# Medicaid Provider Bulletin

Published for the Medical Providers of Hawaii
By the Department of Human Services, Med-QUEST Division

VOLUME I, Issue 5
September 2002

# New Recipient ID cards

**In this issue:**



Effective November 2002, MQD will be issuing all recipients a new permanent identification card. The new card will be plastic and will be issued to both QUEST and fee-for-service clients. QUEST clients will use the card for dental services only. They will still receive a separate identification card from their managed care plan for medical services. Each client will be issued his/her own card. The face of the card will include the recipient's name, date of birth and Medicaid ID number. A sample of the card is included in this bulletin ***(See Attachment A).***

Because these are permanent ID cards, providers will need to verify eligibility each time that the recipient receives services. Several options will be available at no cost to providers to verify eligibility. These include an automated voice response system (AVRS - see story in last month's bulletin), a web-based eligibility verification system (scheduled for phased roll-out beginning November 2002), the ACS Provider Inquiry Unit at 952-5570/ 1-800-235-4378 (available after November 1, 2002) and the MQD Provider Hotline at 692-7360/1-800-518-8887.
The AVRS and web will be available 24 hours a day, 7 days a week, 365 days a year.

*Continued on page 2*

*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.*

**Recipient ID cards** *continued from page 1*

Information that will be provided from the AVRS and web-based systems include dates of eligibility, enrollment information, Medicare and other third party liability, cost share amount, and whether the client is a lock-in recipient. Providers must use their new HPMMIS provider ID number (to be mailed in early October 2002) to access the AVRS and the web based verification system. Information can be retrieved by date of birth, name and gender or social security number, if the Medicaid ID number is not known. A quick reference to using the AVRS is included in this bulletin ***(See Attachment B).*** The phone number for the AVRS is 1-800-882-4608.

Recipients who lose their ID cards should call the enrollment call center at 524-3370 or 1-800-316-8005 to request a replacement card. Recipients have been notified of these changes through an insert with their monthly paper cards since September 2002. Additionally the Med-QUEST Division will be conducting a public relations campaign to educate recipients about their new cards. ■

***Check your mail for:***

# New Provider Manuals and New Provider Numbers

During October, MQD and ACS will be generating and distributing revised Provider Manual and new Provider ID numbers for the new HPMMIS claims system.

The Provider Manual will be produced on a compact disc (CD) for your convenience. If you would prefer a hardcopy manual, you may contact MQD and request one. The new revised manual will have detailed information on the billing changes that will be implemented in conjunction with the new claims system.

A new Medicaid Provider ID Number will be assigned to each provider:

- Most providers will be assigned a single six-digit Medicaid provider number.
- Providers will also be assigned new two-digit service location numbers.

Providers will be required to include all eight digits (six–digit provider ID plus the appropriate two-digit service location number) on all claim forms.

Please contact MQD at 692-8099 if you have not received your new provider ID numbers by mid-October. ■

*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.*

# Status of the Project

MQD has entered into an innovative partnership with the State of Arizona to share Medicaid data processing systems to 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 cut-over in October 2002 with the new claims system producing provider payments in early November 2002.

Major HAPA project accomplishments to date include:

- Completion of user acceptance testing
- System modifications to the recipient and provider subsystems to support claims processing
- Completion of provider education sessions
- Continued iterations of pre-conversion data runs of HMSA suspended and paid claims and prior authorizations

The HAPA team and ACS are currently busy testing and finalizing operational procedures in preparation of cut-over. ■

# Upcoming ACS Focused Provider Training Sessions

To learn more about the upcoming changes to claim forms and billing procedures please attend one of the ACS sponsored Medicaid Provider Training Sessions in your area. ■

# New Med-QUEST Website goes live Oct. 1.

Med-QUEST will be launching its new website on Oct. 1. Complete with provider newsletters, the provider manual, and other great information, the new site will offer the medical community up-to-date information about the State Medicaid program.

After Oct. 1 you may log on to ***www.medquest.us*** to access the new site. If you would like to share your thoughts or suggestions with the Med-QUEST Division about the site, just click on "Contact Med-QUEST" and send us an e-mail.

## Key Transition Dates – *Please forward this section to your billing office.*

The HAPA claims project continues its progress towards the transition to the new claims system. There are some key dates in the next month that will impact the various providers. Please mark your calendars.

| Activity | Target Date | Description |
|---|---|---|
| First date for access to AVRS for eligibility verification | 9/24, Tuesday | ♦ Providers can begin utilizing the AVRS system to access recipient eligibility information.<br>♦ New Medicaid Provider ID numbers will be needed to begin accessing the AVRS.<br>♦ AVRS toll free number is 1-800-882-4608. |
| MQD and ACS mail out new Medicaid Provider ID numbers | Mid-October | ♦ Providers will receive new Medicaid Provider identification numbers via mail.<br>♦ Contact MQD at 692-8099 if you have not received your new provider ID numbers by October 11th. |
| MQD and ACS mail out revised 2002 Provider Manuals | Mid-October | ♦ Providers will receive the revised 2002 Medicaid Provider Manual on CD. |
| Final date for hard copy claims and claim adjustments to be submitted to HMSA | 10/18, Friday, 3 p.m. | ♦ HMSA will receive hard copy claims from providers up to this date.<br>♦ After this date the PO box will be transferred to ACS.<br>♦ Claims received after this date will be data entered by ACS into the new claims system. |
| Final date for correspondence (written and fax) inquiries to HMSA | 10/18, Friday | ♦ HMSA will receive correspondence (mail and fax) through this date.<br>♦ Inquiries after this date should be sent to ACS at 952-5595 (fax) or mail to:<br>1440 Kapiolani Blvd., Suite 1400<br>Honolulu, HI 96814<br>♦ There may be a delay in responding to written inquiries after this date, while the information is being transferred to the new claims system. |
| Final date for EMC transmissions from providers to HMSA | 10/24, Thursday, 11:59 p.m. | ♦ HMSA will receive EMC transmissions from providers up to this date and time.<br>♦ After this date, EMC providers that are certified with the new system should follow the new procedures and format for EMC submissions. |

| Activity | Target Date | Description |
|---|---|---|
| | | ♦ Submitting Medicaid claims data after this deadline could result in provider's files being rejected or misdirected. |
| Final date for HMSA to receive and process medical authorization requests | 10/24, Thursday | ♦ HMSA will receive authorization request up through this date.<br>♦ Requests received after this date will be processed by ACS. |
| Final date for HMSA to notify providers of approved or denied authorizations | 10/28, Friday | ♦ HMSA will notify providers of approved authorizations up through this date.<br>♦ Determinations for outstanding and new requests after this date will be done by the MQD Medical Standards Branch and processed by ACS. |
| Final check pick-up/mailing to providers from HMSA | 10/31, Thursday | ♦ HMSA will distribute the final checks to providers on this date. This is HMSA's last payment run. Any claims not paid will be transferred to the new claims system.<br>♦ HMSA will have the final ERAs available for providers through 11/7. |
| Status reports mailed to providers by HMSA | 10/31, Thursday | ♦ HMSA will be mailing to providers a list of outstanding claims that were transferred to ACS and the new claims system. |
| Final day for HMSA provider call center | 10/31, Thursday | ♦ HMSA will receive phone inquiries through this date.<br>♦ After this date, the 1-800 neighbor island phone number will be transferred to ACS. |
| First day for ACS provider call center | 11/1, Friday | ♦ ACS will begin receiving phone inquiries from this date. |
| First checks to providers by ACS | 11/8, Friday | ♦ ACS will distribute the first payments to providers on this date. |
| Web access for eligibility verification and claims status inquiry | Staggered release beginning in November | ♦ Providers will receive web access to recipient eligibility information and claims status.<br>♦ Access to this website will be rolled out on a staggered basis beginning in November. |

## ACS Contact information

**Effective November 1, 2002:**

**Claims:** P.O. Box 1220
Honolulu, HI 96807-1220

**PA:** P.O. Box 2561
Honolulu, HI 96804-2561

**Urgent PA Fax #:** 952-5562

**Correspondence:** 1440 Kapiolani Blvd., Suite 1400
Honolulu, HI 96814

**Provider Inquiry Unit Phone #s**

**Oahu:** 952-5570 **Neighbor Islands:** 1-800-235-4378

# Upcoming Changes to Claims Processing – *Please forward to your Billing Office.*

***Professional and Other Providers***

- EPSDT providers when recommending a follow-up visit for a recipient must enter an "E" into form locator 24H on the HCFA (CMS) 1500 claim form.
- Ambulance destination modifiers must be used on claims submitted for emergency transportation.
- A referring provider must be identified when submitting a claim with consultative codes or for inpatient Podiatry.
- Providers must bill injection administration fees on a HCFA 1500 with appropriate CPT codes. If a J code is submitted on a HCFA 1500 claim it will be denied as non-covered.

***FQHC Providers***

- FQHCs must use the UB92 form to bill.

***Facility and Long Term Care Providers***

- Long term care providers must bill bedhold charges using a revenue code 180. Each new incident of bed hold days must be billed as a separate line item. If units on a service line exceed 3 units (days) a prior authorization will be required or the claim will be denied.
- Providers must split bill when a QUEST client hits the 61st day in an inpatient facility, is on waitlisted status for SNF and becomes FFS.
- Facilities must bill SNF waitlisted services with bill type 11x and occurrence span code = 75.
- Facilities must bill ICF waitlisted services with bill type 11x and occurrence span code = 74.

- Current administrative rules require outlier claims to be billed 60 days after the outlier threshold has been met. Providers can now bill for charges in excess of the outlier threshold thirty days after a patient reaches outlier status, monthly thereafter and upon discharge.

***Pharmacy Providers***

- Non –drugs (supplies) currently billed on a form 204 should be billed using a HCFA 1500.

***Other Changes***

- Services to the Home and Community Based Program (SSD) must be billed on a separate claim. The claim must include a "W" in the Prior Authorization field in order to be processed correctly.
- For any service requiring a PA, the PA and claim must match exactly on all codes or the claim will deny. For example, if a PA is submitted and approved with a code for a 45-60 minute office visit and subsequently the provider bills the claim with a code for a 20-30 minute office visit the claim will deny because the codes will not match.
- When a prior authorization is approved or denied, the referring and rendering providers will both receive letters informing them of the decision. The hardcopy form will not be returned. Recipients will also receive a letter to notify them of denials.
- Each line of the HCFA 1500 will be listed on the RA. If a HCFA 1500 claim is of mixed status, those line items approved will be listed under the paid section and those line items denied will be listed under the denied section of the RA.
- Servicing and referring providers cannot be the same on a claim.
- When sending in an adjustment to a claim already submitted the provider must submit all lines on the claim so as not to void out the lines previously submitted correctly.
- A copy of the original RA does not need to be submitted with an adjustment, however for adjustments and voids the original Claim Reference Number (CRN) must be placed in Field Locator 22 on the HCFA 1500 and field locator 37 for UB92s.

# Provider Education Sessions Questions & Answers

Many providers and provider representatives attended the Medicaid Provider Education Sessions presented by the Med-QUEST Division in conjunction with Medifax and ACS in August and September.

Attendees learned more about the HAPA project and many of the upcoming changes to Medicaid claims processing. Individuals were also introduced to ACS, the new fiscal agent, and were introduced to some of the new features and services being implemented through Medifax such as the Automated Voice Response System.

Provider inquiries raised in these sessions as well as those received at hquestions@medicaid.dhs.state.hi.us have been documented here to ensure that information is communicated to all individuals that may be impacted by the project. MQD appreciates the effort by providers to prepare for the transition and to submit questions regarding the project. Please continue to send inquiries to hquestions@medicaid.dhs.state.hi.us.

In addition, ACS is conducting focused Medicaid Provider Training Sessions. Please see the attached schedule for the session nearest you ***(See Attachment C).***

| QUESTIONS | ANSWERS |
|---|---|
| **Eligibility** | |
| 1. Will the eligibility verification system indicate whether a PA is required for the service? | No. The eligibility verification systems prompt the user for the dates of service that eligibility is being verified but does not prompt for the services. |
| 2. When will the web based eligibility verification system be ready? | It is scheduled for a staggered release beginning in November 2002. Additional information will be provided at a later date. |
| 3. How can long-term care facilities find out what a recipient's cost share is? | The cost share amount will be provided on the automated voice response system, the MEVS system, and the web eligibility verification system or by calling the provider call center. In addition, MQD is planning on producing a monthly report to LTC facilities listing the individuals in their facility and their cost share amount. |
| 4. When a recipient is eligible for a benefit up until a particular age, how is that age calculated? | The age is calculated at the end of the recipient's birth month. For example, if a recipient is eligible for a service until the age of 21 and the recipient's birthday is 8/1/1981, then the recipient will be eligible for the service through 8/31/02. |
| 5. When will recipients be told of the changes to the ID cards? | Information is being disseminated to recipients with their September and October Medicaid eligibility cards. |
| 6. What will be the procedure for a recipient who has lost their card? | They should call the MQD enrollment call center at (808) 524-3370 or (800) 316-8005. |
| 7. Do all children automatically get EPSDT benefits? | Yes, all individuals up to the age of 21 are eligible for EPSDT services. |
| 8. Will the AVRS include QUEST recipient information? | Yes, it will include information for both QUEST and FFS recipients. It will also indicate the plan in which the recipient is enrolled. |
| 9. How soon after eligibility is determined will the AVRS and other systems have this information? | Eligibility is updated daily in the State's eligibility system called HAWI. It is transferred each evening to HPMMIS. It is available the next morning to the AVRS and other eligibility verification systems. |
| 10. What provider number should be used for AVRS? | The new provider numbers that will be mailed in late September/early October. If a provider or group has more than one number, then any active provider number can be used. |

| QUESTIONS | ANSWERS |
|---|---|
| 11. Will the AVRS indicate when QUEST clients are in the fee for service window? | Yes |
| 12. What are the instances when a client could lose eligibility mid-month? | Generally, a client will only lose eligibility mid-month if they become incarcerated or die. In addition, clients awaiting eligibility determination can be presumptively eligible for a finite period of time that could end mid-month. |
| 13. Will the AVRS system provide information on covered services? | No. |
| 14. Is there a time limit to be on AVRS? | No. |
| 15. Does AVRS provide TPL information? | Yes. |
| 16. Does AVRS provide the PCP? | No. The provider should contact the recipient's health plan for that information. |
| 17. Does AVRS provide cost share information? | Yes. |
| 18. Does AVRS provide information if Medicaid eligibility is pending | No. |
| 19. Will cost share for LTC recipients be shown if in a facility on the first of the month? (e.g. if patient sees a physician on the first of the month and the physician looks up the cost share information.) | The cost share information will be available from the first of the month. |
| 20. When will plastic ID cards be sent out? | They will be issued during the last two weeks of October. |
| 21. Will LTC recipients receive the plastic ID cards? Where will LTC resident ID cards be sent? | Yes, these recipients will receive cards. They will be sent to them at the facility's address. |
| 22. Will QUEST recipients also receive a plastic ID card? | Yes. QUEST recipients will receive a plastic ID card. QUEST recipients will use this card for the time they are in the fee-for-service "window" prior to enrollment and to access dental services. Once enrolled in a QUEST plan, the plan will also send a plan ID card to recipients for medical services. |
| 23. Is the new system going to be able to hold claims until a recipient becomes eligible? | No. Claims will be denied if the recipient is not eligible. |
| 24. If the recipient has a TPL that is incorrect, how can it be fixed? | The provider or the recipient should notify the MQD caseworker or contact the MQD Finance Office TPL unit to make the correction. |

| QUESTIONS | ANSWERS |
|---|---|
| 25. For newborns – what is the process for getting the baby to be Medicaid eligible? | If the mother or any one else in the newborn's household is Medicaid eligible the eligibility caseworker simply needs to be notified and the newborn's recipient ID number will be issued. If no one in the newborn's household is Medicaid eligible the baby must be enrolled with Medicaid through the standard Medicaid enrollment process. |
| **Provider Numbers** | |
| 26. Is the Medicaid provider number going to stay the same? | No, all providers will receive a new provider number. Provider numbers will be mailed in early October. |
| 27. Will the new provider numbers apply to FQHCs also? | Yes. The new provider numbers apply to ALL providers. |
| 28. How many provider numbers will I be assigned if I have more than one tax ID number and pay to address? | Only one provider number will be issued unless the types of service provided at each facility are vastly different. |
| 29. Currently the provider number identifies a provider's specialty that impacts the dollar amount of payment. How will the new provider number impact this? | Except for dentists, the new fee schedule is not specialty specific. For long term care facilities where the reimbursement differs by level of care, the bill type on the claim form will identify the appropriate level of care. |
| 30. Do we use one provider number for long term care split bills- i.e. one bill for room/board and the other for ancillary charges? (for example: currently we have 4 provider numbers one for SNF R&B one for ICF R&B, one for SNF ancillary, and one for ICF ancillary.) | Long term care providers should continue to split the charges onto two separate bills – one for room and board and a separate claim for ancillary services that are paid in addition to their PPS reimbursement. Both claims will be submitted with the same provider number. In addition, long-term care providers should also split bill when a client changes level of care. The bill type on the claim form will identify the level of care. The claims can be submitted with the same provider number. |
| **Claims Processing** | |
| 31. Will the remittance advice list all reasons for denial or just one? | The remittance advice will list all reasons that caused the claim to deny. In addition, the remittance advice will list pended claims. |
| 32. What will be the frequency of payments and remittance advices? | Weekly on Fridays. |

| QUESTIONS | ANSWERS |
|---|---|
| 33. How long will newborn claims take to process? Is it possible to pre-register the newborn? Can the mother be billed if she fails to apply for Medicaid? | Newborn claims will have the same processing time as non-newborn claims. It is not possible to pre-register a newborn.<br>The mother can be billed for the newborn's bills if she and all members of the newborn's household are currently ineligible for Medicaid and she fails to apply for Medicaid. If the mother and/or any other member of the newborn's household are Medicaid eligible the newborn is automatically eligible for a year. However, the eligibility caseworker must be notified to acquire a valid recipient ID number for the newborn claims to be processed. |
| 34. What are the procedures for correcting claims that are paid an incorrect amount? | Contact the ACS provider call center. They will research the claim and respond appropriately. |
| 35. Currently providers are required to attach the original remittance advice to a claim that is being resubmitted. Will this be the requirement with the new FA? | No. However, adjustments and voids must include the original Claim Reference Number (CRN) and be designated as an adjustment or void appropriately.<br>For the HCFA 1500:<br>- Place "A" for Adjustment or "V" for Void in form locator 22 under Medicaid Resubmission Code<br>- Place the original CRN # in form locator 22 next to the A or V.<br>For the UB92:<br>- Adjustment or Void is designated by bill type<br>1. Bill type XX8 = Void<br>2. Bill type XX6 = Adjustment<br>- Place original CRN # in form locator 37A |
| 36. Will ACS accept hard copy claims dropped off at their offices? | Yes. |
| 37. If the claim has TPL, does the TPL remittance need to be attached to the claim? | For non-pharmacy claims, only if the claim was denied by the TPL. |
| 38. When billing with 10-digit client ID on the UB, will the 0s need to be added to the front? We are not including the zeros now. What about claims billed with the check digit? | Yes, the client number should be billed with leading zeros. Claims with the check digit will continue to be accepted and processed. If a claim is submitted with 11 digits in the recipient ID field, the last digit will be dropped. |

| QUESTIONS | ANSWERS |
|---|---|
| 39. Will the cut off for claims processing be based on service date? | No. ACS will process paper claims submitted after October 18th and EMC claims submitted after October 24th, regardless of service date. In addition, any HMSA pended claims will be transferred to ACS. |
| 40. When the final pended claims report is received from HMSA and some claims submitted are not included, should these claims be resubmitted? | Wait until the RA for November 8th to see if the claim is listed there. If not call ACS or submit. |
| 41. Can HMSA produce a pended claims report now? | No. |
| 42. If the claim was denied because a recipient's TPL was incorrect, does the claim need to be resubmitted? | Yes. |
| 43. Do Medicare claims that do not crossover need the Z9009 code? | No. Indicate the Medicare amount paid in the appropriate fields:<br>On the UB92:<br>- Place Payor name "Medicare" in form locator 50<br>- Place Medicare amount paid in form locator 54<br>- Place deductible and coinsurance amount in form locator 39 and 40.<br>o If submitting a claim coordinated with Medicare Part A, enter in FL39A: A1 with deductible amount and in FL 40A: A2 with coinsurance amount.<br>o If submitting a claim coordinated with Medicare Part B, enter in FL 39B: B1 with deductible amount and in FL 40B: B2 with coinsurance amount.<br>On the HCFA 1500:<br>- Place in form locator 24K the coinsurance and deductible amount paid per line separated by a slash. |
| 44. What are the billing requirements for FQHC? | FQHCs will be required to bill on UB-92 instead of HCFA 1500 October 19th. |

| QUESTIONS | ANSWERS |
|---|---|
| 45. How should catch-up immunizations be billed? | Appropriate CPT codes with EP modifiers will need to be utilized for catch-up and preventive EPSDT visits. Appropriate CPT codes with EP modifiers will be reimbursed at the EPSDT rate and those without the modifier will be reimbursed at the fee schedule rate. Z9000 codes can no longer be used. |
| 46. Will there be any changes to long term care providers PPS reimbursement? | No, not at this time. A separate study is being conducted on reimbursement for LTC. |
| 47. Currently long term care providers are required to submit a separate bill each time a client changes level of care. Will this change? | No, providers must continue to generate separate bills with the appropriate bill type for each level of care. |
| 48. What happens when a client becomes waitlisted? | At the time a person becomes waitlisted, the provider needs to generate a discharge claim for the acute status and a new claim for the waitlist status. |
| 49. How should non-drugs, currently billed on the 204 Prescription Drug Claim form, be billed? Will we be able to use the HCFA (CMS) 1500 claim form? Can they be electronically submitted? | Starting October 19, 2002, non-drugs (i.e. DME, supplies) that are currently billed on a form 204 should be billed using a HCFA 1500. They can be billed electronically using the NSF 2.0 format The form 204 will be discontinued for DME and supplies. ACS PBM will also accept the HCFA 1500 form for drug claims, but they will continue to accept the 204 form for drug claims. |
| 50. Will there be any changes to when bedhold days can be billed and what will be covered? | No, there is no change to the current policy in regards to when and for how long providers can bill bedhold days. The only change is for those bedhold charges that are covered, providers should bill with revenue code 180. |
| 51. Will the claims from Medicare continue to cross-over to Medicaid and will there be any down time while the cross-over is tested so the provider would have to bill the claims hardcopy? | MQD is currently testing the crossover of claims with each of the Medicare carriers. We do not anticipate any down time in receiving and processing these transmissions. Providers should not have to submit these claims via hard copy. |
| **Prior Authorizations** | |
| 52. Will there be any changes to authorization dates? | No. |
| 53. Will outpatient mental health visits still require PA? | Yes. |
| 54. How can Des over the weekend be approved? | These will be handled the same as emergency services. |

| QUESTIONS | ANSWERS |
|---|---|
| 55. Will there be changes to the 1147 process? | No. |
| 56. Will there be changes in the PA forms? | The PA forms are being redesigned to reduce the number of forms and make them more user-friendly. These forms will be included in the Provider Manual and on the MQD website. |
| 57. Is the 1018 form staying? | Yes. |
| 58. For 1144 forms currently submitted hardcopy, can they be submitted via fax or electronically? | Urgent requests can be submitted via fax. Currently, all other requests must be submitted hardcopy. |
| 59. On the 1144 form for Home Health there are separate forms for the four disciplines. Will the modifications to the forms allow 1 form to be used? | Yes. Home Health will be submitted on the 1144 form with appropriate substantiating medical documentation. |
| 60. For PA requests, can providers receive a verification of receipt? | A verification of receipt is not available. |
| 61. Will PA training be provided? | ACS is looking into providing prior authorization training. |
| **Electronic Claims Submission** | |
| 62. Is there security for EMC submissions? | Yes. |
| 63. Will EMC transmission ever be a requirement for providers? | Not currently planned. |
| 64. Can adjustment claims be submitted electronically? | Yes, as long as they are within the filing deadline. |
| 65. Will the QUEST health plans have the same EMC requirements as Medicaid? | EMC requirements are determined by each health plan. |
| 66. Can more than one EMC file be submitted each day? | No. A provider can submit only one file of each claim form type each day. |
| 67. In question 22c of the Provider Bulletin volume 1 issue 2 the response was “no carriage return or line feed is needed. Will one be allowed to be used? | This information was incorrect. A carriage return or line feed is required at the end of each record. |
| 68. We are interested in submitting electronic medical claims when ACS becomes Medicaid's fiscal agent, we do not submit electronically today. How can we get prepared for this? Can we get all the information? | Information regarding ECS submissions will be available on the MQD web site. |

| QUESTIONS | ANSWERS |
|---|---|
| 69. I would like to have more information about ECS transmissions for Pharmacy providers. Will the program be compatible with the new Medicare HIPAA formats? | ECS transmissions for pharmacy providers for non-drug claims will need to comply with NSF 2.0 standard format. MQD is currently working to implement the HIPAA formats but they will not be available until next year. |
| **General** | |
| 70. Will the ACS focused training have video conferencing? | No, unfortunately this service is not available in the locations where the focused training is being conducted. |
| 71. What will be the timing of EFT? | Friday mornings. |
| 72. Will the state no longer be affiliated with HMSA? | Yes, HMSA will no longer serve as the Medicaid fiscal agent after October 31, 2002. |
| 73. Will the new system provide PS&RR reports at year-end to assist with cost report submission (similar to Medicare)? | Yes, MQD is working on designing a similar report. Due to the changeover, this may not be available until a full year of claims has been processed by the new system. |
| 74. What will happen to coupons? | Coupons will still be provided in selected circumstances, for example, prisoners, spenddown clients and certain foster children. However, the number of instances where coupons will be provided will be minimized. Also, the coupon will only be honored if the recipient is eligible on the date of service. |
| 75. How will the facility know if the cost share amount has been met? | The ACS call center can respond to these inquiries after November 1st at 952-5570/1-800-235-4378 |
| 76. What is the TPL recovery coordination process? | Federal law mandates that for any service other than EPSDT, services for pregnant women and other limited circumstances, proof of payment/denial by the primary payor is required before trying to recover payment from Medicaid. |
| 77. Will there be any changes to critical access hospitals' reimbursement amounts? | No. |
| 78. Will PAs that were authorized by HMSA be transferred to ACS? | Yes, PAs that were approved by HMSA will be honored by the new claims system. In addition, PAs that have been received but a determination has not yet been made will also be transferred to the new claims system. |

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|---|---|
| 79. What is the website address for where the provider bulletin will be posted? | The Med-QUEST website address is: **www.medquest.us**. It will be available in early October and will include PA forms, enrollment forms, and the provider manual as well. The eligibility verification/claim status website is a separate website that will be released on a staggered basis after November. |
| 80. Will the 239 form (Medicaid correspondence form) continue to be used? | There will be a new form utilized for correspondence. The 239 form will no longer be used. |
| 81. Will the new HPMMIS claims system be able to provide the providers Patient Control Number on their RA so the payments can be easily identified? Also, will ACS be changing their programming for pharmacy claims so that the Providers Patient Control Number will be printed on their remittance? | The patient account number from the claim will be returned on the RA.<br>The HPMMIS system will not impact the ACS PBM pharmacy claim processing system. |