



Medicaid

Provider Bulletin

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PROVIDER INQUIRY PROCEDURES

In order to assist you in timely manner, please have the following information available before calling the ACS Provider Inquiry Unit:

1. Provider Identification Number
2. Recipient's (patient's) 10 digit HAWI Identification Number
3. The dates of service of the claim/prior authorization you are calling about.

All new claims take an average of two weeks to process. If a claim has been denied please make the appropriate corrections and submit as a new claim. Resubmission claims take longer to process than new claims.

Frequently Asked Questions:

Q: How do I know if my claim has been denied or approved?

A: Every time your claim is processed a Remittance Advice (RA) is created. The RA report is separated into 4 sections: Approved Claims, Denied Claims, Claims in Process and Voided Claims. Find the page that has your patient's name and claim information. Look at the top middle section of the page and you should either see: "Approved Claims", "Denied Claims", "Claims in Process" or "Voided Claims". If the claim is listed on the page where "Approved Claims" appears at the top of the page then a check that includes payment for that claim should be mailed to you the following Friday. If your claim is on the "Denied Claims" page and you need further assistance with your denial, call the ACS Provider Inquiry Unit at 952-5570 on Oahu or 1-800-235-4378 from the neighbor islands.

Q. What if my claim only paid for one unit?

A. Check FL24G of your CMS 1500 form and make sure you have the correct number of units or days listed. If it is left blank, the claim will only pay one unit. For the UB92, check FL46.

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Pass It On!

Everyone needs to know the latest about Medicaid information. Be sure to route this to:

- Office Manager
- Billing Department
- Medical/Clinical Professionals
- Other Support Staff

Questions about claim filing deadlines may be directed to the ACS Call Center at please call the Provider Inquiry Call Center at: 952-5570 on Oahu or 1-800-235-4378 on neighboring islands.

GUIDELINES FOR PROVIDER REFUND CHECKS

If your facility submits refund checks to ACS, please ensure the following is included with your refund:

1. Refund checks for claims paid by Hawaii Medicaid should be made payable to ACS Medicaid or Hawaii Medicaid and mailed to ACS, P.O. Box 1206, Honolulu, Hawaii 96807-1206.
2. The check amount must be the same dollar amount to the claims that are being refunded.
3. Supporting documentation with the refund check must include the following:
 - a. Claim Reference Number (CRN)
 - b. Recipient name and Recipient identification number
 - c. Date of service
 - d. A specific reason why you are refunding the money
 - e. A copy of the insurance carrier's EOB must be provided for TPL or other insurance over payments
 - f. Provide copies of Remittance Advices for duplicate payments. If the claims were paid prior to October 31, 2002, please provide copies of the Explanation of Benefits that were provided by the previous Fiscal Agent (HMSA-Medicaid).
4. Refund checks for claims paid by Prescription Benefits Manager (PBM) should be made payable to: ACS Prescription Benefits Manager and mailed to PO Box 967, Henderson NC 27536-0967.
5. If the above information is not submitted with your refund check, it will be returned to you with a form letter indicating the specific documentation required to process your request.

REFERRING PROVIDERS

Per the Medicaid Provider Manual Chapter 4.3.4, *only* Medicaid providers may be referring providers. When a referring provider is required on a claim or authorization, please indicate the referring provider's eight-digit Medicaid number on the form.



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Q. When will I get my check?

A. Checks are issued the following Friday after the Remittance Advice is sent out and will

arrive via US postal service.

There is an option to pick up your checks at ACS on Fridays. You will need to sign and submit an authorization form, which you can obtain by calling the ACS Provider Inquiry Unit at 952-5570 on Oahu. Checks are available for pick-up from 8:00 AM to 5:00 PM at 1440 Kapiolani Blvd., Suite 1400, Honolulu, HI 96814.

A quicker option is to receive payment through Electronic Funds Transfer, or EFT. With this service, the money will be directly deposited into your account. Please call the ACS Provider Inquiry Unit or contact your Field Representative for more information at 952-5570 on Oahu or 1-800-235-4378 from the neighbor islands.

SUBMITTING ADJUSTMENT OR VOID CLAIMS

To ensure that processing of adjustment or void claims is being done correctly, please follow these submission guidelines: When submitting an adjustment claim, or requesting that a claim be voided, please be sure to enter an "A" (for adjustment claim) or "V" (for void claim) in FL22 on the CMS 1500 claim form or FL2 on the ADA 2002 form. For the UB92 use bill type XX6 for adjustments, and for a void claim use XX8. In addition, please provide the original 12-digit Claim Reference Number (CRN), found on your remittance advice in the applicable field.

The entire claim should be submitted exactly as originally billed, with any corrections circled, and deletions crossed out, etc. This will ensure that it is clear what you are requesting to be changed or voided. For a claim originally submitted with multiple lines, please submit all lines, even if only making an adjustment or void request for one line. Do not cross out lines that have already paid, unless you want them voided.

Any adjustment or voided claims where information is different than what was originally submitted, without indication that you wish to change that field, will be returned to you for clarification.

EMERGENCY VISIT ON SAME DATE AS INPATIENT DISCHARGE DATE

If a recipient is discharged from an inpatient hospital stay and subsequently returns to the emergency room for a similar diagnosis, the emergency room services are considered part of the inpatient stay and therefore are not covered.

WAIVER OF FILING DEADLINE FOR WAIVER AND FEE FOR SERVICE CLAIMS

If the claim being submitted is more than 12 months from the date of service, a waiver is required to prevent a denial for past filing deadline. Requests to waive the filing deadline for home and community-based waiver service claims must be submitted to:

SSD/MWS
810 Richards Street, Suite 501
Honolulu, HI 96813

Requests to waive the filing deadline for fee-for-service claims must be submitted to:

DHS/MQD/FO
Post Office Box 700190
Kapolei, HI 96709-0190

For both fee-for-service and community-based requests, you must list the names of the recipient, date(s) of service and CRN. Please include documentation and a description of the extenuating circumstances. If you have several claims for which you require a waiver, you may list these claims on a single request letter. If your waiver is approved, you must attach a copy of the waiver letter to each claim and submit the claims to ACS within the allotted time noted on the waiver approval.

Questions about claim filing deadlines may be directed to the ACS Call Center at :952-5570 on Oahu or 1-800-235-4378 on neighboring islands.

CORRECTION: **TO SEPTEMBER 2005 PROVIDER BULLETIN OUTPATIENT SURGICAL BILLING**

Hospital facilities were notified of outpatient surgical billing instructions on page 8 of the September 2005 Bulletin. Memo 05-04 details these billing instructions and can be accessed at www.med-quest.us.

ELIGIBILITY TERMINATES IN THE MIDDLE OF CONFINEMENT

When recipient eligibility terminates with Medicaid Fee For Service during an acute non-outlier inpatient stay, the claim should be billed accordingly:

- In FL04 (Type Of Bill): XX1
- In FL22 (Patient Status): 30
- In FL06 (Statement Covers Period): the through date must be the last date of the recipient's eligibility



MODIFIER 59

The modifier -59 requires that supporting medical records be submitted with the claim. This modifier is

used to indicate that a procedure/service was distinct or independent from other services performed on the same day for the same recipient. Appropriate examples of when to use modifier -59 are:

- A different session or encounter
- A different procedure or surgery
- A different anatomical site or organ system
- A separate incision/excision, separate lesion, or separate injury (or the area of injury in extensive injuries), that are not ordinarily performed on the same day by the same physician

When two procedures are performed at the same anatomic site at the same session, and one is the comprehensive procedure code and the other is the component procedure code, modifier -59 should NOT be used. While both are different procedures, they are bundled when performed at the same site and same session.

Before billing with a modifier -59, providers should:

- Check the CCI Edits to verify that modifier -59 can be used with the procedure
- Verify that the procedure performed is in fact a separate/distinct procedure per the definition and examples above.

DUPLICATE BILLING ERRORS

When billing the same procedure multiple times for the same recipient on the same day, please remember that you **must**:

- Bill all procedures for the same recipient/same DOS on the same claim **AND**
- Bill all repeat procedures on the same claim line (**preferred method**) **OR** bill the **FIRST** of the repeat procedures on 1 line and **ALL** the remaining repeat procedures on a subsequent line with the modifier –76. Be sure to add the appropriate number of units to indicate the number of times the procedure was repeated

Billing all repeat procedures on the same claim line is the preferred option. This should eliminate duplicate billing errors, potential invalid modifier/procedure code combination errors, streamline claims processing, and expedite payment.

While Medicare may allow repeat procedures to be billed separately, Medicaid does not and will deny repeat procedures billed separately as duplicate errors.

Medicare may also require some codes to be billed on their own claim, separate from other procedures billed for that recipient on the same DOS (i.e., mammogram). Medicaid will also deny these procedures as duplicate billing errors (more than 1 claim for the same recipient for the same DOS).

To resolve duplicate billing errors, Medicaid requires that the provider:

- Submit a single adjusted claim (with the original paid claim CRN #) directly to Medicaid so that all services for the same recipient and same DOS are billed on the same claim (including mammogram services), using one of the above billing options.
- If the claim is for a Medicare recipient, attach the Medicare EOMB reflecting the Medicare payments for all services billed on the adjusted claim.

H E L P F U L H I N T S

WHEN BILLING OUTLIER CLAIMS

- The first claim (interim bill type 112) should indicate in FL06 (Statement Covers Period) the date of admission through the date the covered charges equal the outlier threshold amount specified for your facility.
- All claims (bill type 112, 113, 114) must have condition code 61 (FL24-30)
- All claims (bill type 112, 113, 114) must have the same admission date (FL17)
- Bill type 112 must be approved before bill type 113 or 114 claims will approve
- In order for the claim to brand as surgical, all interim claims must indicate the surgical ICD-9 procedure code and surgical date.
- Psychiatric and out of state claims do not qualify for outlier rates.

Please refer to Medicaid Provider Manual 11.1.4.4 (chapter 11, page 9) for additional information on outlier claims.

ACS FIELD SERVICES TEAM

The ACS Field Services Team is available to provide on-site training for newly enrolled providers and refresher training for existing providers. They also assist in electronic billing, remittance advice and electronic funds transfer installations. The Field Services Team is divided into territories and by island. They are dedicated to providing outreach and education to Hawaii's Medicaid Provider Community. To contact your Field Services Representative please call the Provider Inquiry Unit at 952-5570 on Oahu or 1-800-235-4378 from the neighbor islands.

RECIPIENT INQUIRIES

Our office is unable to provide claim or eligibility status to recipients. The Provider Relations number, 952-5570 on Oahu or 1-800-235-4378 from the neighbor islands, is strictly for Medicaid Provider inquiries. Recipients who have questions regarding their Medicaid eligibility status should be directed to contact their eligibility worker. If they do not know who their eligibility worker is they can call the Med-QUEST Division at 587-3540 on Oahu or the Med-QUEST office on their respective island for this information.

WINASAP2003

ACS EDI Gateway's free data entry software, WINASAP2003, allows you to submit HIPAA-compliant claims. The claims are sent electronically from personal computer to ACS EDI Gateway. Benefits include:

- No charge claims submission 24 hours a day, 7 days a week
- No charge software, training, and installation.
- No charge call center technical support Monday through Friday, 8:00 AM to 5:00 PM
- Elimination of paper processing and postage expenses
- Reduced overhead and reduced processing time and increases overall revenue
- Faster Turn around time between claim submission and claim payment



CHECK CLAIM STATUS AND ELIGIBILITY ONLINE AT NO CHARGE

DHS Medicaid Online (DMO) is a resource available to all Hawaii Medicaid providers with a valid provider number. DMO allows providers to verify recipient eligibility and claim status via the internet. To enroll for DMO, go to <https://hiweb.statemedicaid.us>.

Upon completion of the registration process, an authentication letter will be mailed to you. Features include: verifying claims status submitted under your Provider Identification Number (PIN), and recipient eligibility. If you are enrolled with a group payment ID, you will be able check the status off all claims billed with PINs associated with your group ID number.

If you require assistance with DMO, call the ACS Provider Inquiry Unit at 952-5570 on Oahu or 1-800-235-4378 from the neighbor islands.

For additional questions or to set up an appointment for installation and training please call the ACS Provider Inquiry Unit at (808) 952-5570.

BILLING MEDICARE EXHAUST

When billing claims when Medicare benefits have been exhausted, the claims must be split on the exhaust date. In order to avoid a denial, you must submit two claims: the Medicare primary portion and the Medicaid primary portion.

For the Medicare primary portion (before the exhaust date):

- The coverage period in FL6 should be dated up to and including the exhaust date
- In FL32, indicate the occurrence code A3 and the Medicare exhaust date
- Attach the Medicare explanation of benefits (EOMB)

For the Medicaid primary portion (after the exhaust date):

- The coverage period in FL06 should be dated from the day after the exhaust date was met.
- In FL32, indicate the occurrence code A3 and the Medicare exhaust date

For example, a recipient's claim spans the month of April but Medicare exhausts on April 15. The first claim will cover April 1-15, with the occurrence code A3 and date of April 15. The second claim will be dated April 16-30, also with the occurrence code A3 and the date of April 15.

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Hawaii Medicaid

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