Medicaid Provider Bulletin

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Mark your calendar!

Provider education sessions coming to a town near you.

In this issue:

Provider education sessions begin in late August. These sessions will give you detailed information regarding the new claims processing system, Fiscal Agent, recipient ID cards and changes in billing practices. Sessions are currently scheduled for:

August 27, Tuesday
Maui Arts & Cultural Center
1 Cameron Way
Kahului, Maui

August 28, Wednesday
Queen's Medical Center
Conference Center Building (next to the Hawaii Medical Library)
1301 Punchbowl St.
Honolulu, Oahu

August 29, Thursday
Queen's Medical Center
Conference Center Building (next to the Hawaii Medical Library)
1301 Punchbowl St.
Honolulu, Oahu

September 4, Wednesday
Hilton Waikoloa Village
425 Waikoloa Beach Drive
Waikoloa, Hawaii

September 5, Thursday
Hawaii Naniloa Resort
93 Banyan Drive
Hilo, Hawaii

September 6, Friday
Radisson Kauai Beach Resort
4331 Kauai Beach Drive
Lihue, Kauai

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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.*

Status of the Claims Project

MQD HAS ENTERED INTO an innovative partnership with the State of Arizona to share Medicaid data processing systems that will 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 cutover in October 2002 with the new claims system producing provider payments in early November 2002.

Major project accomplishments to date include:

- Documentation of system requirements and design
- Selection of the new fiscal agent
- Coordination with third parties, including Medicare for crossover claims
- Development of policies and procedures to support the new system
- Finalization of requirements for the conversion of HMSA claims and prior authorization documents

The next month will be busy for the HAPA team as they prepare for user acceptance testing and review the converted HMSA claims. ■

Reserve a date! *continued from page 1*

Registration will begin at 8:30 a.m. Each session is scheduled from 9 to 11 a.m. The sessions will include an overview of the claims project, the new recipient identification cards, the automated voice response system for eligibility verification, the new provider ID numbers and other impacts to the providers. Representatives from MQD, Medifax and ACS will be present. Pre-registration is not required. All providers are encouraged to attend to find out more about the changes being made. ■

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 this summer 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.

Important: Check your mail for Provider Verification Information

Beginning in late July through August, MQD will generate and mail letters to providers to verify information that Medicaid has on record to communicate with and pay providers. The letters will include all information that MQD has for the provider, including:

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

Every effort is being made to update the system for the most accurate and current information available. Please be aware that this information will be used by the new claims system to adjudicate claims and make payments. Please take the time to carefully review all of the information in the letter. Return to MQD any corrections or updates as soon as possible. Changes will only be accepted in writing. Failure to correct the information could result in inaccurate payments or claims processing with the new claims system.

If you do not receive a verification letter by September, contact MQD at 692-8099. ■

ECS Provider Survey

If you are a provider that currently submits claims electronically and have not received an ECS Provider Survey, please contact us to receive a copy of the survey:

Fax us:
692-7972

OR

Email us:

hquestions@medicaid.dhs.state.hi.us

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. ■

Upcoming changes to claims processing

In preparation for the conversion to the new claims system, MQD has requested that HMSA change portions of its claims processing. Changes include:

- **No More Turn-Around Documents**. Effective from mid-September, HMSA will stop generating turn-around documents (TADs) to providers. Instead, claims that would normally pend due to incorrect or incomplete information will be denied.

  HMSA will generate a new denial detail document that will provide a list of the reasons the claim was denied. The new denial detail document will look like a TAD, how ever, it will be printed on yellow paper. Providers should use this new denial detail document to correct and resubmit the claim. HMSA will not correct claims based on any denial detail documents returned with corrections.

  Refer to the sample document titled, "Important Notice: Do Not Return This Form." Please note, that the new claims system will not pend claims and generate TADs.

- **No More Pends for Medical Authorizations**.

  Effective from mid-September, HMSA will no longer pend medical authorization requests for additional information. If additional information is required, HMSA will deny the authorization request and the provider will need to resubmit the request. Please note, that this is for the transition period only. After the new claims system is implemented, medical authorization requests that need additional documentation will be pended for 30 days.

- **Recovery of Outstanding Credit Balances.**

  HMSA and MQD have identified providers with outstanding credit balances (due to voids or adjusted claims). Providers may receive letters requesting payment for these credit balances. In some circumstances, the provider may have a credit balance on a provider number, which is no longer valid, or different than the provider number under which the credit balance was accrued. For these providers, HMSA will be transferring the credit balance amount to a related provider number that uses the same tax ID number, so that the credit can be offset by claims to be paid. The remittance advice will identify the credit balance amount transferred to the new provider number.

- **Listing of Outstanding Checks.**

  HMSA and MQD will be transferring to the State Department of Budget and Finance (B&F) a list of provider checks that have not been cashed. B&F will be publishing a list of these stale dated and escheat checks. Providers should check the list to ensure that they do not have any un-cashed checks from Medicaid.

- **Limit to Medical Authorizations.**

  Effective August 2002, all medical authorizations, with the exception of incontinence supplies and level of care determination (1147), will be limited to 6 months. Incontinence supplies will be limited to one year. This will be for the transition period only. ■

Reminder: Proper billing with HCPCS codes

Claims which are submitted for multiple and different size gauze pads that are prescribed and dispensed on the same day which require the same HCPCS code, will be paid only if the following format on the Form 204 is used:

- A descriptive entry of name and size of the gauze pads;
- Each is to have a distinct and separate RX number assigned to it;
- Place a large bracket to note the different sizes under the same HCPCS code and;
- Enter the total of all the different sizes in only one metric quantity box, date the dispensed box, charges, days supply, and brand necessary.

Please review the correct and incorrect billing examples attached to the back of this newsletter.

If the "correct" method of billing is not followed, only one HCPCS will be paid and the other will be rejected as a duplicate billing.

If you have any questions regarding the above HCPCS code information, please contact Lynn Donovan, Med-QUEST Division Pharmacy Consultant at 692-8116. Questions may also be faxed to 692-8131.

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 Coverage Management Branch (HCMB) at 692-8099. ■

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.

Question	Response
General	
1. How will prisoners charges be handled? Currently, we receive a coupon from the prison facility and this is used to bill the charges to Medicaid. How will this work in the new environment?	Both the Office of Youth Services and the Public Safety Division will be providing HPMMIS a list of its recipients. The recipients will be issued an identification number to assist in claims payment. This list will be used to adjudicate claims.
2. Will eligibility for baby cases be accessed via cross-reference to the mother's eligibility?	Unfortunately, babies and their mothers are not always in the same eligibility case. The automated eligibility systems will allow providers to look up recipient numbers based on a combination of name and date of birth or social security number. Providers that need the baby identification number and are unable to locate them, can call the provider call center and they will assist in identifying the baby's number.
3. It is our understanding that it is the mother's responsibility to report the birth to Medicaid. We have had numerous experiences where baby's birth is not reported and we've had to "chase" the mother to report the birth to Medicaid. Couldn't we bill the mother for baby's charges if the mother has failed to report the birth to Medicaid?	No, providers cannot bill the mother for the baby's charges. Providers should work with the mother and the eligibility worker to process the applications.
4. How will cost share be communicated to the provider on each patient's account?	Cost share amounts will be available on the automated eligibility verification and web eligibility verfication systems.
5. Will coupons be eliminated?	Coupons will not be eliminated, however their use will be reduced. Due to the various means that will be available for a provider to verify eligibility, the need for coupons should be reduced.

6. Will the patients' picture be on their ID card?	As is currently, the client's picture will not be on the ID card. Providers should request additional verification of identification if they feel it is necessary.
7. When can we expect to receive the billing manual/requirements? Will Z codes still be used?	The revised provider manual is scheduled for distribution in late August/early September. Z codes will still be used except for EPSDT, TPL and GET.
8. When will we be provided with a contact at the carrier.	ACS is in the process of establishing its Honolulu office and hiring its staff. Additional information will be provided at a later date.
9. Will paper claim requirements change?	Some paper claim requirements will change. For example, third party liability payment amounts will be required to be entered in the "Reserved for Local Use" field rather than the Z code. Some of these have been communicated in prior provider bulletins. A comprehensive list of billing changes will be communicated shortly to providers.
10. Could we be provided with a list of eligibility vendors currently providing eligibility verfication services for Hawaii Medicaid?	Currently Medifax is the only vendor providing eligibility verification services for Hawaii's Medicaid program.
11. If we are currently filing hard copy Medicaid claims (not electronically), will we be able to continue filing hard copy Medicaid claims with the new fiscal agent?	Yes, in fact HMSA will be transferring its P.O. Box to ACS. Therefore, hard copy claims can continue to be mailed to the same address.
Provider Numbers	
12. When can we expect the new provider number?	New provider numbers will be mailed in September.
13. What will the new provider number format be?	Provider numbers will be 6 characters with a two-digit service location number.
14. When can we expect the new two-digit service location numbers and are they similar to the place of service codes?	Service location numbers will be mailed in September. They are a two-digit identifier for each service location used as a suffix to the provider number. They are not similar to the place of service codes.

Electronic Claims Submission	
15. Will the new HPMMIS electronic claim standards apply to pharmacies?	Drug claims are not affected by the new HPMMIS system. ACS will continue to accept and process these claims as the Pharmacy Benefit Manager (PBM).
16. We send our supply claims to HMSA using a HCPCS code. How can we bill for supplies?	The process will continue to be the same. Supplies should be billed on a HCFA 1500 using HCPCS codes through HPMMIS. The new claims system will process these claims.
17. Will NSF 3.01 be an acceptable format for HCFA 1500?	No, currently we can only accept NSF 2.0 for HCFA 1500s.
18. Why were the newer versions of NSF not chosen?	Currently HPMMIS can only accommodate these versions of the NSF. Changes will be made by October 2003 to be compliant with the EDI transaction standards.
19. Is there some significance to the fields that were sent vs. those that are not used? How should fields that are not applicable be filled? We assume that the files will follow standard and be fixed length records.	Fields that are not applicable are not used by HPMMIS and should be sent as spaces. The layouts follow the NSF specifications and are fixed length records.
20. We would like to know how your software will validate the fields it receives on electronic claims.	More information is needed to respond to this question. Please provide specific questions. We will be providing ECS providers with an ECS manual that may answer some of your questions.
21. We are not familiar with the remittance formats, so we will need full specifications.	Specifications were provided in the ECS survey letter mailed to providers. Additional information regarding transmission standards will be given to providers participating with ERA.
22. When is testing of EMC scheduled to occur?	Certification of providers for EMC and ERA will begin in late August through October.
23. How soon would we be able to receive an ERA file for review and testing on our system?	ERA will be part of the certification process from late August through October.

24. In most cases, the submission of a hard copy claim form is required as it is being submitted along with an explanation of benefits remittance advice from a primary health insurance plan. Would you please confirm that this requirement will continue.	Yes, providers will be required to attach explanation of benefits remittance advice from other insurance carriers. Failure to submit this information could result in delay of claims processing or denials.
25. Will the HIPAA formats ANSI 837 version 4010 and ANSI 835 be accepted on November 2002?	No, HPMMIS will not be ready to accept these formats by November 2002. Future modifications are being made to the system for HIPAA compliance. MQD intends to be HIPAA compliant by October 2003.
26. Could we receive both the electronic and hard copy RA?	No, providers that receive the electronic RA cannot also recieve a hard copy RA. The electronic RA is formatted as a fixed length record layout with defined record types. Providers can upload this information to a database, such as Excel if necessary to print.
27. Our office would like to start submitting our claims electronically. Can we be sent some information on EMC and the NSF 4.0 and NSF 2.0 standards?	Registration forms and file layouts will be posted to the MQD website soon.
28. If we have not received the survey but are currently submitting claims electronically, can we still fill out this survey to send and remit electronic claims to Medicaid on time? What is the deadline for receipt of the survey?	Yes, surveys can be faxed to 692-7972. Every attempt will be made to certify current EMC providers by late October.
29. We have reviewed the information regarding the new ECS file layouts for claims and remittance. Since we currently use the NSF format for claims we compared the layouts with our current NSF layout and it appears that the file layouts we received were incomplete. Since the remittance file layout records were of different lengths, we assume that this file layout is also incomplete. When can we expect a complete set of file layouts for claims and remittance.	The file layouts received for claims and remittance are complete. The remittance advice records are of fixed length, the balance of the ERA file layouts are fillers.