claim will deny.
- The Transmission Window for ECS is from Midnight to 6:00 p.m. HST Monday through Thursday and from Midnight to 4:00 p.m. HST on Friday. The transmissions must be completed within this time frame.

Medicare Crossover

- Medicare crossover claims do not require the referring provider's Medicaid ID number for consult procedures.

DME Rental Charges

- When billing for rental charges for an entire month, providers should use the first date of service as both the beginning and end dates, i.e. 12/01/02 – 12/01/02 instead of 12/01/02 – 12/31/02.

Med-QUEST Prior Authorizations

Definition of "Urgent" Request for Prior Authorizations

Urgent medical conditions are conditions that require medical care within four days/32 working hours. If the care is not received during this time, a person's life or health may be jeopardized.

- Truly "urgent" requests will be reviewed within 48 hours (two business days) of receipt.
- Retro-authorization of services and incontinent supply requests are not considered "urgent."
- Submitting a request for routine care at the last minute is not "urgent."
- Please *kokua:* Marking "urgent" on requests that are not truly urgent slows down the process and clogs up the system.

Multiple PA Letters

We are aware that the PA correspondence is producing multiple letters, each being mailed separately. We are working to modify the correspondence to list multiple lines on the same letter.

Behavioral Health Alert

Behavioral Health Providers must submit the correct CPT codes, include the number of visits per time period

Continued Page 4

Med-QUEST Prior Authorizations

Continued from Page 3

and the dates of service to ensure timely processing of PAs and associated claims. If a provider is using more than one CPT code, they must state how many visits per code.

Prior Authorizations in HPMMIS

HPMMIS allows only one active PA for a single date of service & service code. Be aware that any new PA approved with the same dates of service & service codes will take the place of previously approved PAs with the same dates of service and service codes. Only service codes specified in the new PA will be approved. Any service codes listed on the old PA, that are not included on the new PA, will be end dated the day before the start of the new PA.

Conditional Authorizations

Recipients Pending Eligibility

Providers should submit the PA with "DHS Pending" documented in the recipient ID field. The provider must then resubmit the PA with a copy of the conditional letter when the provider has the actual recipient ID number.

Referring Provider Signature

The conditional provider letter is sent out to vendors who submit urgent PA requests without the referring provider signature. The vendor must get the referring provider signature within 30 days and submit it to ACS or the PA will be denied.

Pharmacy Prior Authorizations

Prior Authorization requests for drugs need to be sent to the ACS PBM in Atlanta.

How to Prevent Delays in Prior Authorization Processing

- Write legibly, illegible PA requests will be returned. All the required information must be clearly written or requests for services may be delayed.
- Excessive number of duplicate requests impacts productivity timeliness and delays responsiveness to PA requests. We are currently receiving a high volume of duplicate PA requests. If a PA is sent via fax it doesn't need to be sent hard copy as well.
- Providers must specify the quantities of services requested per a time period, i.e.: 1/month, 6/year etc. to ensure accurate processing of PAs.
- DMEs for less than $50 do not require a PA. PAs will be returned to providers.
- Please use the new revised PA forms. They can be printed off of the new provider manual.
- Recipients with Medicare Primary do not require Prior Authorization, unless it is a service not covered by Medicare.
- When submitting PA do not use group billing number, use servicing provider number.
- On Prior Authorization form 1144, complete the Medicare coverage box below the recipient ID number.

Interisland Travel for Medical Services

Med-QUEST is currently in the process of revising the process for interisland travel for medical services. Please look for further details in future bulletins and memos.

Dental Prior Authorizations

ADA form should **not** be used as a Prior Authorization form. Please use the 1144 Prior Authorization form.

Top 12 Reasons Why Your Claim Didn't Get Paid

Reason	Corrective Action
1. Claim submitted with MMIS Provider ID without the middle zeros or claim submitted with an HPMMIS Provider ID without the leading zeros.	Provider numbers must include all 6 digits (with or without the check digit for old MMIS ID complete with all zeros). Zeros must be included. Use your new Provider ID number.
2. Claim submitted with recipient ID without the leading zeros (with or without the check digit).	Recipient numbers must include all 10 digits (without the check digit).
3. Claim submitted with tax line – Z9020, S9999 D9020 or 091 revenue code.	To expedite processing of your claim, please do not include charges for tax. For UB-92 providers, charges for taxes will cause the entire claim to deny.
4. Dental claim without CDT-3 codes (looks like anesthesia codes).	Dental claims billed without CDT-3 codes will deny.
5. Interim claims (for inpatients and long term care) with a discharge hour or a discharge hour of 0.	Interim claims should have a blank discharge hour.
6. Medicare information submitted on the wrong part of the claim form (deductibles and coinsurance should be listed in FL39-41 on the UB-92, as opposed to FL 55).	Medicare deductibles and coinsurance should be listed in FL 39-41 on the UB-92. The EOB must be attached.
7. Claim does not include an indication of payment from other payors when the recipient has other insurance, or Z codes are being used for TPL amounts.	Payment from other payors should be indicated on the claim. If the service is not covered by the other payor, include a payment received amount of zero.
8. Recipient not eligible for dates of service and/or recipient enrolled in health plan on dates of service.	The recipient must be in the Fee-For-Service program on the date of service and/or date of admission.
9. Provider tax ID number on the claim does not match those for the provider.	The provider tax ID number on the claim must match the information that HPMMIS has on file. If your tax ID number changes, please report the change to MQD on an 1139 form.
10. Outpatient hospital claims with only the revenue code on the claim line and missing the appropriate CPT/HCPCS codes.	Outpatient hospital claims must be billed with a CPT/HCPCS code unless it is an emergency claim with revenue codes 25X and 63X.
11. Claim requiring a prior authorization. No prior authorization on file in HPMMIS.	If a prior authorization was obtained, then resubmit the claim and attach a copy of the approved authorization. Claims for the Medicaid Waiver Program should be resubmitted after contacting case manager.
12. Anesthesia claims billed without the minutes. Also anesthesia claims billed without the ASA modifiers.	Anesthesia claims must include either an 'AA', 'QK', 'QY' or 'QS' modifier. The minutes must be included on the claim with the units below the minutes.

Good to Know ...

New Provider Manual CDs

Provider manuals on CDs have recently been mailed out. Please contact ACS at 952-5700 if you have not received your manual.

Changes to Your Provider Profile

If you need to make any demographic changes, please submit changes on an 1139 form and mail to: DHS/MQD/HCMB, P.O. Box 700190, Kapolei, HI 96709-0190. Medicaid Waiver Providers should submit changes on an "SSD/Medicaid Waiver Provider Application Change Request" form and mail to: Social Services Division, Contracts: Monitoring, 810 Richards, Ste. 501, Honolulu, HI 96813.

Claims Resubmission

We are constantly updating and refining our claims system. If you have determined that a claim has been denied in error, please resubmit your claim.

Codes for Which No Separate Payment Is Made

Effective 02/01/03, the Med-QUEST Division will no longer pay separately for the codes in the table below. Consistent with Medicare policy, when these codes are covered, payment for them is bundled into payment for other services.

R0076	78891	92533	93770	99002	99071
36540	78891-TC	92534	93770-TC	99024	99078
78890	78891-26	93740	93770-26	99052	99090
78890-TC	92531	93740-TC	96902	99054	99091
78890-26	92532	93740-26	99001	99056	99288

Non-Covered Codes

The following is a list of CPT-4 codes that are not currently covered by Medicaid. Medicare considers theses as B status codes for which separate payment is not allowed.

A4270	99000	99116	99142	99372	99379
90885	99050	99135	99361	99373	99380
90889	99058	99140	99362	99374	
96545	99100	99141	99371	99377	

Continued Page 7

Good to Know (Continued)

Long Wait Times to the Provider Inquiry Unit

We apologize for the long wait times you may have experienced. Most of the calls are due to claims status inquiries which usually causes an increase in our talk time due to multiple claim look ups and explanations.

In order to improve access to our call center, if you are checking status on your claims, please complete the Medicaid Correspondence Inquiry Form below and fax to us at (808) 952-5595 or mail to: ATTN: Provider Relations, ACS State Healthcare, 1440 Kapiolani Blvd., Suite 1400, Honolulu, HI 96814.

Provide us with:
- provider name and Medicaid ID #
- patient's/recipient's ID #
- dates of service
- claim number, if available.

We will research the claim and get back to you.

ACS State Healthcare
1440 Kapiolani Blvd., Ste. 1400
Honolulu, HI 96814-369

MEDICAID CORRESPONDENCE INQUIRY FORM

1. Date of Inquiry	2. Provider Name (Last, First, Middle Initial)		
3. Provider Number	4. Address ❑ Pay to Address ❑ Service Address		
5. Telephone Number	6. Name of Contact	7. Correspondence Number	
8. Claim Number (if applicable)	9. Purpose of Inquiry: ❑ Questionable Payment ❑ Adjustment/Correction ❑ Claims Status ❑ Claims Filing Procedure ❑ Other:		
10. Patient Name	11. Patient ID Number	12. FM Code	
13. Dates of Service	14. Payment Date	15. Charge	16. Allowance
17. Remarks			

18. Response to Provider:
- ❑ Claim Paid on _____
- ❑ Denied on _____ Reason: _____
- ❑ Claim Reviewed, Maximum payment made.
- ❑ Adjustment claim initiated.
- ❑ Please submit claim with _____
- ❑ Patient name and ID # not in DHS files.
- ❑ Claim is in the processing system. Please allow additional processing time.
- ❑ Referred to DHS for determination and response directly to you.
- ❑ Unable to match above claim data with computer file data. Please submit copy of claim.

Comments: _____

Shaded area for Medicaid use only

AVRS Helpful Hints

- You must call from a Touch-tone phone with Touch-tone dialing enabled.
- Program the AVRS #, 1-800-882-4608, on speed dial.
- Have your new 8-digit provider ID # and recipient's 10-digit HAWI # or SSN ready.
- Once you are familiar with the AVRS, you can key ahead responses to most prompts. You need not wait until the prompt has been completely spoken to press a key or enter your response.
- Typical call flow: **1111, PIN** & **#, 1, HAWI** & **#, #, #, 3, #,** 3 to start new search, HAWI & #, #, #, 3, #, 3 to start new search**.**
- All menu options may be bypassed by entering your next selection. The only menu option that cannot be bypassed is the verification of recipient information. This is because you should be verifying that the recipient information is correct. After the recipient information, eligibility info, TPL and any other applicable info is given, you may start your next search.
- You have two chances to enter valid data in response to a prompt. If you enter invalid data more than twice your call will be terminated. In this instance, hang up and try your call again.
- Press **7 to repeat the current prompt.
- Eligibility information is typically good for the entire month. Example: You call AVRS on Dec 13 and the recipient is eligible for that date of service. Generally, that recipient will remain eligible through Dec. 31. However, the recipient may not be eligible on a prior date (i.e. December 1). Make sure to specify the date of service when checking eligibility.
- It is important to note that recipients can gain eligibility mid-month. Example: You call AVRS on Dec. 15, and the recipient is not eligible. On Dec. 16 you call AVRS, and the recipient is now eligible.
- Press # to use the current date as the beginning and ending date of service. You will not be able to look up eligibility information for future dates. To request backdated eligibility info enter your start date as mm/dd/yyyy. The end date must be within 30 days of the start date.

- Call 1-800-518-8887, AVRS Hotline, to report technical difficulties.
- To obtain an AVRS User Manual, go to www.medifax.com, click on Products at the top of the page, select User Manuals, select Voice Response System, and select Hawaii Medicaid Eligibility.

State Healthcare
1440 Kapiolani Boulevard, Suite 1400 • Honolulu, HI 96814