Med-QUEST Division

Medicaid Provider Bulletin

Published for the Medicaid Providers of Hawaii.

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In This Issue

AVRS Response Time Improved

The Automated Voice Response System (AVRS) is the primary source of eligibility & enrollment information for Hawaii Medicaid Providers. **Effective July 1, 2003**, Provider Hotline assistance will be limited to providers whose eligibility questions can not be answered by accessing AVRS, MEVS, or DHS Medicaid Online. AVRS was introduced in November 2002. Much has been done to improve the overall effectiveness of AVRS. Effective April 17th, 2003, several changes were put into place.

Changes were made with two objectives in mind:

(1) To make frequently requested information more readily accessible

(2) To decrease the amount of time providers spend on the phone

The eligibility line is accessible 24 hours a day, 7 days a week. AVRS pulls eligibility information directly from HPMMIS, the Hawaii Medicaid claims processing system.

It is the provider's responsibility to verify eligibility prior to rendering services to Medicaid recipients. If you would like to try out AVRS, call 1-800-882-4608. To access the system, you will need your 8 digit provider ID number. The quickest way to search for eligibility information is to use the recipient's 10 digit HAWI ID # or Social Security Number.

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

Mail Returned Checks to:
ACS
P.O. Box 1206
Honolulu, HI 96807-1206

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

Fax Urgent Prior Auth Requests to: (808) 952-5562
(Not Applicable To Medicaid Waiver Program)

Mail MQD Claims to:
ACS
P.O. Box 1220
Honolulu, HI 96807-1220

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

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Updates

FQHC Update

1. **FQHCs must bill with its FQHC servicing provider ID** (not individual ID #) for all services in order to receive the Prospective Payment System (PPS) payment. The Med-QUEST Division will not reconcile payments that were previously billed with a provider's individual provider number.

2. **Payments for medical and dental services can be separated on the remittance advice**. To obtain separate reports, please notify HCMB. MQD will assign a different service locator number that will group the information on the remittance advice.

3. FQHCs should bill for **vision services using rev. code 520 & HCPCS code 92340**. Vision services are part of the medical rate (there is no separate vision service rate established.) These services will be paid at the medical PPS rate.

Waiver Service Update

Effective April 7th, 2003, all waiver service claims with cost share amounts must be submitted directly to ACS at:
P.O. Box 4631
Honolulu, HI, 96812-4631

Do not submit cost share claims to the Social Services Division Fiscal & Information Office.

DHS Medicaid Online

If you are a group provider and are trying to check the status of an individual provider in your group, check the PIN drop down box on the claim search page. If the provider's PIN is not present, you must fill out an 1139 form and send it to HCMB to associate that provider with your group.

IMPORTANT HIPAA NEWS

Get Ready for HIPAA Transactions and Code Sets! Do you submit electronic claims to Med-QUEST, or do you receive electronic remittance advices? Do you intend to do so in the near future? If so, Med-QUEST and ACS urge you to prepare for implementation of HIPAA Transactions and Code Sets (TCS) requirements. If you bill electronically, you must comply with electronic submission requirements by Oct. 16, 2003.

Providers who bill electronically typically use a billing service, or they contract with a software vendor or clearinghouse. The testing required for transactions and code sets compliance is conducted between the developer of the software or the clearinghouse and Med-QUEST. For this reason, it is vital that Med-QUEST and ACS maintain contact with all software developers and clearinghouses that provide services to Hawaii Medicaid providers.

If you plan to bill electronically, please contact your software vendor or clearinghouse as soon as possible. If you use a billing agency, contact them to find out who develops your software or serves as your clearinghouse. Be sure the vendor has access to the Med-QUEST web site, www.med-QUEST.us, and complies with the instructions and information provided on the HIPAA webpage. Please ask them to visit the Web site frequently.

Last Chance to Begin Submitting ECS in the NSF Format

The following items must be submitted to ACS by May 31st, 2003:

1. Completed certification forms
2. ECS test file

Beginning 10/1/03, all ECS submissions will switch to a HIPAA 837 format. If you have any questions please call ACS at 955-4900.

HIPAA Addendum

There will be a generic HIPAA addendum included in the Medicaid provider contract. The addendum will state that if a health care provider is a covered entity, the provider must comply with all HIPAA regulatory requirements.

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DHS Medicaid Online: Getting Started

1. Go to https://hiweb.statemedicaid.us
2. Click on "Create a New Account."
3. Read User Agreement & click "I Agree" to proceed.
4. Enter your 8-digit provider ID # & the tax ID # you provided in your provider enrollment application.
5. Enter a user name of your choice. It must be at least 6 characters in length.
6. Enter a password of your choice. It must be at least 6 characters in length. *Note:* Your password is case sensitive.
7. Enter hint question & answer of your choice. This will allow you access to DHS Medicaid Online if you forget your password.
8. Select individual or master account. You will be allowed one master account per provider ID #. A master account must be established before any individual accounts can be activated.
9. Enter your demographic information and click on continue.
10. If you created a Master Account, then wait for a letter in the mail that will give you an Authentication Code. If you created an individual account, the master account holder for your Provider ID # will receive an e-mail and will be able to activate your account.

Claims Past the Filing Deadline

All claims submitted to Hawaii Medicaid must be submitted within one year of the date of service. *Exception: When Medicare is primary, you have six months from the date listed on the Medicare EOB.* Claims with any other Third Party Liability (TPL) coverage must be submitted within one year of the date of service.

If you are not able to submit your claim (including resubmissions) within the proper filing period, you must obtain a waiver to prevent a denial for past filing deadline. You must request a waiver in writing. If you have several claims for which you require a waiver, you may list these claims on a single request letter. Waiver request letters should be sent to:

DHS/MQD/FO
P.O. Box 700190
Kapolei, HI 96709-0190

If your waiver is approved, you must attach a copy of the waiver each claim and submit to ACS within the allotted time noted on your waiver approval.

Changes to Medicaid Fee Schedule

Effective for dates of service from April 1, 2003, Medicaid claims will be processed with revised reimbursement amounts for certain CPT & HCPCS codes. Changes include the following:

a. Per Medicaid rules, the Medicaid allowed amount cannot exceed the Medicare allowed amount. There were 165 procedure codes where the current Medicaid rate exceeded the Medicare 2003 fee schedule amount. For these codes, the Medicaid allowed amount has been decreased to the Medicare 2003 fee schedule amount.

b. Allowed amounts for DME procedures were increased by 4% to include payment of general excise tax. DME rates that were already paid at the Medicare allowed amount were not increased by 4%. Note, allowed amounts for professional services were already established to include the 4% general excise tax.

c. As explained on page 7 of the February 2003 Provider Bulletin, modifier 32 will be used to identify asterisked procedures when performed in a non-facility setting. Payment for asterisked procedures have been adjusted to reflect the rate when the procedure is performed in a facility setting and the procedure is billed without the modifier 32.

The fee schedule will be posted on the MQD web-site at www.med-quest.us. Please note, this fee schedule is constantly being reviewed by MQD and may be modified as necessary.

Billing NDC Codes With Dates of Service Prior to 8/1/01

Do not send claims with NDC codes for dates of service prior to 8/1/01 to ACS PBM. These claims should be sent with a waiver of the filing deadline to: ACS Fiscal Agent, P.O. Box 1220, Honolulu, HI 96807-1220.

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