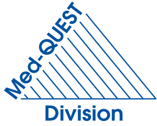


Medicaid

Published for the Medicaid Providers of Hawaii.

Provider Bulletin

Volume 3, Issue 1

Feb. 2004

In This Issue

Page 2

Surgery: Operative Reports

59200: Insertion of Laminaria

Home & Care Home Visits

Anesthesiology: Clarification of Regional Blocks & Epidural Catherization

A4647: Gadolinium

Newborn Care: 99436 and 99440

ESRD Billing Clarification

Page 3

Correcting or Changing PAs

Urgent PA Process

Claims Denying for No PA Found

Bundling Codes for Critical Access Hospitals

Adjusting Units and Billed Charges

Surgical Trays

Page 4

Opthalmology: Vitrectomy

Page 5

Differences between ACS FA & ACS PBM

Page 6

E1399 and K0108 Modifiers

Conjoint Psychotherapy

Submitting Electronic Adjustments on the 837i

Requests for Reconsideration

Page 7

Provider Agreements to be Updated

Miscellaneous CPT Codes

Medicaid Policy: Late Fees

Coverage of Diabetes Self Management Training

Page 8 & 9

New Form 240: Request for Reconsideration

New Form 239: Medicaid Inquiry Correspondence Form

Check Claim Status and Eligibility Online for Free

DHS Medicaid Online (DMO) is a free online resource available to all Hawaii Medicaid providers. *DMO* allows providers to verify recipient eligibility and claim status via the internet. To access *DMO,* go to website address: https://hiweb.statemedicaid.us.

In order to access *DMO,* you must first complete the registration process. Upon activation of your account, you can verify eligibility information for recipients enrolled in FFS and QUEST plans and check the status of claims submitted under your PIN.

Eligibility, plan enrollment, and TPL can be verified by supplying the recipient's:

1) HAWI ID #,
2) Social security number or
3) Name, date of birth and gender.

When checking claim status and payments, you must:

1) Identify the recipient (see above),
2) Select a provider ID number (PIN), and
3) Enter dates of service.

Claim status can be verified for claims submitted under the PIN provided during the registration process. If you enrolled with a group payment ID, you will be able to check the status of all claims billed with PINs associated with your group payment ID.

Go to: https://hiweb.statemedicaid.us today and start checking eligibility and claim status with ease. The information supplied via *DMO* is pulled directly from the Hawaii Medicaid claims processing system. Which means the information you receive from *DMO* is the most up to date information available. If you require assistance with *DMO*, call the ACS Provider Inquiry Unit.

Volume 3, Issue 1

Feb. 2004

Billing Clarifications

SURGERY: OPERATIVE REPORTS

Operative reports should be submitted with claims when three or more surgical procedures are performed on the same day. If operative reports are not submitted, claims will be denied with instructions to resubmit with an operative report. To expedite the review and processing of claims, please submit all of the surgical procedures and services performed on the same day on one (1) claim form.

59200: INSERTION OF LAMINARIA
Insertion of laminaria (59200) is no longer separately reimbursable.

HOME AND CARE HOME VISITS

Claims for home and care home visits must be submitted with a report or progress note. Documentation should indicate that the recipient is homebound; i.e. confined to his or her place of residence because of a medical condition.

CPT codes 99321 - 99323 or 99331 - 99333 (visits to a care home) should be submitted using place of service code 33. These visits must be to evaluate and/or treat a medical condition(s). Routine visits to a care home are not covered. When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual code number. Documentation supporting the use of modifier 22 should be submitted with the claim.

ANESTHESIOLOGY: CLARIFICATION ON REGIONAL BLOCKS AND EPIDURAL CATHETERIZATION

Regional nerve blocks and epidural catheterization for the provision of post-operative pain control performed in the immediate period before or after the administration of general anesthesia is not separately reimbursed. The administration of medication through the epidural catheter in the immediate postoperative period is also not separately reimbursed. Payment of these services is included in the reimbursement for the anesthesia. Also, regional blocks and epidural catheterization related to the surgical procedure(s) for which general anesthesia is being administered are not separately reimbursed. Epidural anesthesia for deliveries is reimbursable.

A4647: GADOLINIUM (MAGNEVIST)

Payment for A4647 is included in the payment for the Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) procedures. A4647 (contrast material) (contrast material) is not separately reimbursed.

NEWBORN CARE: 99436 AND 99440

Reports are no longer required for 99436 (attendance at delivery, when requested by a delivering physician) and 99440 (initial stabilization of a newborn and newborn resuscitation.

Clarification of December 2003 Provider Bulletin

Use 90925 when billing for 29 days or less. Units should be 29 or less. Use the monthly codes 90918 -90921 when billing for anything greater than 29 days. Bill only one (1) unit.

Published for the Medicaid Providers of Hawaii.

Provider Bulletin

Good to Know

CORRECTING OR CHANGING PRIOR AUTHORIZATIONS

To change approved PAs, providers must submit a new signed 1144 with a request that specifies the information to be changed.

For example, a provider submits a new signed 1144 with a request to change code from E0277 to E0372. Code E0277 would be revoked and code EO372 would be approved.

URGENT PA PROCESS

Please note: Fax # (808) 952-5595 is **not** a PA fax line. PAs should be mailed to ACS, P.O. Box 2561, Honolulu, HI 96804-2561.

Only urgent PAs may be faxed. Urgent PAs must be marked "URGENT" and faxed to (808) 952-5562. The turn around time for urgent PAs is 48 hours. After the 48-hour period, you may call the ACS Provider Inquiry Unit to check the status of the PA.

CLAIMS DENYING FOR NO PA FOUND

Please do not resubmit claims that deny for "No PA found." In order for the claim to process correctly, there must be a PA in the system. Please contact the ACS Provider Inquiry Unit to check on the status of the PA. If the PA is approved and no other denials affect the claim, a Provider Inquiry Associate can submit the original claim for reprocessing.

BUNDLING CODES FOR CRITICAL ACCESS HOSPITALS

Effective January 1, 2004, MQD will follow Medicare rules as it pertains to bundling for critical access hospitals.

ADJUSTING UNITS AND BILLED CHARGES

When adjusting units to a previously submitted claim, remember to also adjust the billed charges accordingly.

SURGICAL TRAYS

Supplies provided in a physician's office in conjunction with a surgical procedure (codes10000 to 69999) should be coded as a surgical tray. Use the following codes for surgical trays:

Code	Description	Detail
A4550	Small surgical tray (suture removal)	Does not require a surgical procedure on the same day
A4550 -52	Surgical tray directly related to surgical procedure(s) on the same day	Use when cost is under $200
A4550 -22	Surgical tray directly related to surgical procedures on the same day	Use when cost is over $200

Surgical trays are NOT reimbursed in outpatient hospital or nursing facility settings.

Volume 3, Issue 1

Feb. 2004

OPHTHALMOLOGY: VITRECTOMY

When two ophthalmology procedures that include vitrectomy are performed in the same operative session, vitrectomy will be reimbursed only once. This affects the following CPT codes:

Code	Description	Allowance
67108	Repair of retinal detachment with vitrectomy, any method with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	$ 1,520.16
67036	Vitrectomy, mechanical, pars plana approach	$ 821.70
67038	Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping	$ 1,209.64
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation	$ 874.98
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation	$ 1,214.68

If 67108 and 67038 are billed on the same date of service, the claim will be reimbursed as follows:

- 67108 is paid in full ($1,520.16) as the first of multiple procedures performed since the allowance for this procedure is greater than the allowance for 67038.

- 67038 - Since vitrectomy is included in 67108, the vitrectomy portion of 67038 is subtracted and only the epiretinal membrane stripping is reimbursed; i.e.,

$1,209.64	67038 - Vitrectomy with epiretinal membrane stripping (EMS)
- 821.70	67036 - Vitrectomy only
$ 387.94	Reimbursement for EMS only
x .50	EMS is the second of multiple procedures (mod 51), it is reimbursed at 50%.
$ 193.97	Final reimbursement for 67038

If 67108 is billed with 67039 or 67040, only 67108 will be reimbursed since 67039 and 67040 are included in 67108.

If 67038, 67039 and/or 67040 are billed on the same date of service, vitrectomy is reimbursed only once. For example, if 67038 and 67040 are billed together, the claim will be paid as follows:

- 67040 is paid in full ($1,214.68).

- 67038 - Since vitrectomy is included in 67040, the vitrectomy portion of 67038 is subtracted and only the epiretinal membrane stripping is reimbursed; see example above.

ACS Fiscal Agent	ACS PBM
Bill non-drug supplies and DME	Bill NDC codes (drugs)
Call 1-800-235-4378 or 952-5570 for questions regarding billing non-drug supplies and DME	Call 1-877-439-0803 for questions regarding billing drugs
ACS Provider Inquiry Unit is open on weekdays from 7:30 am - 5 pm	ACS PBM is open 24 hours a day, 7 days a week
For updated information regarding non-drug supplies and DME covered by Medicaid, visit: www.med-quest.us	For updated information regarding drugs covered by Medicaid, visit: www.himed-questffs.org
Use PA Form 1144A (last updated 8/03) when requesting a PA for non-drug supplies & DME	Use PA Form 1144B when requesting a PA for drugs
Send non-urgent PA 1144A Forms to PA P.O. Box 2561 Honolulu, HI 96804-2561 Only urgent 1144A Forms should be faxed to (808) 952-5562	Fax all PA 1144B Forms to 1-888-335-8474
Submit *claims for non-drug supplies & DME on the CMS-1500 to: ACS Fiscal Agent Claims P.O. Box 1220 Honolulu. HI 96807	Submit *claims for drugs on the 204 Form, CMS-1500, or Universal Claim Form to: ACS PBM 365 Northridge Rd., Center One, Ste. 100 Atlanta, GA 30350

* The only supplies paid by ACS PBM are those provided by Home Infusion Providers either as part of the global infusion codes or as TPN and enteral "B" codes associated IV pumps and IV stands. Suppliers of enteral products should continue to submit their claims to ACS FA if they are not a home infusion provider known to ACS PBM.

Provider Bulletin
Published for the Medicaid Providers of Hawaii.

Volume 3, Issue 1 6 Feb. 2004

E1399 AND K0108 MODIFIERS

Modifiers will be added to all approved prior authorizations for code E1399 and K0108. Modifiers U1, U2, U3, etc. will be added to all E1399 or K0108 prior authorization requests. This allows each code to be entered as a separate activity. Providers should bill code E1399 or K0108 with the modifier it has been assigned.

If a provider specifically designates code E1399 or K0108 with a NU or RR modifier, the first E1399 or K0108 will be authorized with the NU or RR modifier. All subsequent E1399 or K0108 requested will have modifiers U1, U2, U3, etc.

Please use the modifiers as noted on your approved prior authorization. Billing without the modifier(s) listed on your PA will cause your claim to deny.

CONJOINT PSYCHOTHERAPY

Providers should bill for only one person (even though there are others involved in this conjoint therapy). The number of units should be billed as one (1).

SUBMITTING ELECTRONIC ADJUSTMENTS ON THE 837I

Use bill type "xx7" when submitting an adjustment on the 837i. The use of claim frequency code "7" voids the original claim and replaces it with the adjustment claim.

REQUESTS FOR RECONSIDERATION

MQD and ACS have developed a process where providers can request review of a denied claim. This is not an appeal process but a request for reconsideration. Claims for services provided are processed in accordance with Medicaid policies and regulations and payment is made based on the Medicaid fee schedule.

If a provider feels a claim has been incorrectly denied, the provider can submit a request for reconsideration indicating the reasons for the request. Providers may also use this process to request reconsideration of the allowed reimbursement amount for specific services.

Providers should use the Request for Reconsideration - Form 240 (see p. 8) to initiate this process. Form 240 includes the information necessary to review a request. Upon receipt, ACS will conduct the preliminary research to ascertain that the claim was processed and paid correctly in accordance with Medicaid policy. Claims processed incorrectly will be submitted for reprocessing. If ACS determines that the claim was processed correctly, ACS will forward the request for reconsideration to Med-QUEST (MQD) for review. MQD will make the final determination.

NEW MEDICAID CORRESPONDENCE INQUIRY FORM

Please use the new full page Form 239 - Medicaid Correspondence Inquiry Form. Make copies of the form on page 9 for use on all future inquiries. Do **not** use this form for claim adjustments. All adjustment and void claims should be sent directly to ACS Claims PO Box 1220, Honolulu, HI 96807-1220. Effective March 1, 2004, all written claim inquiries not submitted on the 239 Form will be returned to the provider.

Published for the Medicaid Providers of Hawaii.

Provider Bulletin

Volume 3, Issue 1

Feb. 2004

Good to Know

PROVIDER AGREEMENTS TO BE UPDATED WITH HIPAA DISCLOSURES

The Med-QUEST Division must ensure that all participating Medicaid providers have the required HIPAA disclosures in their provider agreements. Therefore, MQD will be sending updated agreements that include the required HIPAA information to all providers that have not updated their contracts. Upon receipt of the updated provider agreement, please complete and send to the Med-QUEST Division at P.O. Box 700190, Kapolei, HI 96709-0190. All updated provider agreements must be returned to MQD no later than March 31, 2004.

MISCELLANEOUS CPT CODES

Do not use miscellaneous codes if a suitable CPT code is available. If the service provided was beyond the scope of a specific CPT code(s), submit the code with a modifier 22 and a report. If a specific CPT code is not available, a miscellaneous code may be used. All miscellaneous CPT codes require reports. The report can be progress notes, operative report, radiology report, etc.

MEDICAID POLICY: LATE FEES

According to Medicaid regulations, Medicaid will not reimburse late charges.

COVERAGE OF DIABETES SELF MANAGEMENT TRAINING

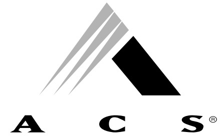
Effective March 22, 2004, Medicaid will implement Medicare's policy regarding the coverage of Diabetes Self Management Training (DSMT). Thus, payment will be extended only to education programs recognized by the American Diabetes Association (ADA).

The following additional requirements must be met:

- DSMT must be ordered by the patient's health care provider.
- DSMT should be conducted via group training sessions.
- Individual DSMT will be allowed only if the patient's condition does not allow for effective learning in a group training session. Acceptable patient conditions include deficits in hearing and vision, homebound status, mental retardation, or learning disabilities.
- DSMT must be necessary to ensure a patient's compliance with diabetes therapy and/or provide the patient will the skills and knowledge to manage diabetes.
- DSMT includes medical nutrition therapy. Medical nutrition therapy will not be reimbursed separately.

Specific Hawaii Medicaid Requirements:

- Prior authorization on the 1144 Medical Authorization Form must be obtained for individual DSMT.
- A maximum of twenty (20) 30-minute sessions (10 hours) will be reimbursed in the first twelve (12) months. Thereafter, a maximum of four (4) 30-minute sessions (2 hours) will be reimbursed. These maximums apply to both individual and group training sessions.
- Reimbursement will be at the Medicaid 2003 rate.
- The provider of the service must be an ADA recognized program. (Qualified providers may obtain an 1139 Provider Application Form from the MQD website, www.med-quest.us. The form and instructions can be found in the Medicaid Provider Manual, Appendix B or call the Med-QUEST Division at 692-8099.)



ACS State Healthcare
1440 Kapiolani Blvd., Ste. 1400
Honolulu, HI 96814

Request for Reconsideration

FORM 240

Directions: Providers may use this form to request reconsideration of the allowed reimbursement amounts for specific services. Please limit your reconsideration requests to one claim per Form 240. All fields on Form 240 are required and must be completed. Upon completion, please send Form 240 and any attachments to ACS, 1440 Kapiolani Blvd., Suite 1400, Honolulu, HI 96814. Upon receipt, ACS will conduct the preliminary research to verify that the claim was processed and paid in accordance with Medicaid policy. Claims processed incorrectly will be submitted for reprocessing. If ACS determines that the claim was processed correctly, ACS will forward the request for reconsideration to Med-QUEST (MQD) for review. MQD will make the final determination.

Date of Request:	Provider Name:	Contact Name:
Provider ID #:	Provider Phone #:	Provider Fax #:
Provider Address (Street Address, City, State and Zip Code):		Provider E-mail Address:
Claim Reference Number:	HAWI ID #:	Date(s) of Service:
List of Attached Documents:		
Reconsideration Justification :		

Date ACS Completed Research:___________

Completed By: ___________________________

Forwarded to ☐ MQD

☐ ACS CLAIMS RESOLUTION

ACS State Healthcare
1440 Kapiolani Blvd., Ste. 1400
Honolulu, HI 96814

A C S®

FORM 239

Medicaid Correspondence Inquiry Form

1. Date of Inquiry	2. Provider Name (Last, First, Middle Initial)		
3. Provider Number	4. Address ❑ Pay to Address ❑ Service Address		
5. Telephone Number	6. Name of Contact		
7. Claim Number (if applicable)	8. Purpose of Inquiry: ❑ Questionable Payment ❑ Claims Status ❑ Claims Filing Procedure ❑ Other: *** Do <u>not</u> use this form for claim adjustments. Send resubmissions to the appropriate ACS Claims PO Box.**		
9. Patient Name	10. Patient ID Number		
13. Dates of Service	14. Payment Date	15. Charge	16. Allowance
17. Remarks			

18. Response to Provider: (**For Office Use Only**) Completed by ______ Date ______

❑ Claim Paid on ______ Amount ______

❑ Denied on ______ Reason: ______

❑ Claim sent to Claims Dept. for reprocessing. ______

❑ Patient name and ID # not in DHS files. ______

❑ Claim is in the processing system. Please allow additional processing time. ______

❑ Claim is being researched. (We are currently working to resolve this issue.) ______

❑ Unable to match above claim data with computer file data. ______

❑ Please submit claim with
- ❑ Medicare/TPL EOMB
- ❑ Approved waiver of filing deadline
- ❑ Other

❑ Claim date exceeds one year filing deadline

❑ Submit copy of FFS claim to:
ACS Claims P.O. Box 1220, Honolulu, HI 96807-1220

❑ Submit copy of Waiver Services claim to:
ACS Claims P.O. Box 4631, Honolulu, HI 96812-4631

❑ Submit filing waiver request letter to:
MQD/FO/TPL, 1001 Kamokila Blvd., Ste. 317,
Kapolei, HI 96707

Comments: ______

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

State Healthcare
1440 Kapiolani Boulevard, Suite 1400 • Honolulu, HI 96814