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#### **4.1 Claim Forms**

The following claim forms are approved for filing claims for goods or services provided to Medicaid recipients:

- CMS (formerly HCFA) Form 1500
- American Dental Association (ADA) Claim Form (Version 1999 v. 2000)
- Prescription Drug Claim Form 204
- Transportation Provider Claim Form 208 for air transportation
- CMS (formerly HCFA) 1450 (UB-92) for institutional services

Modified or proprietary forms will not be accepted.

##### *4.1.1 Form Availability*

Nationally developed forms such as the CMS (formerly HCFA) 1450 (UB-92), CMS (formerly HCFA) 1500 and ADA claim forms can be ordered from the U. S. Government Printing Office. In addition, forms can be obtained from vendors in Hawaii. Refer to Appendix 1 for the contact information and phone numbers.

##### *4.1.2 Procedure and Diagnosis Code Sources*

The procedure coding system recognized by the Medicaid Program is the Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) as adopted by DHS. HCPCS consists of current year CPT-4 codes, HCFA codes, and state-assigned codes.

Diagnosis numerical coding is required based on the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

For acute inpatient claims, the surgical procedure codes listed in the ICD-9-CM Annotated Volume III are used in Form Locator 80-81E of the HCFA 1450 (UB-92) claim form to determine appropriate surgical versus medical classifications.

#### **4.2 Third Party Liabilities**

Federal regulations specify that all other readily available sources of medical insurance are primary to Medicaid. A third party liability (TPL) refers to another health coverage or responsible payor whose resources are available to the patient in addition to Medicaid.

**Therefore, providers must bill the other insurance including Medicare and await payment or rejection notification before filing a claim for Medicaid payment.**

#### *4.2.1 Determining Third Party Resources*

A provider or his staff should verify whether any other medical coverage is available to a patient by using one of the eligibility verification modes offered by DHS, such as the Automated Voice Response System (AVRS), and by asking the patient. Refer to the AVRS Program guide for more information on verifying a recipient's eligibility information.

Information regarding third party coverage is required on all claims. Accident claims must also provide the accident date and type of accident (work, auto-related, etc.). Claims are denied if this required information is not provided.

Services may be filed directly with the Medicaid Fiscal Agent if the liability of a third party is in question or cannot be determined within 30 days from the date of medical care.

#### *4.2.2 Common Third Party Resources*

##### a) Medical and Dental Health Insurance

Services must be billed to third parties for payment or rejection before being submitted to the Medicaid Program. The third party payment must be indicated on claims submitted to the Fiscal Agent as this amount is deducted from the Medicaid allowance in determining Medicaid payment.

- For the CMS (formerly HCFA) 1500 form, enter the TPL information in the appropriate fields (FL 9, 9a, 9d, 11c-d). Enter the TPL payment amount in the "Reserved for Local Use" field (24K). An amount must be listed for each line.
- For the UB-92 form, enter the TPL information in the appropriate fields (FL 50-55). Enter the TPL payment amount in the "Prior Payments" field (FL 54) on the applicable row identifying the TPL.
- For the ADA form, indicate TPL information in the appropriate fields (FL 31-37). Enter the TPL payment amount in the "Examination and treatment plans Deductible" field (FL 59).

Claims for patients with third party coverage that do not indicate a third party payment or denial will be rejected to bill the third party.

If a third party payer denies a service that is normally covered, a rejection notice must be attached to the Medicaid claim showing the reason for the denial, e.g., pre-existing illness, TPL cancelled, patient ineligible, etc.

Services that are known to be excluded under a patient's third party insurance, such as routine physical examinations for patients with Medicare or dental services for a patient with

only a basic medical insurance policy do not require denial notices. For these claims, a statement in the “Remarks” field on the claim regarding the non-covered status of the services rendered is sufficient.

b) Health Maintenance Organization (HMO)

Medicaid does not pay for a service if the patient is covered by an HMO or had prepaid benefits but chose not to go to the designated facility for the services. Medicaid pays only if the service is excluded from coverage under the HMO. Medicaid does not pay for the services if the patient chose not to utilize the available HMO benefits and instead sought services elsewhere. Examples of HMO plans are HMSA-Health Plan Hawaii (HPH) Plan, Kaiser Health Plan and Veterans Administration (VA) (service connected disability).

c) No-Fault

If a Medicaid recipient has purchased private, no-fault auto insurance (TPL code 52), and was involved in an auto accident, was a passenger in a car insured with standard coverage, or was a pedestrian or bicyclist struck by a car with standard no-fault coverage, claims should be filed directly with the private no-fault insurance company.

If a Medicaid recipient is involved in an auto accident as either a driver or passenger of a vehicle insured through the Hawaii Joint Underwriters Plan (HJUP), claims can be filed directly with Medicaid, as the Joint Underwriters Plan does not cover medical services. These claims must indicate the injuries were auto-related and include the date of the accident in the accident date field of the claim and a brief description of the accident.

d) TRICARE

TRICARE, formally known as CHAMPUS, is a medical benefits program to help pay for civilian medical care provided to active duty members and their families; retirees and their families; and survivors of all uniformed services who are not eligible for Medicare. Benefits are also available to the spouse or children of a veteran with a total, permanent service-connected disability, or the surviving spouse or children of a veteran who dies as a result of a service-connected disability. Since TRICARE is primary to Medicaid, claims must be filed with TRICARE first.

In addition to standard TRICARE coverage, two other alternative TRICARE plans are available: TRICARE Prime and TRICARE Extra. Members with TRICARE Prime must receive services from TRICARE Primary Care Providers. The person should be referred to the TRICARE Primary Care Provider for services. If a Medicaid recipient with TRICARE Prime coverage fails to utilize the services of a TRICARE Primary Care Provider, neither TRICARE nor the Medicaid Program will cover the services, including pharmacy services.

TRICARE Extra coverage applies when a standard TRICARE member goes to a TRICARE Primary Care Provider, resulting in a lower co-payment. Although it is preferred that a recipient with standard TRICARE coverage go to a Primary Care Provider, it is not mandatory and claims will not be denied by Medicaid for not utilizing the services of a Primary Care Provider.

TRICARE members also have dental, drug and vision coverage.

e) Medicare

Recipients who are age 65 or older, blind, or disabled or being treated for end-stage renal disease (ESRD) may have Medicare coverage. Recipients age 65 or older qualifying for both Medicare and Medicaid coverages are automatically enrolled in Medicare Part B by their caseworkers. Part B premiums are paid by DHS on the recipient's behalf.

Unless the service is not a Medicare benefit, all claims must first be filed with Medicare. If the service is not covered under Medicare, the provider may bill Medicaid using the applicable Medicaid claim form. To expedite processing, the provider must indicate the non-coverage status under Medicare and follow the claim procedures outlined in 4.2.2a regarding non-coverage indication of services.

#### *4.2.3 Medical Reimbursement*

A Medicaid recipient may sometimes receive a check from his/her health insurance plan for services covered under that health plan. For example, if a recipient has an indemnified dental or vision plan, that plan's payment might be directed to the recipient. Or, in the case of HMSA, if you are not a participating provider with HMSA, payments are directed to the recipient.

When providers bill the Medicaid Program, they may only bill Medicaid the reimbursable amount that remains after applying the other health plan's payment. This is true regardless of whether that payment is made directly to the provider or not.

### **4.3 Claims Submission**

Providers may submit hard copy or electronic claims to Medicaid for reimbursement.

#### *4.3.1 Hard Copy Claims*

A maximum of 25 lines may be included on a CMS (formerly HCFA) 1500 form or ADA 1999 v. 2000 form. Claims that exceed 25 lines must be split billed. In addition, all services rendered on the same day should be billed on the same form. Hard copy claims must be mailed to the Medicaid Fiscal Agent. Refer to Appendix 1 for the mailing address.

#### *4.3.2 Electronic Claims*

Submission of electronic claims will require National Standard Format (NSF) version 4.0 for the UB-92 form and NSF version 2.0 for the CMS (formerly HCFA) 1500 form. Electronic claims must be submitted via virtual private network (VPN). All providers that elect to submit electronic claims are required to participate in a testing and certification process and will receive a separate Electronic Media Claim (EMC) Manual. Refer to the EMC Manual for additional information regarding the electronic submission of claims.

#### *4.3.3 Medicaid Recipient Identification Numbers*

Medicaid recipients will no longer be assigned a check digit at the end of the client number. Only the ten character recipient HAWI ID number (including leading zeros) will be required to submit a claim.

#### *4.3.4 Provider Medicaid Numbers*

Providers are assigned a single six-digit Medicaid provider number with a two-digit service location code by DHS. In addition to the Medicaid provider number, the service location number must be submitted on the claim form as part of the provider number. Only Medicaid providers may be referring providers and when a referring provider is required to be indicated on a claim, the provider must indicate the referring provider's Medicaid number on the claim.

#### *4.3.5 Filing Deadline*

All claims for Medicaid services must be submitted to Medicaid for payment within 12 months of the date of service. This includes all claims submitted to the Fiscal Agent whether initial claims, resubmitted outstanding claims, or additional payment requests. The one year filing deadline excludes Medicare crossover claims and voided claims and adjustments that result in a recoupment by Medicaid.

For cases involving retroactive eligibility for a recipient, the 12-month filing period will begin 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, 2001 and applies for Medicaid benefits. The patient's application is approved on June 1, 2001. The facility has until June 1, 2002 to submit the Medicaid claim.

#### *4.3.6 Waiver of Filing Deadline*

Claims submitted to the Fiscal Agent beyond the 12-month filing deadline must show evidence that claims were previously submitted within the 12-month filing deadline. Claims without such documentation but with extenuating circumstances that may be considered for waiver of the filing deadline are:

- a) Claims with delays resulting from third party payments. Documentation of timely filing attempts with the third party must be indicated on the request.

- b) Claims with delays resulting for acts of nature, e.g. hurricane, floods, etc.

Address waiver requests to the MQD Finance Office. Refer to Appendix 1 for the address.

Providers will be notified by Med-QUEST of the waiver decision, and if approved, claims may be submitted to the Fiscal Agent for payment. The approval letter must be attached to the claim when submitted.

#### *4.3.7 Prior Authorizations*

Claims for services requiring prior authorizations do not require the prior authorization number to be recorded on the claim, however a prior authorization must still be obtained and will be verified by the claims processing system. Providers rendering services for a recipient in a Home and Community Based Waiver must submit a prior authorization number on the claim. Refer to the Home and Community Based Waiver Provider Manual for more information on the filing guidelines for Home and Community Based Waiver recipients.

#### *4.3.8 Additional Payment Requests*

All adjustment claims that request additional payment, must be received by Medicaid within one year of the original claim payment date. Requests for payment reconsideration based on medical necessity or level of care reviews should be sent to the MQD Medical Standards Branch. Routine requests for additional payment due to incorrect claim information such as dates, procedure codes, ID numbers, etc., may be sent to the Fiscal Agent. Addresses can be located in Appendix 1.

#### *4.3.9 Special Claim Filing Procedures*

- a) Patients With Medicare Coverage

Claims for Medicaid recipients, who also have Medicare coverage, must be received by Medicaid within six months of the Medicare remittance advice date or within one year of the date of service, whichever is greater.

To ensure the accuracy of crossed-over claim information, providers submitting on an UB-92 or CMS (formerly HCFA) 1500 claim form, must indicate Medicaid payer information.

- b) Spend-down Recipients with Medicare Coverage

“Spenddown” recipients are not eligible for Medicaid coverage until their cost share has been paid. These patients may have a Medical Assistance Coupon (Coupon). The following procedures must be used when submitting a claim for spend down recipients with Medicare/Medicaid coverages:

- 1) Medicare must be billed first using the applicable claim form.
- 2) The patient's cost share must be applied to the co-insurance, deductible, or any Medicaid-only covered service remaining on the claim after Medicare payment.
- 3) A copy of the claim may be submitted to the Fiscal Agent if any portion of the co-insurance, deductible or Medicaid-only covered service remains after application of the Medicare payment and the patient's cost share. A copy of the Medicare payment summary (EOMB) must be attached to the claim and the patient's cost share deducted from the balance.
- 4) If there is no balance following Medicare payment and deduction of the cost share, do not file a claim with Medicaid.

c) Newborns

Claims for newborns must be submitted with the newborn's Medicaid identification number. Claims submitted with the mother's Medicaid identification number will be denied.

d) Inmates of Public Institutions

Although not eligible for Medicaid, the Medicaid program processes the claims for services provided to inmates of Public Institutions. Services may be billed to the Medicaid Program using existing approved Medicaid claim forms. Firmly attach coupons to the back of claims to document eligibility. Claims must be completed with the appropriate procedure and diagnosis codes and submitted according to standard Medicaid procedures.

e) Patients Covered by Another State's Medicaid Program

Claim filing procedures vary from state to state as individual States administer their own Medicaid Program following federal guidelines.

When treating a patient covered under another state's Medicaid Program, providers must verify the patient's coverage with a Medicaid card or document, which identifies the patient as Medicaid eligible. If unable to provide evidence of eligibility, the patient may be billed as a private patient.

If a patient provides evidence of coverage under Medicaid, a claim can be filed with the State Agency or fiscal agent for the Medicaid Program of the State where the patient resides. If the fiscal agent is not known, the patient may be billed with instructions to present the bill to the State's Medicaid fiscal agent upon returning home.

f) QMB Plus Recipients

Medicare is the primary insurer and therefore the claim should be submitted to Medicare first. Medicare assignment must continue to be accepted for the claim to automatically crossover to Medicaid.

The provider should make sure that Medicaid information is included on the claim form so that the claim will automatically "crossover" to the Medicaid fiscal agent for processing. Eligibility information sent to Medicare is also a determinant for claims to crossover.

Appropriate claims, which automatically "crossover" to Medicaid for processing will result in payment of the coinsurance and deductible for services, covered under Medicare. Any services not covered by Medicare, but covered under Medicaid will be paid. A separate claim may need to be submitted to Medicaid for these non-covered Medicare services. Medicaid will only coordinate payment up to the Medicaid fee schedule.

g) QMB-Only Recipients

A claim for services provided to an QMB-Only recipient should be submitted to Medicare as the primary insurer. For an QMB-Only recipient, Medicare assignment is optional. If assignment is accepted, claims submitted to Medicare fiscal intermediaries and carriers with crossover agreements with our fiscal agent will automatically "crossover" to Medicaid for payment of the coinsurance and any deductible. Since QMB-Only recipients are not eligible for Medicaid, payment for services covered by the Medicaid program, and not covered by Medicare, will not be made.

h) Coupons

Whenever a recipient presents the coupon, the provider should review the validity of the coupon (refer to 3.5.2 Medical Assistance Coupon for verification of a Medicaid coupon) and code the **exact** necessary information from the coupon onto the claim. The coupon must be securely attached to the back of the claim when submitted to the Fiscal Agent to document the Medicaid eligibility for the patient.

Providers should make sure that coupons do not cover the Medicaid Statement as the statement is an integral part of the claim and must be clearly visible.

Coupons may not be photocopied. If additional coupons are required for multiple claims the patient should be directed to the eligibility worker for additional coupons if necessary.

## i) Transplant Recipients

Claims for recipients that are approved for a tissue or organ transplant other than corneal or kidney transplants should be submitted to State of Hawaii Organ and Tissue Transplant (SHOTT) Program. Refer to Chapter 8 Transplant Services for more information.

**4.4 Claim Processing**

When a claim has been submitted and all required elements are included, the claim will be processed through the Hawaii Prepaid Medicaid Management Information System (HPMMIS). If the recipient has no other health insurance coverage, the claim will be paid based upon the Hawaii Medicaid fee schedule. If the recipient has other insurance coverage, the payment amount will be coordinated with the coverage from the primary payer.

Claims submitted with invalid, inconsistent or missing information will be denied. Claims will not be returned for the correction of the above reasons nor will turnaround documents (TADS) be generated and sent to the provider. Such claims will be denied and must be corrected and resubmitted for payment.

*4.4.1 Medicaid Reimbursement with TPL Payments*

For claims coordinated with a third party resource except Medicare, Medicaid pays the difference, if any, between the Medicaid maximum allowance and the third party payment:

Example:

Claim Total	\$255.00	Medicaid Allowance	\$228.00
TPL Payment	<u>\$185.00</u>	TPL Payment	<u>\$185.00</u>
Balance Billed to Medicaid	\$70.00	Medicaid Payment	\$43.00

When the third party payment exceeds the Medicaid allowance, the provider is entitled to the amount paid by the third party; however, no Medicaid payment can be made:

Example:

Claim Total	\$255.00	Medicaid Allowance	\$228.00
TPL Payment	<u>\$234.00</u>	TPL Payment	<u>\$228.00*</u>
Balance Billed to Medicaid	\$21.00	Medicaid Payment	\$ 0.00

\*Although the actual TPL payment is \$234.00, the TPL payment deduction is limited to the maximum Medicaid allowance (\$228.00).

#### *4.4.2 Medicare Coordination of Benefits*

##### *4.4.2.1 Medicare Part A Coordination*

Providers are required to supply Medicaid payer information on the UB-92 claim form (FL 50-60). In addition, providers must indicate a patient's Medicare deductible (code 'A1') and coinsurance (code 'A2') in the "Value Codes" fields (FL 39). Claims submitted without applicable Medicare deductible or coinsurance amounts will be denied. Claims with this information will cross over to Medicaid once Medicare payment adjudication has been made.

Providers must separately bill for Medicare covered Skilled Nursing Facility (SNF) days and Medicare non-covered SNF days (FL 7 to 9). Providers must use the occurrence code 'A3', 'B3', 'C3', 'D3', or 'E3' (Benefits Exhausted) to identify SNF claims where Medicare covered days are exhausted. These claims will be processed according to Medicaid benefits.

##### *4.4.2.2 Medicare Part B Coordination*

DHS has negotiated with Medicare Part B for coordinated payment of claims for patients with both Medicare and Medicaid coverage. Medicare is the primary insurance payer. Following Medicare payment determination, Medicaid generally pays for the lesser of the deductible and co-insurance or Medicaid fee schedule, as well as for any routine services not covered under Medicare, but which are benefits under Medicaid. Medicaid will not pay any charges connected with services excluded from Medicaid coverage, such as treatment of tuberculosis or Hansen's Disease. For services determined to be psychiatric by Medicare, the Medicaid Program will pay the difference between the Medicaid allowance for the procedure less the Medicare payment.

##### *4.4.2.3 Coordination Criteria*

Medicaid may only pay on claims in which Medicare assignment was accepted by the provider. If assignment was not accepted because providers were unaware of a patient's Medicaid coverage, a claim may be submitted to Medicaid following Medicare payment, but the assignment must be indicated and signed in the proper field of the claim form.

Medicaid also abides by the utilization decisions made on a claim by Medicare with the exception for durable medical equipment (DME).

##### *4.4.2.4 Method of Coordination – Medical Services*

Claims must first be submitted to Medicare for payment. When claims are processed for payment, Medicare will either electronically transfer claim and payment information to Medicaid for coordinated payment processing, or report payment information on a provider's Medicare payment report summary. This summary (EOMB) must be submitted with the hard copy claim to the Medicaid Fiscal Agent for coordinated processing.

*4.4.2.5 Coordination Procedures – Electronic File Transfer*

a) Claim Submissions

Claims should be submitted to Medicare for payment determination. When Medicare has made payment, claim and payment information will be electronically transferred to Medicaid using the Medicare Provider Identification number for coordinated payment of co-insurance and/or deductibles as appropriate. Notification of this transfer is provided by Medicare.

b) Multiple Payers

Medicare payment information transfer may be done only once per patient claim. If a patient has supplemental Medicare coverage, payment information will go directly to the supplemental coverage insurer if properly identified on the Medicare claim form as a supplemental insurer. If there is a balance that may still be submitted to Medicaid, the hard copy claim must be submitted with the Medicare/Other Payers payment report attached.

c) Exception Situations

Medicare Noncovered Routine Services – Services denied by Medicare as routine services not related to an illness or injury will not be transferred. If the denied service is a benefit of the Medicaid program, a hardcopy claim must be submitted to Medicaid with an indication of the Medicare noncovered status.

d) Coupon Claims

Claim and payment information may be transferred; however, if eligibility was confirmed by Coupon, eligibility information may not yet be contained in the Medicaid computerized eligibility file and claims may be denied by Medicaid. If this occurs, a copy of the claim submitted to Medicare with the Medicare payment report attached must be submitted to Medicaid. The Coupon must be securely attached to the claim, following procedures for submitting hardcopy claims for coordinated Medicare/ Medicaid payment.

*4.4.2.6 Coordination Procedures – Hardcopy Claim Submittals*

As with electronic transfer procedures, claims should be completed as normally done when submitting claims to Medicare for payment.

Following Medicare payment and proper claim form completion for Medicaid processing, claims may be submitted to the Fiscal Agent along with a copy of the Medicare payment summary. If a copy of the Medicare payment summary showing Medicare's payment summary lists more than one claim that is to be submitted to Medicaid, a separate copy of the applicable portion of the payment summary must be attached to each claim.

The Medicare payment summary must be photocopied for provider records as it will not be returned.

#### *4.4.3 Durable Medical Equipment Filing Procedures*

Coordination procedures apply only to DME items covered by Medicare. They do not apply when the patient is in a hospital, SNF or ICF; or when provided by Medicare-participating home health agencies who should continue to bill Medicare Part A or B as applicable first.

#### *4.4.4 Pricing and Payment Processing*

As mandated by state law, non-institutional services will be paid using a fee schedule. All services that were paid on usual and customary charges will be paid on a fee schedule. This includes physician, diagnostic and therapy services. Outpatient hospital services that require a HCPCS or CPT code will also be subject to the fee schedule. The fee schedule does not apply to inpatient, dental and ASC services. General excise tax will no longer be paid as a separate line item. The fee schedule reimbursement rates will be all inclusive.

#### *4.4.5 Editing Process*

The claims system attempts to apply all edits during a single processing cycle. This enables us to report all errors to the provider and avoid claims failing new edits after the provider has corrected and resubmitted the claim. However, if certain data are missing, incorrect or invalid, completion of the entire processing cycle may not be possible.

When a claim fails an edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed in the denied claims section of the Remittance Advice with an edit number, decimal point and a single digit that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice. See Appendix 1 for information on the Remittance Advice.

Examples of edit codes:

H001.1 – Service Provider ID – Field is Missing

H001.3 – Service Provider ID – Field is Not On File

L023.1 – Diagnosis Codes #1 – Invalid for Recipient Age & Gender

L023.2 – Diagnosis Codes #1 – Invalid for Recipient Age

L023.3 – Diagnosis Codes #1 – Invalid for Recipient Gender

If one or more edits is (are) failed during the editing process, there are two possible outcomes:

The claim may stop processing and “pend” for internal review when the error detected concerns data or procedures that may be resolved by MQD or the Fiscal Agent.

When a claim requires medical review, for example, it will pend internally until someone from the Medical Standards Branch reviews the services being billed.

Internally pended claims are generally handled without input from the provider.

The exception is when medical documentation is requested for a claim under review.

The claim may be denied if the data required for adjudication is complete but the service does not meet MQD policy requirements. For example, if a provider was not registered or if a recipient was not eligible on the date of service, payment would be denied.

MQD’s intention is to process all clean claims in a timely manner.

A Claim Reference Number (CRN) is assigned to all claims on initial submission to MQD. The first five characters of the CRN represent the Julian date the claim was initially received by MQD. The remaining numbers make up the claim document number assigned by the claims processing system. The CRN does not change regardless of the number of times the claim is resubmitted or adjusted.

When submitting documentation (e.g., Medicare EOMB) subsequent to the submission of a claim, the CRN of that claim should be provided to enable MQD to link the documentation to the claim.

Providers also must provide the CRN when resubmitting, adjusting or voiding a claim. If a claim is resubmitted without the CRN, the claim will be treated as a first time submission and may not pass the appropriate filing deadline. The claim also may be denied as a duplicate of an existing claim.

#### *4.4.6 Adjustments, Voids and Resubmissions of Claims*

The claims processing system is designed to discourage erroneous payments by requiring edits through which all claims must pass prior to payment. Although much effort is made to prevent inaccuracies, they may occasionally result from incorrect procedure or eligibility data, post-payment reviews resulting in identification of a third party liability, or a retroactive denial of a service by the DHS Consultant.

#### *4.4.6.1 Overpayments*

Overpayments of \$10 or more are recovered by Medicaid. If a post-payment review of a claim by the DHS Consultant results in an overpayment determination, notification is sent to the provider explaining the reason for the overpayment, the amount involved, and the action to be taken. Overpayments are deducted from the provider's future Medicaid payment. The Remittance Advice accompanying the payment shows the deduction.

Overpayments discovered by providers must be promptly reported to Medicaid for appropriate adjustments. Reimbursements received from an accident insurance, such as no-fault motor vehicle insurance, for the a service already paid by the Medicaid Program, must be reported to Medicaid to initiate an adjustment, or refunded to the Program no later than 30 days from receipt of the insurance payment.

If a third party payment results in an overpayment for services already paid in full by Medicaid the overpayment will be adjusted by the amount of the third party payment or the Medicaid allowance for the claim, whichever is lower. This conforms with Medicaid guidelines which specify that Medicaid payment when coordinated with a third party payment is the difference between the calculated Medicaid allowance and the third party payment. Refer to Section 4.4.1 of this chapter.

#### *4.4.6.2 Underpayments/Non-payment*

A provider may submit a request for payment or additional payment if records indicate a routine claim may have been denied or underpaid due to incorrect claim information such as service date, charge, procedure code, ID number, etc.

#### *4.4.6.3 Claims Submittal*

Providers may submit adjustments to previously submitted claims or void claims to correct previously submitted claims. Providers may also resubmit a denied claim. For the CMS (formerly HCFA) 1500 form, adjustments must have an adjustment/resubmission code indicated in the "MD Resubmission Code" field (FL 22) and the original CRN listed in the "Original Reference Number" field (FL 22) on the new claim. If a UB-92 form is being adjusted, the claim must have the appropriate bill type that identifies the claim as an adjustment. The original Claim Reference Number (CRN) must be listed in the FL 37. For voids using the CMS (formerly HCFA) 1500 form, the new claim must be submitted with the original CRN listed in FL 22 on the new claim, a resubmission code, and if voiding a UB-92, the correct Bill Type is needed to identify the claim as a void.

#### *4.4.7 The Remittance Advice*

The remittance advice (RA) accompanies the weekly Medicaid payment to providers and reports all processed claims whether they are paid, denied, pended or in process; as well as all claim

adjustments. For a samples of the remittance advice and the information included, please refer to Appendix 1.

The “Non-Facility” RA is forwarded to providers that submit CMS (formerly HCFA) 1500 forms. The “Facility” RA is forwarded to providers that submit UB-92 forms.

#### *4.4.7.1 Remittance Advice Sections*

Each RA is divided into five (5) sections: Paid Claims, Adjusted Claims, Denied Claims, Voided Claims and Claims in Process (includes claims reported on a previous RA and still in process). The last page of each RA contains processing notes. This page provides an alphabetical listing of denial reason codes and pricing explanation codes. For CMS (formerly HCFA) 1500 and ADA 1999 v. 2000 claim forms, if some of the lines on a single claim are paid

and some of the lines are denied, the lines will be displayed in different sections on the RA. The paid lines will be listed in the Paid Claims section and the denied lines will be listed in the Denied Claims section.

##### a) Paid Claims

Paid claims are claims for which Medicaid has made payment, and are listed in the “Paid Claims” section of the RA. The allowed amount for each paid claim is listed first followed by any deductions to calculate the net amount paid for the claim.

##### b) Adjusted Claims

For each adjusted claim, the new allowed amount is listed first with the previous amount paid to the provider subtracted from the new allowed amount. A new net paid amount is then calculated which may result in additional payment to or a recoupment from the provider.

##### c) Denied Claims

Denied claims were not paid due to recipient eligibility, benefit limitations or claim submission reasons. Denied claims are listed in the “Denied Claims” section with the corresponding denial reason code(s). Denied claims will not be paid or returned to providers. The RA is the only notification of claim denial.

##### d) Voided Claims

The allowed amount is listed as a negative amount and any previous deductions will be added to the allowed amount. As a result, the net paid amount is the amount to be recouped from the provider.

e) Claims In Process

The RA will also list claims reported as in process and have not been adjusted.

*4.4.7.2 Electronic Remittance Advice*

The RA is available to providers in an electronic format. Providers that receive electronic RA's will not receive hard copy RA's. To begin receiving an electronic RA, contact the Fiscal Agent. See Appendix 1 for the phone numbers.

*4.4.8 Medicaid Payment Schedule*

Medicaid payment checks are drawn on funds provided by the State. Checks for claims processed during the week are generally mailed the following week. To inquire about Electronic Fund Transfer options contact the ACS Provider Inquiry Unit. See Appendix 1 for the phone numbers.

*4.4.8.1 Expired Checks*

Medicaid checks expire 90 days from date of issuance. Expired Medicaid Payment checks must be returned to the Fiscal Agent. See Appendix 1 for the applicable address.

A note should be attached explaining the reason for the return.

*4.4.8.2 Lost Checks*

Lost Medicaid payment checks must be reported to the Fiscal Agent for a stop payment request to be made and for the issuance of another check. Please allow 2 weeks for the Fiscal Agent to reissue a replacement.

**4.5 Claim Inquiries**

Inquiries regarding claim information may be directed to the Fiscal Agent on weekdays from 8:00 a.m. to 4:00 p.m. Representatives are available to provide claim information and answer claims payment inquiries. Refer to Appendix 1 for phone numbers and address.

*4.5.1 Information Limitations*

The information the Fiscal Agent may furnish to a provider is limited by Federal restrictions regarding confidentiality.

*4.5.1.1 Information Available from the Fiscal Agent*

The fiscal agent is able to provide the following:

- a) Claim Filing Procedures – Provide instruction on proper claim filing procedures and research unpaid claims.

- b) Claims Payment Information – Furnish provider payment information through the weekly remittance advice and advise a provider on how a claim was processed.
- c) Eligibility – Verify a patient’s coverage under a Medicaid ID number as provided by a provider.

*4.5.1.2 Information Not Available from the Fiscal Agent*

a) Recipient Information

- Recipient Personal Data – Personal data such as addresses is not released. This information must be obtained from the patient.

b) Payment Information

The Fiscal Agent does not release payment information to unauthorized providers. This information is available only to the provider of service or his/her staff.

*4.5.2 Common Inquiries and Required Information*

Sufficient data from a provider is required for Medicaid to accurately respond to inquiries. The following are the most common types of inquiries and the required accompanying information.

a) Paid / Rejected Claim Inquiry

Required from provider: Provider name and number, patient’s name, Medicaid ID number, FM code, service date, charge on claim, claim number, payment date, procedure in question.

e) Medicaid Reimbursement Determination

Required from Provider: Provider name and number, procedure, procedure code, charge for the procedure, service date, and diagnosis.

*4.5.3 Outstanding Medicaid Claims Inquiry*

Claims appearing as unpaid on a provider’s records may have been paid or rejected to the provider. Medicaid provides a standardized inquiry service to aid providers in researching unpaid claims.

*4.5.3.1 Method of Inquiry*

All written inquiries to the Medicaid Program should be made on the Medicaid Correspondence Inquiry Form. A supply of this form may be obtained from the Fiscal Agent. See Appendix 1 for the contact information.

The Medicaid Correspondence Inquiry Form provides a standardized format in which to submit an inquiry and receive a response. This standardization reduces much of the response time. A clarifying letter or other documentation may be attached to the form when additional space is needed.

The Correspondence Inquiry Form may be used to request claim status research, inquire about claims filing procedures, or question payment amounts. In most cases, claim attachments are not necessary. If possible, internal methods are used to reprocess claims that are found to be outstanding more than 30 days from the date of the last submission. However, in cases where the data provided does not match data in the system at the point of research, providers are asked to resubmit a copy of the outstanding claim.

Outstanding claims submitted without a Correspondence Inquiry Form, letter, or other notification identifying the specific problem with a claim are sent through the processing system as routine claims. Representatives will not be able to identify the claim as one requiring special handling if documentation outlining a specific claim problem is not provided on an attached letter or Correspondence Inquiry Form.

The Medicaid Correspondence Inquiry Form is not appropriate for written inquiries regarding benefit information, policy determination, and coverage limitations.

#### *4.5.3.2 Waiting Period for Claim Status Inquiries*

Inquiries should be initiated for claims outstanding more than 30 days from the date of the last submission to Medicaid. Although most “clean” claims are paid within 30 days, additional processing time may be required if claims must be manually reviewed for medical necessity or to verify inconsistent claim information.

#### *4.5.3.3 Inquiry Procedures*

The Medicaid Correspondence Inquiry form is a three-part form consisting of an original copy, provider copy and Fiscal Agent copy. The form is divided into provider, inquiry and response sections and can accommodate up to three separate claim or informational inquiries. Please refer to Appendix 1 for a sample of the form and instructions for completion.

#### *4.5.3.4 Inquiry Form Submittals*

When inquiry forms are completed and prepared for submittal, the provider should make a copy for his/her files. The original form should be mailed to the Fiscal Agent (refer to Appendix 1 for the contact information).

The Fiscal Agent will research the inquiry and indicate the appropriate response on the form. A copy of the form will be returned to the provider. The Fiscal Agent will retain the original inquiry form for internal records.

Providers should review the response provided on the copy returned by the Fiscal Agent and take action as necessary. If a response is unclear or further information is desired, providers may call the Fiscal Agent. Phone numbers are listed in Appendix 1.

#### *4.5.3.5 Research Limitations*

Medicaid's claims research service is not a substitute for accurate claims accounting by the provider as staff limitations do not allow extensive research services on a routine basis. The following steps will be taken if a pattern of paid claims are submitted for research:

- a) If research shows a pattern of more than 50% of a batch of resubmitted claims were paid, only a 20% sampling of future batches will be researched.
- b) If more than half of the 20% sampling are paid, the claims will be returned with a request that the provider review his claims accountability system.
- c) Complete research on batches of unpaid claims will be resumed when a sampling shows that the problem in the provider's accountability system is resolved and the resubmitted claims are indeed unpaid.

#### *4.5.4 Procedure Code Inquiries*

Effective November 1, 2002, the Med-QUEST Division (MQD) will not be accepting requests for 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 assist providers in determining appropriate CPT or HCPCS codes when a claim has been denied or a request for medical authorization 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 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.

**4.6 Provider Billings To Recipients***4.6.1 Billing Limitation*

Providers must accept the Medicaid Program's established rates as payment in full. Providers may not bill or collect from Medicaid recipients the difference between a provider's charge and the total payments received from all sources including Medicaid.

A provider may bill and accept payment from a Medicaid recipient only for:

- a) TPL payments – A patient is responsible for turning over to the provider all payments received from a third party insurance carrier.
- b) Patient's cost share – Spend-down patients with designated cost shares are responsible for paying a portion of their medical expense on a monthly basis. A provider may collect this cost share only if indicated on the patient's coupon.

Example:

		<u>Medicaid Allowance</u>
Claim Total	\$900.00	\$800.00
TPL Payment	- \$600.00	- \$600.00
Patient's Share	<u>- \$ 50.00</u>	<u>- \$ 50.00</u>
Bal. Billed To Medicaid	\$250.00	\$150.00

The provider may collect \$650 from the patient, representing the TPL payment and the patient's cost share as long as it is less than the cost share amount noted on the coupon. If the cost share is less than the amount owed, the provider may collect up to the cost share amount and bill any difference to the Medicaid program. The difference of \$100 between the balance billed to Medicaid and the ultimate Medicaid payment cannot be billed to the patient.

*4.6.2 Acceptable Billing Situations*

Although patients covered under Medicaid are not responsible for amounts other than any third party payments or patient cost shares, a provider may bill a Medicaid patient under certain circumstances.

- a) Patient did not present himself as a Medicaid recipient.

A Medicaid recipient must show his Medicaid ID card as proof of Medicaid coverage. If the patient presented himself as a private patient, or failed to identify himself as a Medicaid patient, a provider may treat and bill him for the services as a private patient. The Medicaid

Program does not infringe on a provider's right to just compensation for services provided under a private agreement with his/her patient.

If a provider chooses to bill Medicaid for services rendered, no amounts other than third party payments or cost share amounts may be billed to the patient.

b) Patient requested non-covered service.

Ineligible services (e.g. immunizations for travel purposes) and procedures denied by the DHS Consultant on an applicable authorization form may be billed to the patient if the patient insists on the services even when informed that Medicaid would not pay for them. The patient is responsible for all charges made in connection with the ineligible service.

c) Patient failed to utilize prepaid health benefits from designated facilities.

All prepaid health insurance benefits must be utilized before Medicaid benefits are claimed. Medicaid does not pay claims for patients who chose not to seek services available to them at a predesignated health center, such as HMSA's HPH Programs, Kaiser, or the Veterans Administration. Services rejected by Medicaid for this reason may be billed to the patient.

d) Patient received care from a non-designated provider.

"Lock-in" recipients whose medical care is restricted by DHS must receive all medical care from their designated primary care physician. All non-emergency services provided by a provider other than the primary physician may be billed to the patient unless the patient was referred by the primary care physician.