Med-QUEST Division

Medicaid Provider Bulletin

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In This Issue

Page 2

Clarification: Insertion of Laminaria

PA Requirements for Diabetic Supplies

Billing Medicare Denials

Newborn Plan Enrollment

Page 3

Status on DDMR Waiver Project

Identifying Supernumerary Teeth

Multiple Resources for Resolving Provider Inquiries

Page 4 & 5

Reporting HIPAA Violations

Prior Authorization Requests for Oxygen

Returned Prior Auth Requests

Top 5 Reasons Claims are Returned to Providers

10 Step Process for Signing Up for DHS Medicaid Online

Page 6

Billing a Range of Dates on Medicare Coordinated Claims

Modifier 59 - Distinct Procedural Service

Miscellaneous DME Require PA

Returning Medicaid Payments

Page 7

Billing ASC Codes

Intra-Articular Hyaluronic Acid Derivative Injections

Waiver Billing Rules

Page 8

Paracervical Blocks

2 For 1 Psych Exhange Procedure

Appropriate Use of the 240 Form

Electronic Claim Submission: Fast and Free

Are you interested in getting claim payments faster? Are you tired of keying errors, RTPs and mail delays? There is a tool available to you that can reduce the number of keying errors, reduce paperwork and cut the number of steps involved in submitting a Medicaid claim in half. What is this tool? It is WINASAP2003.

MQD and ACS are pleased to introduce the availability of WINASAP2003, a new **free** electronic claims software. WINASAP2003 allows you to submit an unlimited number of claims electronically, an unlimited number of times a day, 24 hours a day, seven days a week. It is an easy to use Windows-based program that is capable of submitting HIPAA compliant electronic claims for professional and dental services and services rendered in an institution. It is ideal for use by providers who submit less than 300 claims per month. WINASAP2003 is available to all Medicaid providers at no cost. **Free** installation and training services are also available. Claims are entered and submitted through a computer via a toll free dial up number.

WINASAP2003 is not a practice management system. It does not interface with other practice management or billing systems. However, it has special capabilities that help save you time and money.

Time Savings:

- WINASAP2003 features a special capability that allows for repetitive claim generation each month. This feature is geared for use

Continued on page 2

Volume 3, Issue 2

2

Nov. 2004

Billing Clarifications

Electronic Claim Submission Fast and Free

continued from page 1

by nursing facilities and waiver service providers.

- WINASAP2003 retains provider, recipient and coding information, so you only have to data enter the information once. For example, after entering and saving a recipient's information in the appropriate database, you can begin to create a claim. Simply select the recipient's name from a drop down box and the HAWI ID #, date of birth, address and TPL information you entered in the database will automatically populate the appropriate fields.
- Quicker data entry of claims.
- Once claims are submitted, you will know within the hour if the claim file has approved or rejected. Rejection notices are the equivalent of an RTP. Instead of waiting several days for a claim to be returned, you will be able to correct and resend the claim file within 24 hours.

Money Savings:

- WINASAP2003 and electronic claim submission are available for free.
- Electronic claims submission eliminates mail preparation and postage expenses.
- Claim submission to payment turnaround time is shorter.

Save time and money by submitting your claims **electronically.** Call the ACS Call Center at 952-5570 or 1-800-235-4378 to sign-up for WINASAP2003. Complete the testing process and start streamlining your claims submission operations.

PA REQUIREMENTS FOR DIABETIC SUPPLIES

When the total billed charges for diabetic supplies exceed $125 in a month, a prior authorization is required.

The following codes are included in the $125 total billed charges:

A4206, A4210, A4250, A4253, A4259.

Glucometers (E0607, E2100, E2101, etc.) require prior authorization. Other diabetic supplies such as insulin infusion pumps sets and needles require prior authorization if monthly costs exceed $50. Diabetic shoes and inserts require a PA.

BILLING MEDICARE DENIALS

If Medicare denies a claim, but Medicaid covers the service, bill a brand new paper claim to Medicaid. The EOMB noting the denial reason code must be attached to the claim. If Medicare denies the service because it is not medically necessary, Medicaid will also deny the claim.

REMINDER: NEWBORN PLAN ENROLLMENT

All newborns will remain in the mother's health plan for a minimum of 30 days before they are enrolled in a different plan. For example, if a mother is enrolled in FFS, the newborn will have eligibility through the FFS plan for at least 30 days. Foster children are also affected by this policy.

CLARIFICATION OF FEB. 2004 PROVIDER BULLETIN

Insertion of laminaria (59200) is no longer separately reimbursable, **except during second trimester abortions.**

Published for the Medicaid Providers of Hawaii.

ATTENTION DDMR WAIVER PROVIDERS

The reconciliation project is complete. Of the claims ACS received:

75% were sent to DOH to approve additional PA units

25% were immediately reprocessed.

Denied claims were returned by SSD to each provider. All claims are currently being processed.

DENTAL PROVIDERS - IDENTIFYING SUPERNUMERARY TEETH

To identify a permanent tooth as a supernumerary tooth, add "50" to the tooth number. For example,

Permanent tooth number	11
	+ 50
Supernumerary tooth number	**66**

To identify a primary tooth as a supernumerary tooth, add "S" to the tooth letter. For example,

Primary tooth letter	A
	+S
Supernumerary tooth letters	**AS**

MULTIPLE RESOURCES FOR RESOLVING PROVIDER INQUIRIES

Providers generally use the ACS Provider Inquiry Unit (PIU) to resolve Medicaid inquiries. In order to provide customer service to all Medicaid providers, PIU generally limits providers to three inquiries per call when there are other calls in queue. If there are no other providers waiting to be helped, Provider Inquiry Associates can assist providers with more than three inquiries. DHS Medicaid Online, the Automated Voice Response System and ACS Written Correspondence are alternate resources providers can use to resolve an unlimited number of Medicaid inquiries.

AVRS provides eligibility and TPL information 24 hours a day, seven days a week. A valid eight-digit provider ID number is required to access AVRS.

DHS Medicaid Online (DMO) is another time saving option available to providers who have access to the internet. DMO is a free service and allows Medicaid providers to check eligibility and claim status online. On DMO, instant responses are provided to an unlimited number of eligibility and claim status inquiries. See page 5 for complete instructions on how to sign up for DMO.

Written inquiries can be sent to ACS Written Correspondence. Use the 239 Written Correspondence Form when mailing or faxing inquiries. Otherwise, inquiries can be e-mailed to hi.providerrelations@acs-inc.com. Please do not send recipient's protected health information (PHI) via e-mail. Examples of PHI include the recipient's name, HAWI ID, SSN, address, and telephone number. Identify claims by using the CRN that appears on your remittance advice. The CRN is not considered PHI. Transmitting CRNs via e-mail does not violate any requirements of the HIPAA Privacy Act.

A final resource available to providers is the ACS Field Services Unit. Field Reps. are able to visit providers and assist with claims resolution, as well as explain Medicaid billing policies and procedures. Field Reps. are also able to help providers submit claims electronically.

Volume 3, Issue 2

Nov. 2004

Volume 3, Issue 2

Nov. 2004

Good to Know

REPORTING HIPAA VIOLATIONS

If you receive protected health information (PHI) on a recipient that you do not service, please call the ACS Provider Inquiry Unit immediately to report this disclosure. Accidental disclosures of PHI can occur when a provider uses an incorrect provider ID number (PIN) on a claim. If the incorrect PIN is a valid one, the patient's PHI will be reported on another provider's remittance advice.

This is a HIPAA violation that must be reported to the ACS Call Center. Providers are responsible for reporting any inappropriate disclosures to ACS and to their internal HIPAA Privacy contact.

PRIOR UTHORIZATION REQUESTS FOR OXYGEN

When requesting oxygen (portable or a concentrator), please include current oxygen saturation in the PA request. Oxygen saturations done on room air, resting and done within 30 days of the request qualify as current oxygen saturations. If requesting an oxygen concentrator for bleed-in oxygen to either a CPAP or BiPAP, provide physician signed documentation that the patient is compliant with the nightly use of CPAP or BiPAP. Providing this information on the PA request will expedite the review process.

INVALID PA LINES RETURNED TO PROVIDERS

1144s that have invalid lines will be returned to the provider (RTP). For example, if HCPCS for line 1, 2 and 4 are valid codes, the PA will be entered for these lines only. If the code on line 3 is invalid, an RTP coversheet will be sent with a copy of the 1144 noting that the HCPCS code on line 3 is invalid. Lines that have been returned to providers will not be data entered into HPMMIS.

TOP 5 REASONS CLAIMS ARE RETURNED TO PROVIDERS (RTP)

1. **Invalid provider ID.** Never use the group payment ID on claims. The group payment ID is used strictly for payment purposes.

2. **Invalid tax ID number.** The tax ID number (TIN) or SSN submitted on the claim must match the TIN or SSN reported on the provider enrollment form. Please ensure that the TIN or SSN indicated on the claim form is a full nine digits.

3. **Invalid HAWI ID number.** All HAWI ID numbers are ten digits; include all the leading zeros and omit the check digit.

4. **Hard copy Medicare cross over claims submitted without an Explanation of Medicare Benefits (EOMB).** An EOMB must be attached to all hard copy Medicare cross over claims.

5. **Hard copy Medicare cross over claims submitted without a dated EOMB.** ACS requires a date on the EOMB to determine if the claim has been submitted within the filing deadline. Medicare coordinated claims are allowed a filing period of six months from the date of the EOMB.

Published for the Medicaid Providers of Hawaii.

Provider Bulletin

Volume 3, Issue 2

Nov. 2004

DHS Medicaid Online: Getting Started

1. Go to https://hiweb.statemedicaid.us

2. Click on "Create a New Account."

3. Read User Agreement & click "I Agree" to proceed.

4. Enter your 8-digit provider ID # & the tax ID # you provided in your provider enrollment application.

5. Enter a user name of your choice. It must be at least 6 characters in length.

6. Enter a password of your choice. It must be at least 6 characters in length. Note: Your password is case sensitive.

7. Enter hint question & answer of your choice. This will allow you access to DHS Medicaid Online if you forget your password.

8. Select individual or master account. You will be allowed one master account per provider ID #. A master account must be established before any individual accounts can be activated.

9. Enter your demographic information and click on continue.

10. If you created a Master Account, then wait for a letter in the mail that will give you an Authentication Code. If you created an individual account, the master account holder for your Provider ID # will receive an e-mail and will be able to activate your account.

Provider Bulletin

Published for the Medicaid Providers of Hawaii.

Volume 3, Issue 2

6

Nov. 2004

Billing Clarifications

BILLING A RANGE OF DATES ON MEDICARE COORDINATED CLAIMS

When billing a Medicare coordinated claim with a range of dates, the beginning date on the claim must match the beginning date on the EOMB. In addition, the procedure and billed amounts must match.

If the EOMB begin date does not match the begin date listed on the claim, the claim will be returned to the provider (RTP).

RETURNING MEDICAID PAYMENTS

Do not send checks to ACS to refund overpayments. Instead, please advise ACS Written Correspondence of the overpayment. The claim will be reprocessed to recover the overpayment. The take back of money will be reflected in the adjustment section of the remittance advice.

MODIFIER 59 - DISTINCT PROCEDURAL SERVICE

Modifier 59 should **only** be used to identify a procedure that is distinct or independent from other services performed by a physician on the same day such as:

- A different operative session
- A different patient visit
- A different procedure
- A different anatomical site, organ system, incision/excision, or a separate injury.

However, when another established modifier is appropriate, it should be used rather than modifier 59. Modifier 59 should be used only when it best explains the circumstances.

Modifier 59 is not covered when billed with 77427 and evaluation and management codes (99201-99499).

Modifier 59 should not be billed with the following:

- Diagnostic laboratory codes (8XXXX). Modifier 91 (repeat clinical laboratory diagnostic test) is more appropriate.
- Diagnostic radiology codes. Modifier 76 (repeat procedure by same physician) is more appropriate.

If used with radiation oncology codes (77XXX), a report must be submitted with the claim clearly identifying the different site, different patient encounter, different therapeutic session, and/or a procedure that is clearly not included as a component of another procedure.

MISCELLANEOUS DME REQUIRE PA

All miscellaneous durable medical equipment codes require prior authorization (e.g. E1399, E0108, A4649, etc.) regardless of its billed charge.

Published for the Medicaid Providers of Hawaii.

Provider Bulletin

Volume 3, Issue 2 | 7 | Nov. 2004

BILLING AMBULATORY SURGERY CENTER (ASC) SERVICES

It is important to remember that the order in which the ASC codes appear on the claim determines how the procedure(s) will be reimbursed. For correct reimbursement :

1) The ASC code(s) billed on your claim, must appear on the claim before the non-ASC surgical codes
2) The first ASC code on the claim will be paid at 100% of the appropriate ASC group rate
3) All other ASC codes on the claim will be paid as follows:
   - if procedure is not directly related to the primary ASC code on the claim, it will be paid at 50% of the ASC group rate.
   - procedures included in primary ASC code on the claim, will be paid $0.00.

INTRA-ARTICULAR HYALURONIC ACID DERIVATIVE INJECTIONS

Effective thirty (30) days from the date of this newsletter, intra-articular hyaluronic acid derivative injections for the treatment of osteoarthritis of the knee will require prior authorization. These products must be billed using HCPCS codes. The following identifies the product and appropriate HCPCS code.

Name of product	**HCPCS**
Hyalgan and Suparts (sodium hyaluronate, per 20 to 25 mg. dose for intra—articular injection)	J7317
Orthovisc High molecular weight hyaluronan)	J7317 22
Synvisc (Hylan G-F 20, 16 mg. For intra-articular injection)	J7320

RULES FOR BILLING MEDICAID WAIVER SERVICES AND RECONCILING PAYMENTS

1. Use the Automated Voice Response System (AVRS) or DHS Medicaid Online (DMO) to verify that clients are Medicaid eligible and approved for waiver services during the entire billing period. Call the ACS Call Center to confirm suspension period dates. Do not bill for any of the dates included in the recipient's suspension period.
2. Wait for a prior authorization letter that specifies the procedure and number of units approved for each client.
3. Verify that services were actually performed.
4. Bill in accordance with the client's individual service plan and prior authorization.
5. Use DMO to check claims status.
6. Use the weekly remittance advice to identify corrective actions for all claims not paid in full:
   - Fix billing errors and resubmit claim in accordance with appropriate instructions.
   - Call case managers for underpaid claims due to insufficient PA units or services denied due to lack of PA.
   - Call ACS to correct data entry errors.
   - Call SSD to fix suspensions.

Provider Bulletin

Published for the Medicaid Providers of Hawaii.

Volume 3, Issue 2

Nov. 2004

Policy Updates

PARACERVICAL BLOCKS

Effective on and after the date of this memo, paracervical blocks are covered when all of the following conditions are met:

1. The paracervical block is performed as anesthesia in place of general anesthesia for a specific surgical procedure.

2. The surgical procedure is performed in the physician's office. Example of surgical procedures: diagnostic or therapeutic dilation and curettage (D & C.)

3. The paracervical block is coded as 64435. Do **not** submit 64435 with modifier 47 (anesthesia by surgeon.)

Paracervical blocks are **not** covered in the following situations:

- The surgical procedure is performed in the inpatient or outpatient hospital when general anesthesia or a regional block is performed by an anesthesiologist or a certified nurse anesthetist.

- Hawaii Medicaid does not cover the surgical procedure.

- Coverage of blocks is included in the payment of the surgical procedures according to Medicare's Correct Coding Initiative (CCI) rules.

No adjustments will be made to claims processed prior to the date of this bulletin; that were submitted with modifier 47.

2 FOR 1 PSYCH EXCHANGE PROCEDURE

When exchanging one inpatient psych day for two outpatient psych visits, please use the following procedures:

- Submit the claim with an 1144 prior authorization request indicating a two for one exchange and the medical necessity of the request.

- If the recipient is over 21 years of age, please include an acknowledgement form signed by the recipient. The acknowledgement must state that the recipient agrees to exchange one inpatient psych day for two outpatient psych visits, and that this exchange will result in loss of an inpatient psych benefit.

- If the recipient is under 21 years of age, only the 1144 prior authorization request is required.

For more information, please call the ACS Provider Inquiry Unit.

APPROPRIATE USE OF THE 240 FORM

If a claim issue has been reviewed by the ACS Provider Relations Department (Call Center, Written Correspondence or Field Reps.) and you do not agree with the research results, you have the option of submitting a 240 Request for Reconsideration Form. Please do not use the 240 Form for general claim inquiries. General claim inquiries should be submitted on the 239 Written Correspondence Form.

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)

ACS EDI Team: hi.ecstest@acs-inc.com

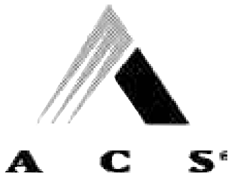
DHS Medicaid Online: https://hiweb.statemedicaid.us

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



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