Changes to Medicaid Claims Processing – *Effective: October 25, 2002*
Please Forward to your Billing Office

NEW PROVIDER ID NUMBERS

- The new provider ID number is a six-character number with a two-character service location. Most providers will have a single provider ID number.
- 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. Claims submitted with the current MMIS ID number will be accepted through December 31, 2002.
- Providers should use their new provider ID number, ALL eight digits, to access the AVRS.

RECIPIENT ID NUMBERS

- Beginning October 20, recipients will receive a permanent Medicaid ID card. The new cards will be plastic and will be issued to all QUEST and FFS clients. QUEST clients will use the card ONLY for dental services, for medications prescribed by their treating dentists and during the fee-for-service "window" period. They will continue to receive a separate card from their managed care plan for medical services and for medications prescribed by their QUEST medical plan providers. Providers will be responsible for verifying eligibility at the time of service for the recipient. Several options will be available at no cost to providers to verify eligibility:
  - Automated voice response system (AVRS): 1-800-882-4608
  - Web-based eligibility verification system (phased release after Nov. 2002)
  - ACS Provider Inquiry Unit (active Nov 1, 2002, 7:30 am - 5:00 pm M-F): 952-5570(Oahu), 1-800-235-4378 (Neighbor Islands)
  - MQD Provider Hotline: 692-7360 (Oahu), 1-800-518-8887 (Neighbor Islands)
- Providers must bill with the 10-character recipient HAWI ID number. The check digit will no longer be used. Leading zeros must be included. Claims with the check digit will continue to be accepted and processed, provided that all 10 characters, plus the check digit are submitted.
- Providers will be required to bill newborn claims using the newborn's recipient ID number. Newborn claims submitted with the mother's ID number will be denied.

GENERAL CLAIMS PROCESSING

- Vision and hearing claims must be submitted on HCFA 1500 claim forms.
- Providers can bill a maximum of 25 lines on the HCFA 1500 and ADA claim forms. If the claim has more than 25 lines, then it should be split billed. If more than 25 lines are submitted on one HCFA 1500 form the claim will be denied.
- General Excise Tax is no longer paid as a separate line item; it is included in the fee schedule amount. If it is billed it will be denied.
- Providers will be required to bill drug administration fees on a HCFA 1500 with appropriate CPT codes (CPT – examples: 90782, 90471, 90472). If a J code is submitted on a HCFA 1500 claim it will be denied.
- Ambulance destination modifiers must be used for emergency air ambulance transportation.
- Hospitals must enter a condition code of '61' in form locator block 24 on outlier claims for the claim to be considered for outlier payment. Claims submitted without the '61' condition code will not be paid as an outlier claim. Outlier claims can be billed thirty days after reaching outlier status and monthly thereafter.
- Nursing facilities should bill appropriate bed hold days using revenue code 180. Bed hold days must be billed consistent with current policy guidelines as described in the provider manual.

- At the time that a person becomes waitlisted, the hospital must generate a discharge claim for the acute status and generate a new claim for the waitlist status using the appropriate bill type and occurrence codes:
  - SNF Waitlisted: Bill Type: 11X and Occurrence Span Code: 75
  - ICF Waitlisted: Bill Type: 11X or 21X and Occurrence Span Code: 74
- Facilities should continue to bill subacute services with the appropriate bill type and revenue code:
  - Hospitals: Bill type: 17X and Revenue code: 19X
  - Nursing Facilities: Bill type: 27X and Revenue code: 19X
- Providers will be required to obtain and submit the referring physicians provider number on claims for inpatient podiatry and when consultative codes are utilized on a claim.
- Servicing and referring physicians on a claim cannot be the same. If a referring provider is required (for example inpatient podiatry), the claim must have a referring provider on the claim with his or her own provider ID different from the servicing provider.
- When submitting an adjustment to a claim already processed, providers must submit all lines on the claim (even those that were originally correct) so as not to void out the lines previously submitted correctly. Servicing provider, billing provider, and recipient must match or the claim will be denied. If servicing provider, billing provider or recipient need to be changed, then the original claim should be voided and a new claim submitted.
- The original RA does not need to be submitted with an adjustment. However, adjustments and voids must include the original Claim Reference Number (CRN) and be designated as an adjustment or void appropriately:
  - For HCFA 1500s:
    - Place "A" for Adjustment or "V" for Void in form locator 22 under Medicaid Resubmission Code
    - Place the original CRN number in form locator 22 next to the "A" or "V"
  - For UB92s:
    - Adjustment or void is designated by bill type
      - Bill type XX8 = void
      - Bill type XX6 = adjustment
    - Place the original CRN number in form locator 37A

TPL and MEDICARE COORDINATED CLAIMS

- Providers are required to submit the TPL paid amount on the HCFA 1500 for each line item in field 24K.
- If the TPL denied the claim, the remittance advice from the TPL must be submitted with the claim.
- Providers need to indicate the Medicare paid, coinsurance and deductible amounts in the appropriate fields and submit the Medicare EOB/RA with the claim:
  - UB92:
    - Place Payor name "Medicare" in form locator (FL) 50 and amount paid in FL 54
    - Place deductible and coinsurance amount in FL39 and FL40.
      - If submitting a claim coordinated with Medicare Part A:
        - Use value code 'A1' with the deductible amount
        - Use value code 'A2' with the coinsurance amount
      - If submitting a claim coordinated with Medicare Part B:
        - Use value code 'B1' with the deductible amount

  - Use value code 'B2' with the coinsurance amount

- HCFA 1500:
  - Place in form locator 24K the paid amount, coinsurance and deductible amounts paid per line separated by a slash.

EPSDT PROVIDERS

- EPSDT providers will be required to bill on HCFA 1500 claim forms.
- Local codes will no longer be used for billing EPSDT services. Appropriate Evaluation and Management codes with "EP" modifiers will be utilized for preventive visits and catch-up immunizations. Appropriate Evaluation and Management codes with "EP" modifiers will be reimbursed at the premium rate and those without the modifier will be reimbursed at the fee schedule amount.
- EPSDT providers must enter an "E" in form locator 24 H on the HCFA 1500 claim form when recommending a follow-up visit with themselves or a specialist.
- Requests for medically fragile case management services are sent directly to ACS.

FQHC PROVIDERS

- FQHC providers will bill on the UB-92 claim form with a bill type of 73X, revenue code 520 and CPT code 99212 for medical and psychological services. Dental services will be billed on the ADA 1999 v. 2000 form with CDT-3 code D0120.
- Overall the billing practices are similar to Medicare, expect psychologists who currently bill with revenue code 910, will be required to use revenue code 520 for Medicaid claims. If revenue code 910 is submitted to Medicare, it will automatically be paid as '520' when crossing over to Medicaid.

ANESTHESIA PROVIDERS

- Anesthesia services must be billed with ASA codes, any claims received using the surgical codes will be denied.
- Like Medicare, a valid HCPCS modifier is required for all anesthesia codes. AA has been added as a valid modifier.
- A time unit will be 15 minutes. It will NOT vary from the time unit of 15 minutes in the first hour to the time unit of 10 minutes in subsequent hours.
- Providers must report both minutes and units. For electronic claims, report the minutes in Record type "FAO". For hard copy claims, include the units in the line below the minutes.

DENTAL PROVIDERS

- Dental providers will be required to use CDT-3 codes.
- Hard copy dental claims must be submitted on an ADA 1999v.2000 claim form.
- Dental providers may submit claims electronically. Contact ACS for more details.
- Dentists should indicate the referring provider ID number, when appropriate, in form locator 47 (Dentist's License Number) on the ADA 1999 v. 2000.
- For dental resubmissions, enter "A" to adjust, or "V" to void, along with the original claims reference number in form locator 2 under Prior Authorization number.

PHARMACY PROVIDERS

- There are no impacts or changes to drug claims currently submitted to ACS PBM EXCEPT the new recipient number must be used. The prescriber DEA number or new HPMMIS Medicaid provider number must be submitted. New payor sheets will be mailed to pharmacy providers.

- Non-drugs (e.g. supplies, DME) that are currently billed on a Form 204 should be billed using a HCFA 1500 and submitted to ACS FA. As is current policy, the only "supplies" paid by ACS Pharmacy Benefits Manager (PBM) are those provided by Home Infusion Providers as either part of the global infusion codes or as TPN and enteral "B" codes and associated pumps and IV stand. These should continue to be billed to ACS PBM. Suppliers of enteral products must submit their claims to ACS FA if they are not a home infusion provider known to ACS PBM.
- Pharmacies should follow the same guidelines in billing on the HCFA 1500 as are used when billing Medicare.

REMITTANCE ADVICE (RA) and PAYMENT

- Weekly checks will be mailed separately from the hard copy remittance advice.
- Providers that receive an ERA may elect to receive an electronic funds transfer. Contact ACS for more information.
- Turnaround documents (TADs) will no longer be generated. Claims that fail edits will be denied. Denied claims will have to be resubmitted for processing. All denial reason(s) will be listed on the remittance advice (RA).
- Each line on the HCFA 1500 will be listed on the RA. If a HCFA 1500 claim is of mixed status (some lines are denied and some are paid) 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.
- The remittance advice will list pended claims (claims received but not yet paid or denied).

ELECTRONIC CLAIMS SUBMISSION

- Electronic claims must be billed using NSF Version 4.0 for UB-92 and NSF Version 2.0 for HCFA 1500. All electronic providers must be re-certified before they can begin submitting electronic claims. Claims must be submitted via Virtual Private Network (VPN).
- When an adjustment to a claim is submitted electronically, the system will compare the adjustment claim to the original and adjust accordingly.

PRIOR AUTHORIZATIONS

- Some of the Prior Authorization (PA) forms have changed. With the exception of the 208, they are no longer multi-copy forms and can be electronically downloaded from the MQD web site at www.MedQUEST.us or copied from the provider manual. Current versions of the forms will be accepted for a limited time.
- Letters will be sent to both referring and rendering providers informing them of the determination. The hardcopy PA form will not be returned. Letters will also be sent to recipients to notify them when an authorization request has been denied.
- An authorization is required for DME that exceeds $50.00 per line item. The only exception is for diabetic supplies, which require an authorization when it exceeds $125 per month.
- Prior authorization numbers do not need to be included on the claim form. For any service requiring a PA, the PA and claim will need to match exactly 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 on the PA and claim will not match.
- Home and Community Based Waiver Program (Social Services Division Home and Community Based Services Waiver Program) claims must be submitted with a “W” in the PA field. Failure to submit a “W” in the PA field for SSD claims may result in a denial. In addition, if a “W’ is submitted on a claim that is not SSD, this may also result in a denial.

Key Transition Dates

Activity	Target Date	Description
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. ♦ After this date the PO box will be transferred to ACS. ♦ 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. ♦ Inquiries after this date should be sent to ACS at 952-5595 (fax) or mail to: 1440 Kapiolani Blvd., Suite 1400 Honolulu, HI 96814 ♦ 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. ♦ After this date, EMC providers that are certified with the new system should follow the new procedures and format for EMC submissions. ♦ Submitting Medicaid claims data to HMSA after this deadline could result in provider's files being rejected or misdirected.
Final date for HMSA to process medical authorization requests	10/24, Thursday	♦ HMSA will process authorization requests up through this date. Requests received by ACS from 10/19/02 will be forwarded to HMSA. ♦ HMSA will accept faxed urgent requests through 10/24/02, 4:30 p.m. Urgent requests after that time can be faxed to ACS at (808) 952-5562. ♦ Requests received after this date will be processed by ACS.
Final date for HMSA to notify providers of approved or denied authorizations	10/25, Friday	♦ HMSA will notify providers of approved authorizations up through this date. ♦ Determinations for outstanding and new requests after this date will be made 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. ♦ HMSA will have the final Electronic remittance advices available for providers through 11/07/02.
Status reports mailed to	10/31,	♦ HMSA will be mailing to providers a list of

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Activity	Target Date	Description
providers by HMSA	Thursday	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. ♦ 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. ♦ 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 (effective 10/25/02)

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

Provider Inquiry Unit Phone #s

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

CPT and HCPCS Codes

Effective November 1, 2002, the Med-QUEST Division (MQD) will not be accepting requests for providing Level I—Common Procedural Terminology (CPT) codes and Level II—Healthcare Common Procedural Coding System (HCPCS) codes on a routine basis. Providers should obtain these codes from published coding manuals. Failure to use the appropriate code will result in a delay in the processing of a request for authorization or claim.

The MQD will continue to only assist providers in determining appropriate CPT or HCPCS codes when a claim has been denied or a request for medical authorization or claim has been deferred or denied because of a coding error and the provider is unable to determine the appropriate code. The provider should fax their request for a CPT or HCPCS code to the MQD's fiscal agent. A copy of the claim and applicable remittance advice or a copy of the request for authorization or claim and the letter of deferral or denial should be attached to the request for coding assistance. Requests that are submitted without the appropriate documents attached will be returned to the provider without a response.