Medicaid

Provider Bulletin

Published for the Medicaid Providers of Hawaii

SEPTEMBER 2005 *Bringing Quality Healthcare to Hawaii Medicaid Recipients* **Volume 3 Issue 2**

Update on Timely Filing Deadlines

Filing Deadline

You are allowed one year from the date of service to file a claim with Medicaid. Claims with other Third Party Liability (TPL) coverage also must be submitted within 12 months of the date of service.

The one-year filing deadline excludes Medicare crossover claims. When Medicare is primary, you have (6) months from the date listed on the Medicare EOB or 12 months from the date of service, whichever is greater.

For cases involving retroactive eligibility for a recipient, the claim must be submitted within 12 months from the date that DHS approved the recipient's application. For example, a patient is admitted into a long term care facility on January 1, 2005 and applies for Medicaid benefits. The patient's application is approved on June 1, 2005. The facility has until June 1, 2006 to submit the Medicaid claim.

Timely filing requirements are addressed in Chapter 4, page 7 of the *Medicaid Provider Manual*.

Adjustments

Please refer to the Hawaii Administrative Rules§ 17-1739.1-16 (amended May 5, 2005) that states that you are allowed to file adjustments to claims up to *60 days* from the initial date of adjudication (payment or denial of the claim).

Outstanding Claims
It is the provider's responsibility to ensure that claims are received by ACS within the one year claim filing deadline. Because the original claims may get lost or misplaced in handling, providers must follow-up on their outstanding claims before the one year claim filing deadline.

Recoupments/Refunds of overpayment or incorrect payment
Remember there are no time restrictions on repayments to the Medicaid Program.

Waiver of Filing Deadline

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. Evidence must be provided showing that the claim was previously submitted within the 12 month filing deadline. If this documentation is not available, extenuating circumstances must be described. You must submit your written request to waive the filing deadline for fee-for-service claims to:

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

IN THIS EDITION

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

Continued from page 1

Requests to waive the filing deadline for home and community based waiver service claims must be submitted to:

Cindy Oda-Kanno
SSD/MWS
810 Richards Street, Suite 501
Honolulu, HI 96813

For both fee-for-service and community-based requests, your must list the names of the recipient, date(s) of service and CRN. 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.■

Guidelines for Provider Refund Checks

If your facility submits refund checks to ACS, please ensure the following guidelines are followed.

1. Refund checks for claims paid by Hawaii Medicaid should be payable to ACS Medicaid or Hawaii Medicaid and mailed to:

   ACS
   Post Office Box 1206
   Honolulu, Hawaii 96807-1206

2. Refund checks for claims paid by Prescription Benefits Management (PBM) should be payable to ACS Prescription Benefits Management and mailed to:

   ACS PBM
   365 Northridge Road, Suite 400
   Atlanta, GA 30350

3. The check amount must agree to the dollar amount of the claims you are refunding.

4. Supporting documentation must include the following:

   - Recipient's name
   - Date of service
   - HAWI identification number
   - A specific reason why you are refunding the money
   - For overpayments due to third party liability (TPL) or other insurance, you must provide a copy of the insurance carrier's explanation of benefits (EOB).
   - For duplicate payments, provide copies of Remittance Advices (RAs). If the claims were paid prior to October 31, 2002, provide copies of the HMSA Explanation of Benefits.

If the required information is not submitted with your refund check, it may be returned to you with a request for specific documentation required. This may also delay the processing of your refund check.■

Billing Medicare Coordinated Claims

When billing a Medicare coordinated claim, providers must complete all of the required boxes on the claim form and attach the Explanation of Medicare Benefits (EOMB). To indicate that Medicare paid primary, list the Medicare plan information in box 9 or 11 on the CMS-1500 form or in box 50 on the UB-92 form. Attach the Medicare EOMB so that Medicaid can determine the co-payment and/or deductible. If the EOMB is not attached, the claim will deny.

HCPCS and CPT procedure codes have been updated in HPMMIS, the Medicaid fee-for-service claims processing system, to correctly reflect Medicare coverage. If you submit a claim for a code that is listed as a Medicare non-covered service, your claim will automatically be processed as Medicaid being the primary payor. If you submit a claim for a code that is listed as a Medicare covered service, your claim will be denied unless it is submitted with an explanation of Medicare benefits (EOMB) that lists the denial code.

If Medicare denies the claim or does not cover the service, submit a paper claim to ACS for Medicaid payment. List the Medicare plan information in box 9 or 11 on the CMS-1500 form or in box 50 on the UB-92 form. Attach the EOMB showing the Medicare denial reason code. If Medicare denies a service for not being medically necessary, Medicaid will also deny the claim.

Medicaid will pay as the primary payor on these claims only for the following denial reason codes: 26, 27, 31, 32, 33, 34, 35, 46, 47, 48, 96, and 119. For Medicare reason code 49, Medicaid will pay as primary payor in certain situations. Medicaid does not make payment when Medicare denies using other reason codes. The use of the statement "Not a covered Medicare service" on the claim form is not sufficient to initiate Medicaid payment.

SNF Claims
When billing on a UB-92 with a 2xx bill type for skilled nursing facility (SNF), indicate Medicare in box 50 and in the "Remarks" field in box 84 enter "Not a 3-day qualifying stay" if the recipient's inpatient span is not qualified for Medicare coverage. Noting "Not a covered TPL/Medicare service" is not an acceptable written explanation on the claim form in this circumstance.

Please call the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands with questions.■

Patients who Receive Insurance Settlements

Providers should bill Medicaid patients directly for services related to an accident if the patient was injured in an accident and received an insurance settlement.

Please address any questions regarding billing patients who receive insurance settlements to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. ■

Contact the ACS Call Center

Contact the ACS Call Center Team for accurate, complete and quick answers to your claim questions and assistance including but not limited to:

- Claim status
- Billing procedures
- Clarification of Medicaid policies and procedures
- Claims resolution
- Claims payment
- Prior authorization requirements and status
- Covered services
- Service limits
- Check amounts
- Recipient eligibility verification

When you call the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. highly trained and courteous staff is immediately available to answer your claim and eligibility questions. The call center operates from 7:30 a.m. to 5:00 p.m., Hawaii Standard Time, Monday through Friday, with the exception of State holidays.

The ACS Call Center offers professional and responsive customer service. Responses to most inquiries are given to providers at the time of the call. Sometimes a call may require additional research or clarification. In these situations, Agents attempt to resolve the inquiry and complete a callback the same day. In the event that additional more complex research is required, the goal of the call center is to respond within seven days.■

Important Contact Information

Provider Inquiry 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 Authorization Requests to:
(808) 952-5562
(Not applicable to Medicaid Waiver Program)

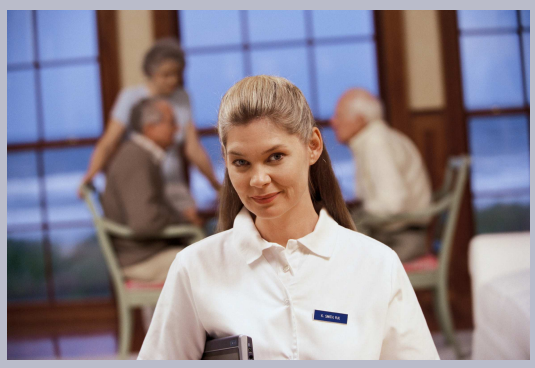
Mail Prior Authorization Requests to
(Not applicable to Medicaid Waiver Program):
ACS
P.O. Box 2561
Honolulu, HI 96804-2561

Reminder to Verify Eligibility

Medical Assistance Coupons serve as temporary identification cards. Chapter 3.5.2 of the *Medicaid Provider Manual* states that "the coupon does not in itself verify the eligibility of an individual and therefore, does not guarantee that Medicaid will cover any Medicaid services."

Even if a provider attaches a coupon to a claim, there is still a possibility the claim will deny. The recipient's eligibility must be in the HPMMIS before the claim can be paid. Providers are reminded to check the AVRS to verify eligibility information before submitting the claim. Using AVRS is always the fastest way to check recipient eligibility. Providers may also contact the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. ■

Procedures for Financial Adjustments



Refunding overpayments due to non-coordination of benefits, other insurance payments, coding errors, etc. are handled two ways:

1, By submitting an adjustment claim form to ACS. The adjustment claim will be reprocessed and the system will automatically apply the appropriate adjustments to the CRN and your PIN. These resubmissions can be submitted on hard copy claim forms or electronically to expedite the adjustment process.

2. By submitting a refund check in the amount of the overpayment. When submitting refund checks, supporting documentation (include what information ACS needs (i.e. CRN, Provider ID number claim submitted under, Date of Service, reason for refund) must accompany the refund check so that the correct claim and provider number can be adjusted.

Please be aware that this process requires the adjustment to be handled manually to adjust the claims associated with the refund check and could delay the processing of the adjustment especially if not all information is provided and must be obtained from the provider.

The manual process requires a thorough review of all supporting documentation and, therefore, ACS strongly discourages providers from submitting refund checks in these situations.

Example to refund a Voided Claim:

A provider (PIN #000000) submits a refund check in the amount of $100.00 to ACS and requests to void a claim that was paid to the provider on April 1, 2004 because the recipient was not their patient. ACS will recoup the original payment and then

RA Financial Impact Overview:

a)	$ 100.00	Allowed Amount paid on 04/01/2004
	($100.00)	Amount after claim is voided. (ACS voids the CRN which recoups the original payment amount)
	($100.00)	Net Paid Amount on PIN # 000000
b)	($100.00)	RA Net Paid Amount
	$ 100.00	Refund Check Amount (ACS credits the refund check amount to offset the voided amount)
	$ 0.00	Financial impact on RA for provider (Pin #000000)

Example of an Adjustment (refund a portion of a claim) to a Claim:

A provider (PIN#000001) submits a refund check in the amount of $50.00 to ACS which was the overpayment amount they received on a claim that was paid on April 1, 2002 in the amount of $100.00. The patient had a primary insurance carrier but ACS had paid the claim with Medicaid as the primary insurance.

Medicaid procedure is to adjust the claim according to the other insurance's documentation then credit the refund check amount.

RA Financial Impact Overview:

a)	$ 50.00	Allowed Amount that should have been paid on 04/01/2002
	($100.00)	Previously Paid Amount. (ACS processes an adjustment to the CRN to recoup the entire original payment amount)
	($50.00)	Net Paid Amount (on PIN #000002)
b)	($50.00)	RA Net Paid Amount
	$50.00	Refund Check Amount (ACS applies a credit for the refund check amount to offset the recouped amount)
	$ 0.00	Financial impact on RA for provider (PIN #000001)

Common Reasons Claims Are Returned to Providers

Reason	Corrective Action	Indicate in Appropriate Field Locator		
		CMS 1500	UB 92	ADA 2000/2002
Invalid provider ID number (PIN)	• Use the 8-digit PIN, 6 base digits and a 2-digit location code separated by a dash, e.g. 123456-01. • Do not confuse PIN with PA number.	FL 33	FL 51	FL 44
Signature is missing	• Person authorized to sign for claims on behalf of the provider must sign all claims submitted to Medicaid. • A rubber stamp may be used but the authorized party must initial in ink.	FL 31	FL 85	FL 62
Recipient HAWI ID number is missing	• Use the recipient's complete and correct 10-digit HAWI ID number. • Do not confuse this number with other recipient insurance or case numbers. • Do not omit leading zeros. • Do not include the check digit. • The correct HAWI ID format can be found on the recipient's plastic ID card.	FL 1a	FL 60	FL 13
Tax ID number is missing or is not 9 digits	• All claims submitted to Medicaid must include the provider's tax ID number or social security number (SSN). • This information must match the information (TIN or SSN) provided on the provider's enrollment form	FL 25	FL 5	FL 45
Name of Referring Physician	• This is only needed for procedure codes 99241-99275 • Must include complete first name, last name and middle initial for claims for consultation code, when Medicaid is the primary payor	FL 17	NA	NA
Diagnosis Code Reference	• This Field Locator is only required for CMS-1500 • Field 21 and 24E must correspond	FL21 FL24E	NA	FL58 FL59

Be sure to check claims before submission to ensure all fields are competed correctly and the information is clearly legible. These simple reminders can help to keep claims from being returned.■

Miscellaneous Codes (A4649 AND 99070) Used For Supplies

The use of Miscellaneous Codes (A4649 and 99070) is strongly discouraged. Please use the appropriate CPT /HCPCS code to ensure timely processing and payment of your claims. Every Miscellaneous Code on a claim requires manual intervention. This could delay the processing and payment of your claim. To help expedite the process if a Miscellaneous Code is used, each Miscellaneous Code should have a clear and concise description.

CMS 1500 Claims:
For each Miscellaneous Code you enter on a CMS 1500 claim, you must also enter an accompanying description of each item in form locator (FL) 19 or FL24 D.

Obsolete Modifiers

Providers are reminded not to use modifiers "**F", "P"** or **"S"** on claims. These were modifiers that were in use with the prior fiscal agent. If these obsolete modifiers are used on a claim, it may cause the claim line to deny.■

Questions about Miscellaneous Codes used for supplies may be directed to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands.■

IT'S FREE…AND FAST

WINASAP

WINASAP electronic claims submission software is being offered to all Medicaid providers at no cost.

Q. *What Is WINASAP?*
A. WINASAP is ACS EDI Gateway's FREE data entry software that allows providers to submit HIPAA-compliant claims electronically from a personal computer to ACS EDI Gateway via a secured 800-phone number. No Internet connection is needed and it is an EASY Windows-based program!

Q. *What Are The Benefits Of Using WINASAP?*
A. WINASAP will allow providers to get their claim payments faster because it reduces keying errors, RTP's, and mail delays. WINASAP can actually cut the number of steps involved in submitting a Medicaid claim in HALF. An unlimited number of claims can be submitted electronically 24 hours a day, 7 days a week, eliminating paper processing and postage expenses, therefore, increasing cash flow through reduced overhead. Notice of rejected claims is available within an hour of submission and corrected claims can be resent within 24 hours. WINASAP also has reference tables, so you only have to enter frequently used information once.

Q. *Who Should Use WINASAP?*
A. WINASAP is perfect for professional and dental services and services rendered in an institution by providers who submit less than 300 claims per month. It also allows for repetitive claim generation each month, which is geared for use by nursing facilities and waiver service providers.

Q. *How Do Providers Get Started?*
A. IT'S EASY! Call the ACS Call Center and request an enrollment form faxed to you or download the form from the web at www.acsgcro.com. After completing the form, fax it back to ACS at (808) 952-5595. An enrollment packet will be sent to you in the mail.

Q. *Is WINASAP Difficult To Install?*
A. No! After receiving an enrollment packet and setting up an appointment, a provider field representative will walk you through the process.

Q. *What If I Need Assistance Later?*
A. ACS offers FREE technical support Monday-Friday, 8:00 am to 5:00 pm at 1-888-333-5641. Provider field representatives are also available to help you at your location.■

NOW AVAILABLE

FREE 835 TRANSLATOR

ACS is offering a free 835 translator referred to as "EZRA" (EZ Remittance Advice) to Hawaii Medicaid providers. This will allow you to pick up 835's (electronic RA) and convert them into a report that is similar to the current hard-copy RA. Improvement has been made to the financial summary page. Hawaii Med-QUEST requires the use of a Cisco VPN client to create a secure connection between the provider's computer and the server where the 835's are maintained. The only requirement for you to receive this free reformatter is an Internet connection.

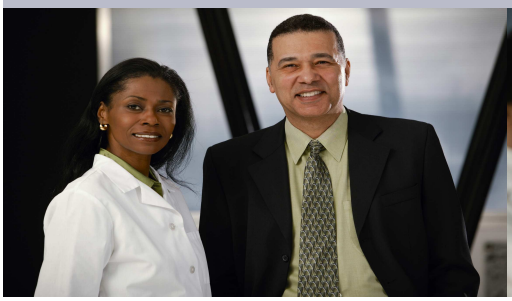
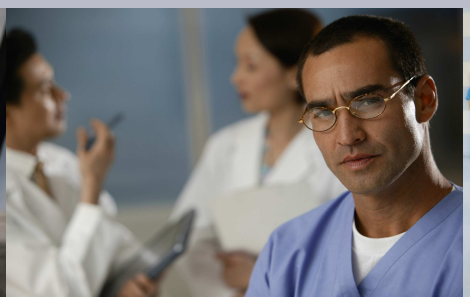
Benefits:

- The RA is available to the provider first thing Monday morning
- There is no chance of the RA getting lost in the mail
- There is no chance of the RA getting delayed in the mail
- The 835 is sent to your file transfer protocol (FTP) folder
- You may also receive Hawaii Medicaid payments via electronic funds transfer (EFT) using the reformatter

Please contact the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands to obtain more information on the free EZRA translator or to sign up for electronic RAs.
ACS will send you an enrollment form and an *Electronic Data Interchange (EDI) Manual* when you request to sign up. Once you have completed the enrollment form, mail it back to ACS at the address below:

ACS Government Healthcare Solutions
1440 Kapiolani Boulevard, Suite 1400
Honolulu, Hawaii 96814

Work Smart…Not Hard - Hurry, Enroll To Begin To Get Your Claims Processed Faster.!


The 24-Hour and 72-Hour Charge Bundling Rule

Hospitals are reminded that Medicaid requires you to comply with Medicare rules requiring bundling of charges for services provided prior to an inpatient admission (commonly referred to as the 24-hour and 72- hour rules). When a patient receives services prior to the inpatient admission, these charges must be included on the inpatient claim and should not be billed separately.

For example, a patient has an outpatient surgical procedure on October 1 and is released home. On October 2, the patient is admitted to the hospital. The hospital is to combine all charges on a single claim. The dates of service on the claim are from October 2 through discharge and the date of admission is October 2. Hospitals can note the surgical ICD-9 procedure on the claim with the date performed of October 1.

Questions about hospital charge bundling rules may be directed to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands.■

Bringing Quality Healthcare to Hawaii Medicaid Recipients

Emergency Room Visits

Please follow the guidelines set forth in Chapter 6 of the *Medicaid Provider Manual* and the June 2005 "Medicaid Provider Bulletin" on multiple emergency room (ER) visits on the same day. Additional guidelines for more complex situations are provided below:

1. 2 ER visits on the same day and same facility: Two ER visits on the same day and same facility, are covered if the diagnoses are not related. Supporting documentation should be submitted with the claim. If the visits are for the same or similar diagnosis, only one visit will be paid.

2. ER visit at one facility and same day ER visit at a different facility: Visits on the same day at two different facilities are covered when both are strictly outpatient ER visits.

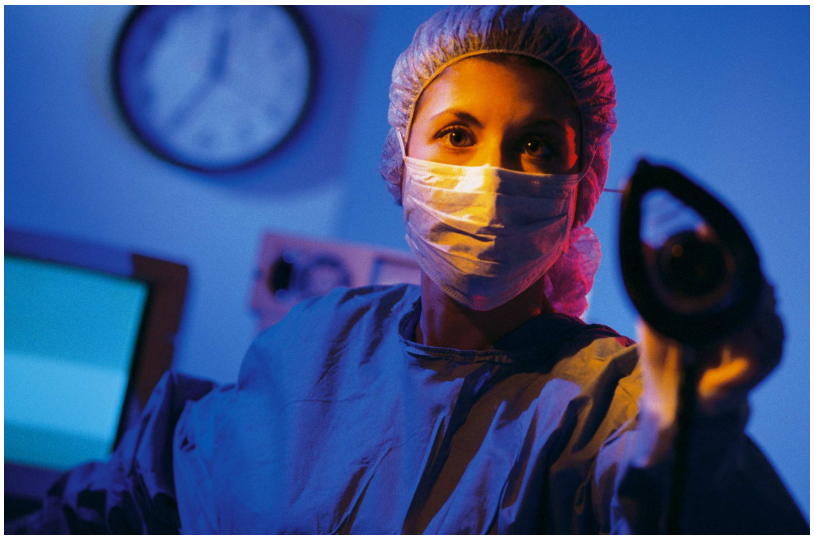
3. ER visit and same day inpatient (IP) admission:
Refer to Chapter 11.2.5.2 of the Medicaid Provider Manual: "Emergency room services that results in an inpatient admission to the acute care hospital are considered part of the inpatient stay…" and should not be billed separately.

Exception: Separate charges can be billed and paid if the ER visit and the IP admission occur at two different facilities

4. The Med-QUEST Division medical review staff may make final determination of coverage for any of the above situations.

If you have questions about billing emergency room visits on the same day, call the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. ■

Surgical Outpatient Billing



Revenue codes 360 to 369 and 490 to 499 are reserved only for ambulatory surgical center (ASC) procedures that have been assigned to ASC payment groups by Medicare. The CPT code must be included on the 36x or 49x claim line and must be recognized by Medicare as an ASC procedure for the date of service.

Non-Medicare ASC procedures billed with revenue codes 36x or 49x will be denied.

ASC billing instructions are as follows:

- Bill revenue codes 370 for anesthesia for outpatient non-surgical procedures
- Bill revenue code 710 for recovery room for these outpatient procedures
- Bill revenue code 929 for outpatient surgical procedures that are not recognized by Medicare as an ASC but were provided under general anesthesia and required a recovery room stay. Appropriate CPT codes in the 10000-69999 ranges must be included in the claim line.

The Med-QUEST Division will review revenue 929 claims.

ACS will review requests from hospitals to have outpatient surgical claims for Medicare recognized ASC procedures that were not paid at an ASC rate. Please submit these requests on Form 239 (Medicaid Correspondence Inquiry Form). ACS will review these requests and send an acknowledgement to the hospital within seven business days.

Hospitals may re-bill outpatient surgical claims that were previously denied or approved for payment with a zero allowance using 929 instead of 36x or 49x. Submit a new claim if the previous claim was denied. Submit an adjustment if the claim was previously approved but paid at a zero allowance.

Hospital facilities were notified of these outpatient surgical billing instructions in ACS Memorandum M05-05 in July 2005.

Please address any questions regarding these ASC billing instructions to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. ■

We're on the web!

http://www.med-quest.us/

Surgical Category of Service

There are multiple checks performed to determine whether a hospital claim is to be classified as a Surgical Stay. By definition, Surgical Stays are stays that:

- Are not in the maternity category of service (determined by the diagnosis code)
- Have a valid surgical ICD-9 procedure code as defined in the ICD-9 Manual, Section 3 as "valid O.R. procedure"

Surgical Versus Medical Classification
For acute inpatient claims, the procedure codes listed in Form Locator 80-81E of the UB-92 claim form are used to determine the appropriate Surgical Stay versus Medical Stay classification/ category of service.

If one of the ICD-9 procedure codes on the claim is listed in the ICD-9 Manual – Volume 3 and identified as a "valid O.R. procedure (see the legend at the bottom of the pages in this section), then the claim will be classified and paid as a Surgical claim. If not identified as a "valid O.R. procedure", then the claim will be classified and paid as a Medical claim.

Once a claim has been classified as a Surgical claim, additional edits are then performed to verify that both a surgical date and an operating room revenue code is present on the claim. If one or the other is not present, the claim will then be denied.

The *Medicaid Provider Manual* (Chapter 11.1.3.3) will be changed to reflect this clarification.

Questions about surgical stays may be directed to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands.■

2 for 1 Psych Benefit Exchange

If the recipient has exhausted the 24 hours of behavioral health outpatient benefit, you may request a two for one exchange. This means that one inpatient day will be substituted for two outpatient days.

Please follow the steps below to request the exchange:

1. Submit the denied claim with a Form 1144 prior authorization (PA) request indicating a two for one exchange.
2. Attach a signed statement clearly indicating the medical necessity and the dates of services affected.
3. Include an acknowledgement form from the recipient if the recipient is 21 years of age or older. The acknowledgement must state that the recipient agrees to exchange one inpatient psych day for two outpatient psych visits.
4. If the recipient is under 21 years of age, submit only the Form 1144 PA request and the letter from the provider along with the claims that have denied.

Although you will be submitting a Form 1144, a PA number will not be generated and you will not receive a PA letter. The Form 1144 is needed by the ACS Claims Resolution staff to reprocess your denied claim. Form 1144 must be attached to each claim you are requesting to be paid on a 2 for 1 benefit exchange.

This information is covered in the November 2004 *Medicaid Provider Bulletin* and is reprinted here as a reminder and clarification. Please address any questions regarding 2 for 1 psych benefit exchange billing instructions to the ACS Call Center at 952-5570 on Oahu/1-800-235-4378. on neighboring islands.■

ADA 2002 Dental Claim Form

The 2002 ADA Dental Claim Form is now available for all Medicaid dental providers to use. The format is slightly different from the 2000 form. The changes in the 2002 form are listed below:

- Box 26. Tooth System: Use this field to indicate units or quantity.
- Box 35. Remarks: Indicate the adult emergency diagnosis 525.9 here. This box may also be used to note if Medicare/TPL Service does not cover the service.
- Box 490. Provider ID: Enter the 8-digit PIN for billing here.
- Box 50. License Number: This field is now required for the dentist license number.
- Box 54. Provider ID: This is required only if there is a referring doctor. The Medicaid provider ID # of that referring provider can be indicated here.

Please note these changes when you are completing the 2002 ADA Dental Claim Form. ACS is still accepting clean claims submitted on the ADA 1999 v. 2000 form.

If you have any questions, call the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. ■

FQHC Billing on the Same Date of Services

Federally Qualified Health Centers (FQHCs) are paid a global rate for all services performed by the FQHC staff for each encounter with a Medicaid recipient per day.

Medicaid must certify FQHC providers to bill medical, behavioral health/psychiatric, vision and dental encounters. The revenue codes used for medical, behavioral health/psychiatric and vision services must have different diagnoses in order for the claim to be paid. If the diagnoses are the same for two or more revenue codes on the same date of service, the claim will deny.

Medicaid will normally pay for one encounter per day. Medicaid will pay for a second medical encounter if the patient suffers an injury or illness requiring a different diagnosis.

Medicaid will pay for a maximum of three non-dental encounters per day when the patient has a medical encounter and other health visit such as behavioral health/psychiatric and/or vision and the provider is certified to provide the specific services. One dental encounter is also allowed per day.

Questions about FQHC billing may be directed to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands. ■

Billing For Transportation

Transportation providers receive a base rate plus mileage. The provider should not submit claims for both mileage and area.

Please address any questions regarding transportation billing instructions to the ACS Call Center at 952-5570 on Oahu or 1-800-235-4378 on neighboring islands.■

September 2005 Volume 3 Issue 2

Hawaii Medicaid

Look inside for these and other important updates:

A C S®
State Healthcare
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Honolulu, HI 96814