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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1739.1

AUTHORIZATION, PAYMENT, AND CLAIMS IN THE FEE-FOR-SERVICE MEDICAL ASSISTANCE PROGRAM FOR NON-INSTITUTIONAL SERVICES

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Historical Note: This chapter is based substantially upon chapter 17-1739, subchapter 1. [Eff 11/13/95, am 01/29/96, am 11/25/96, am 12/27/97; am 09/14/98; am 07/06/99; am 06/19/00; R 10/26/01]

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§17-1739.1-1 Purpose. This chapter shall implement the state plan requirements for payments made by the state Medicaid agency for the fee-for-service component for services received under the medical assistance program. [Eff 10/26/01]
(Auth: HRS §346-59) (Imp: HRS §346-59)

§17-1739.1-2 Definitions. As used in this chapter:

"Automated tests" means laboratory tests automatically conducted through a mechanical testing aid.

"Clean claim" means one that can be processed without obtaining additional information from the provider of the service from a third party.

"Controlled procedure" means a procedure that is rendered often enough by a provider or group of providers that specific usual or customary charge data for the procedure can be established based on the usual and customary methodology.

"Conversion factor" means the element that is used in calculating reimbursement for non-controlled procedures. The conversion factor is multiplied by the number of units assigned to each procedure. Conversion factors are determined by adding all submitted charges for all procedures within a specialty (with the exception of laboratory services) and dividing by the total number of units for all the submitted procedures. This can be determined for specific providers or specialties.

"Cost-share" means the amount identified by the department as an applicant's or recipient's excess income available for meeting a portion of the individual's own health care cost.

"Coterminous" means the health care provider's contract with Medicaid shall be invalid upon termination of the state department of health's certification of the provider's compliance with state and federal requirements.

"Drug formulary" means prescription drugs pursuant to 42 U.S.C. 1936r(8)(d)(4), for which payment may be made by the Hawaii Medicaid program.

"Employer" means one who employs another or who contracts with another for services in return for wages or payment.

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"Enhanced prior authorization list" means non-preferred prescription drugs which require prior authorization.

"Established provider" means one who has been in the Medicaid program for twelve months or more.

"Estimated Acquisition cost" means the wholesale Average cost.

"Federal upper limits (FUL)" for a drug product means the price established by the Center for Medicaid and State Operations.

"Hawaii Medicaid fee schedule" means the schedule of rate of payment for services provided by noninstitutional providers of medical care.

"Median charges" means the middle of all the actual charges made for a given service by a provider.

"Panel test" means a set of two or more laboratory tests done concurrently or in conjunction with the others.

"Part A" means Medicare hospital insurance benefits.

"Part B" means Medicare medical insurance benefits.

"PPS" means the prospective payment system of reimbursement.

"Practitioner" means a licensed doctor of medicine, dentistry, osteopathy, podiatry, and any other individual licensed practitioner of health care services the department chooses to include in its Medicaid program.

"Preferred drug list" means prescription drugs, within specified therapeutic classes, or that are comparatively effective, that are designated as preferred for use as determined by a committee of physicians and pharmacists and approved by the department.

"Primary physician" means a practitioner selected by the recipient to manage the recipient's utilization of health care services.

"Program" means the state-administered medical assistance program as authorized under title XIX of the Social Security Act (42 U.S.C. §§1396-1396j) and chapter 346, HRS.

"Provider" means a provider of health care services, equipment, or supplies that is participating in the Medicaid program.

"QMB" means Qualified Medicare Beneficiaries.

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"Routine nursing salary cost differential" means the amount reimbursed to a provider for the cost of inpatient routine nursing care for aged patients.

"Spend-down" means the monthly process by which an individual's or family's income in excess of the medically needy standard is applied toward incurred medical expenses until the net income no longer exceeds the medically needy standard resulting in eligibility for medical assistance.

"State maximum allowable cost (MAC)" for a multi-source drug product means the average of the estimated acquisition costs of the three least expensive generics available. At least one of the three generic products shall be provided by a manufacturer who participates in the Federal Drug Rebate Program.

"Visiting consultant" is a Medicaid provider who has expertise or knowledge in a specific area and generally recognized by the community as a specialist and this expertise or service is not readily available on a particular island. Included as a visiting consultant are specialists who are requested by other providers to render second opinions or to participate in the medical treatment of Medicaid recipients.

"Wholesale average cost" means the wholesale acquisition cost (WAC) which is defined as the list price paid by a wholesaler, distributor and other direct accounts for drugs purchased from the wholesaler's supplier. Generally, it is the price put by the manufacturer of drug before any rebates, discounts, allowances or other price concessions are offered by the supplier of the product.

[Eff 10/26/01; am 05/10/03; am 03/11/04;
am 04/12/13] (Auth: HRS §346-14; 42 C.F.R.
§431.10) (Imp: HRS §§346-14, 346-59; 42 C.F.R.
§431.10; 42 U.S.C. §1396r(8)(d)(4) and (5))

§17-1739.1-3 Controlling factors for payment.

(a) The department shall pay for the cost of medical care when the department's medical consultants determine medical care to be necessary to the eligible patient's well-being and medical care is provided, under standards generally acceptable to the medical community, by a practitioner approved by the department to participate in Medicaid.

(b) The department shall not increase the payment made to any provider to offset uncollected

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amounts for deductibles, coinsurance, copayments, or similar charges.

(c) No payment shall be made where program rules are violated, or when services furnished are inappropriate to the patient's health care management as determined by the department's medical consultant.

(d) Rates of payment to providers of medical care who are individual practitioners shall be based upon the Hawaii Medicaid fee schedule. The amount paid shall not exceed the maximum permitted to be paid to individual practitioners or other individuals under federal Medicaid laws and regulations, the Medicare fee schedule applicable in the year the service was rendered, the state limits as provided in the appropriation act, the provider's billed amount, or the rate set by the department.

(e) Rates of payment to out-of-state providers of medical care who are individual practitioners shall be the Medicaid rate paid in the practitioner's state, subject to the conditions of section 17-1736-13. In the absence of a Medicaid payment rate, payment will be according to the Hawaii Medicaid fee schedule.

(f) Payments may be prepaid to health maintenance organizations which the department contracts to provide medical care to eligible public assistance recipients.

(g) The department may withhold payment of claims to recoup overpayments, or may withhold payment pending completion of an audit or investigation.

- (1) Payment of pending or future claims may be withheld in an amount reasonably calculated to approximate the amounts of past overpayments.
- (2) Payment of pending claims may be withheld until completion of a pending audit or investigation, at which time the department may initiate actions to recoup the amounts of any overpayments discovered.
- (3) The department shall notify the provider in writing of its intent to withhold payments and shall include reasons for the proposed action, the effective date of the action, and a statement of the provider's right to request administrative review of the proposed action.
- (4) The effective date of withholding shall be

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sixteen calendar days following the issuance of the notice.

(h) For a Medicaid recipient with Medicare coverage, payment on a Medicare covered service shall be the applicable Medicare deductible and coinsurance amounts.

(i) For a Medicaid recipient with Medicare coverage, payment on a service that is not covered by Medicare, but is covered by Medicaid, shall be up to the Medicaid rate.

(j) Payment on a QMB claim shall be the applicable Medicare deductible and coinsurance amounts. [Eff 10/26/01; am 05/10/03; am 02/07/05] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.10, 447.15, 447.57, 447.200)

§17-1739.1-4 Authorization of services. (a) The department shall provide:

- (1) Methods of administration necessary for the proper operation of the Medicaid program; and
 - (2) Procedures relating to the utilization of and the payment for care and services available under the program. Among the procedures the department may employ shall be a system of authorization of selected types of costly health care.
- (b) Authorizations shall insure that:
- (1) Requested services and materials are medically necessary;
 - (2) Any adequate and less expensive alternatives are considered; and
 - (3) Any services and materials provided conform to currently accepted community standards of the profession involved.

(c) Authorization may be required when the department considers or has found a service to be associated with, but not necessarily limited to:

- (1) High or excessive costs provided over extended periods of time without evidence of benefit;
- (2) Questionable or limited value, or both; or
- (3) Subject to abuse;

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(d) The authorization function may be contracted to certain individuals or organizations, including the State's fiscal agent.

(e) The department, through its medical consultants, may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control procedures. The department shall pay for health care services when the department's medical consultants determine that the services are necessary to the patient's well-being and the services are provided under standards accepted by the medical profession. However, no payment shall be made in a situation where the program rules were violated or when services furnished did not involve economical or effective health care management of the patient.

(f) A request for medical authorization, which does not require prior authorization, must be submitted for approval within sixty calendar days before or thirty calendar days after the initial date the service is rendered. Authorization may be obtained by submission of an authorization request adequately justifying the service and signed and dated by the requesting physician. Requests not received within thirty calendar days after the initial date of service shall be denied. The following services require medical authorization:

- (1) Short-term inpatient psychiatric admission;
- (2) Outpatient electroconvulsive therapy; and
- (3) Purchase or rental of durable medical equipment, or the purchase of medical supplies totaling more than a \$50 billed charge per line item per month.

(g) The following services require medical authorization prior to the service being rendered. A request for authorization may be submitted up to sixty days prior to the services being rendered.

- (1) Obtaining special medical services from other United States jurisdictions;
- (2) Termination of regulatory controls, for example, release from physicians' management (reference is to recipients assigned to a primary physician);
- (3) Rental or purchase of hearing aids;
- (4) Replacement glasses, special glasses, or other visual aids;
- (5) Physical therapy and occupational

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therapy for outpatients other than ultrasound therapy for musculoskeletal problems;

- (6) Outpatient speech therapy;
- (7) Lodging, meals, and transportation for recipients and medical attendants to accompany a recipient for medical purposes, including out-of state and inter-island transportation by scheduled carrier, air ambulance, ground ambulance, handicab, or taxi;
- (8) Detoxification;
- (9) Psychiatric outpatient visits (individual or group) and psychological tests on an outpatient basis;
- (10) Certain dental services;
- (11) Admission and Medicaid coverage of persons in long-term care facilities and subacute level of care;
- (12) All surgical procedures that are performed in the outpatient and inpatient hospital settings by podiatrists and for all surgical procedures costing more than \$100 that are performed in the office by podiatrists;
- (13) Home pharmacy services;
- (14) Sleep laboratory and sleep disorder center services;
- (15) Augmentative communicative devices; and
- (16) Other medical services as may be identified by the department.

(h) Services provided without the necessary prior authorizations are subject to denial of payment.

(i) A request for authorization shall be acted upon within thirty calendar days for a non-urgent request and two working days for an urgent request. An exception to this provision is a request for authorization for augmentative communicative devices (ACD's) as indicated in subsection (o). If the request is deferred or denied, a notice to include a reason for the deferral or denial, shall be sent to the provider(s) and the recipient.

(j) An authorization request that requires urgent medical action, shall be acted upon within two working days. For the purpose of this section, an "urgent" medical service or item is a service or item for the diagnosis or treatment of a medical condition which is serious but not an immediate threat to life.

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The service or item is medically needed by the patient within two working days of request to preserve an essential bodily function or prevent a serious complication.

(k) Services which necessitate immediate professional medical action shall not be subject to prior authorization if obtaining prior authorization may delay service and place a patient in jeopardy. The request for authorization must be submitted within thirty calendar days after the initial date of service. The request shall then be processed in accordance with the procedures stated in this section. Requests not received within thirty calendar days after the initial date of service shall be denied.

(l) When a request for authorization is submitted for services which require prior authorization but have already been rendered, an explanation for the delay in submittal must be provided for consultant review. If the explanation adequately justifies the untimely submittal, the request shall be processed in accordance with the procedures stated in this section. If the explanation does not justify the untimely submittal, the request shall be denied. Requests not received within thirty calendar days after the initial date of service shall be denied.

(m) An incomplete authorization form shall be returned to the sender. The form shall be deemed incomplete if the following is incomplete, illegible, or missing:

- (1) The name and the identification number of the recipient;
- (2) The requesting physician's signature, date, and provider number;
- (3) The supplier's name, provider number, dates of service or period requested as determined by begin and end dates, and signature, if the service or item is not being provided by the requesting physician;
- (4) The diagnostic code or description;
- (5) The procedure code; and
- (6) For non-urgent requests, all attached copies of the form must be submitted together intact.

When the newly completed form is received, the form shall be processed in accordance with the procedures stated in this section from the date the completed form is received.

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(n) When a request for authorization is deferred due to lack of supportive documentation to justify a service:

- (1) The provider(s) shall be notified of the deferral. The notice shall include a reason for the deferral giving twenty-one calendar days from the date of the deferral notice to submit the requested information; and
- (2) If the requested information is not received within twenty-one calendar days from the date of the deferral notice, the request shall be denied; or
- (3) If all necessary information is received within twenty-one calendar days from the date of the deferral notice, the request for authorization shall be acted upon within twenty-one calendar days by a DHS consultant or an authorized representative. If the request is denied, a notice to include a reason for the denial, shall be sent to the provider(s) and the recipient.

(o) A request for authorization relating to the purchase, repair, or rental of augmentative communicative devices shall be acted upon within two working days of receipt for an urgent request and within twenty-one calendar days of receipt for a non-urgent request. If the request is approved, the vendor shall be notified. If the request is denied, a notice of denial to include a reason for the denial and appeal rights shall be sent to the recipient and the requesting provider(s). When a request for authorization is deferred due to lack of supportive documentation to justify a service:

- (A) The provider(s) and the recipient shall be notified of the deferral. The notice shall include:
 - (B) A reason for the deferral, identifying the additional information needed to process the request; and
 - (C) Where to send the additional information;
giving twenty-one calendar days to submit the requested information; and
- (2) If the requested information is not received within twenty-one calendar days from the date the request was sent, the request shall be denied; or

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(3) If all necessary information is received within twenty-one days from the date the request was sent, the request for authorization shall be acted upon within two working days for an urgent request and twenty-one days for a non-urgent request by a DHS consultant or an authorized representative. If the request is denied, a notice to include a reason for the denial, shall be sent to the provider(s) and the recipient.

(p) An approved authorization request and treatment plan shall be initiated within sixty calendar days of the signed approval by the department.

(1) If an approved service is not rendered within sixty calendar days of the signed approval, a new request for authorization shall be submitted.

(2) If an extension is needed for partially completed service or if the approved service is not completed within sixty calendar days of the signed approval, a new request for authorization shall be submitted for the new period.

(q) The department, through its medical consultants, may permit exceptions and determine level of care, medical appropriateness, and medical necessity. In disagreements between the provider and DHS's authorized agent(s) regarding authorization of services and level of care determinations, the department's medical consultant's decision shall be final. Further appeal shall be pursued through the appeal administrator's office or the courts.

[Eff 10/26/01; am 05/10/03; am 03/11/04] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§456.1, 456.2, 456.3; 42 U.S.C. §1396r(8)(d)(5))

§17-1739.1-4.1 Prior authorization of drugs.

(a) Selected drugs designated by the medical assistance program through the processes set forth in section

17-1737-71 pursuant to 42 U.S.C. 1396r(8)(d)(5) require prior medical authorization.

(b) Preferred drug list:

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- (1) The department may maintain a preferred drug list containing the names of drugs for which prior authorization will not be required under the medical assistance program. All other drugs not on the preferred drug list, but are in the same drug class as drug(s) placed on the preferred drug list, shall be placed on an enhanced prior authorization list. The department may seek the recommendations of an advisory committee to be comprised of licensed medical and pharmacy professionals regarding the products that may be placed on a preferred drug list.
- (2) The members of the advisory committee referred to in subsection (b)(1) shall be as determined by the department. The composition and number of members may change from time to time.
- (3) The advisory committee shall meet at times and locations as may be requested by the department.
- (4) The advisory committee's recommendations may take into consideration all, or some, of the following:
 - (A) Therapeutic value for the disease or condition under treatment;
 - (B) Clinical efficacy;
 - (C) Safety;
 - (D) Cost; and
 - (E) Other considerations as determined by the committee.
- (5) The advisory committee's recommendation(s) to the department shall be advisory only. The department may accept or reject all, or a portion, of the recommendation(s) of the advisory committee.
- (6) Pharmaceutical products which have been placed on a preferred drug list pursuant to the provisions of this subsection may also be temporarily deleted from the list by the department pending further review and recommendation of the advisory committee

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described in section 17-1737-71(b) or the decision of the department. The circumstances under which the department may temporarily delete a drug from the preferred drug list are for clinical and safety reasons and administrative cost.

(7) Providers will be notified of changes made to the preferred drug list.

(c) A request for outpatient drugs, including prescriptions for nursing facilities, that require prior authorization:

(1) Shall be acted upon within twenty-four hours of receipt when the request is received within the business week; or

(2) In an emergency situation, pharmacies can dispense a seventy-two hour supply of an outpatient drug which otherwise requires prior authorization under the following conditions:

(A) The consequence of delaying the dispensing of the drug is a high probability of serious adverse effects on the person's health. Serious adverse effects are hospitalization, medically necessary emergency room care, and loss of bodily function or life;

(B) There is no similar medication available without prior authorization or the patient has a documented intolerance for the similar agent; or

(C) The patient's physician documents that the patient is unable to use a generic form of a drug because of an allergy or history of a serious adverse reaction to the generic drug.

(d) The department may require certain medications to be prior authorized or may place usage restrictions on certain drugs.

(e) Services provided without the required prior authorizations are subject to denial of payment.

(f) When a request for authorization is submitted for services which require prior authorization but have already been rendered, an explanation for the delay in submittal must be provided for consultant review. If the explanation adequately justifies the untimely submittal, the

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request shall be processed in accordance with the procedures stated in this section. If the explanation does not justify the untimely submittal, the request shall be denied.

(g) An incomplete prior authorization form shall be returned to the sender. The form shall be deemed incomplete if the following is incomplete, illegible or missing. The following are examples and do not represent an exhaustive list:

- (1) The name and the identification number of the recipient;
- (2) The requesting physician's signature, date, and provider number;
- (3) The supplier's name, provider number, dates of service or period requested as determined by begin and end dates, and signature, if the service or item is not being provided by the requesting physician;
- (4) The diagnostic code or description;
- (5) The procedure code; and
- (6) For non-urgent requests, all attached copies of the form must be submitted together intact.

When the newly completed form is received, the form shall be processed in accordance with the procedures stated in this section from the date the completed form is received.

(h) When a request for authorization is deferred due to lack of supportive documentation to justify a service:

- (1) The provider(s) shall be notified of the deferral. The notice shall include a reason for the deferral giving thirty calendar days from the date of the deferral notice to submit the requested information; and
- (2) If the requested information is not received within thirty calendar days from the date of the deferral notice, the request shall be denied; or
- (3) If all necessary information is received within thirty calendar days from the date of the deferral notice, the request for authorization shall be acted upon within twenty four hours by a DHS consultant or an authorized representative. If the request is denied, a notice to include a reason for the denial, shall be sent to the provider(s) and the recipient.

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(j) The department, through its medical consultants, may permit exceptions and determine level of care, medical appropriateness, and medical necessity. In disagreements between the provider and DHS's authorized agent(s) regarding authorization of services and level of care determinations, the department's medical consultant's decision shall be final. Further appeal shall be pursued through the administrative appeals office or the courts. [Eff 03/11/04] (Imp: 42 C.F.R. §§456.1, 456.2, 456.3; 42 U.S.C. 1396r-8(d)(4) and (5))

§17-1739.1-5 Methods of payment. (a) State payments for medical services shall not be provided to anyone except the:

- (1) Provider; or
- (1) Recipient for settlement of a legal suit or fair hearing.
- (b) Payment to an individual shall be prohibited, except in specified circumstances where payment is reassigned to another person, facility, or organization by the provider. The circumstances include payment made:
 - (1) In accordance with a reassignment from the provider to a government agency or reassignment by a court order;
 - (2) To a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider. The agent's compensation for the service shall be related to the cost of processing the billing, and not on a percentage or other basis of the amount that is billed or collected, and the compensation shall not be dependent upon the collection of the payment; and
 - (3) To the following:
 - (A) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over the fees to the employer;
 - (B) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or

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(C) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(c) Payment for any service furnished to a recipient by a provider shall not be made to or through a factor, either directly or by power of attorney.

(d) Participation in the State's Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by Medicaid with the exception of amounts specifically identified as the recipient's spend-down or cost-share.

[Eff 10/26/01] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.10, 447.15)

§17-1739.1-6 REPEALED. [Eff 10/26/01;
R 05/10/03]

§17-1739.1-6.1 Hawaii Medicaid fee schedule.

(a) Payment to providers of medical care who are individual practitioners, including doctors of medicine, dentists, podiatrists, psychologist, osteopaths, optometrists, and other individuals providing services, shall be based upon the Hawaii Medicaid fee schedule.

(b) Payment for noninstitutional items and services, with the exception of prescribed drugs and EPSDT services, shall be based on the Hawaii Medicaid fee schedule. These items and services include, but are not limited to:

- (1) Laboratory services;
- (2) X-ray services;
- (3) Physician services;
- (4) Podiatric services;
- (5) Optometric services;
- (6) Other practitioner services including nurse midwife, pediatric nurse practitioner, advanced practice registered nurse in behavioral health, and licensed social worker in behavioral health;
- (7) Dental Services (including dentures);
- (8) Physical therapy;
- (9) Occupational therapy;

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- (10) Services for persons with speech, language, and hearing disorders (exception: There shall be a flat rate for hearing evaluations.);
 - (11) Durable medical equipment, except eye glass frames and hearing aides;
 - (12) Medical supplies;
 - (13) Sleep services;
 - (14) Other services specified by the department.
- (c) Providers who are visiting consultants to the neighbor islands may be reimbursed travel charges on the condition that an addendum to their provider agreement is submitted with the following information for approval by the department:
- (1) The neighbor island to be visited;
 - (2) Frequency of visits; and
 - (3) Location where individuals are to be seen.
- (d) Reimbursements may be made to providers who are visiting consultants as follows:
- (1) \$8 per patient visit; and
 - (2) An additional \$7 per patient visit if hospital charges for supplies and equipment are assessed to the visiting consultant. Justification shall be required on the individual claim form when requesting this additional fee. [Eff 05/10/03]
(Auth: HRS §346-59) (Imp: 42 C.F.R. §§405.502, 405.503, 447.10)

§17-1739.1-7 Payments to individual practitioners providing therapy services in long-term care facilities. (a) Payment for physical and occupational therapy, and speech, language, and hearing disorder services provided to a Medicaid recipient in a long-term care facility shall be based on a fee schedule established by the department for services provided at fifteen minute time increments.

(b) Payment shall be made for only those covered therapy services specified in sections 17-1737-79, which are determined to be medically necessary, prescribed by a physician, and provided by a licensed or certified therapist approved by the Medicaid program.

(c) Payment shall be made only upon submission of a Hawaii claim form (UB-82 or DHS-1500), by a provider eligible to bill for the services under the Medicare and Medicaid programs. Facilities with

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Medicare numbers shall use the form UB-82. Individual therapists shall use the form DHS-1500.

(d) In the case of speech evaluation and training, and hearing evaluation and hearing aids, an authorization form (DHS 1144), shall be attached to the claim form.

(e) In the case of persons eligible for both Medicare and Medicaid who reside in an intermediate care facility, payment shall be made only if Medicare payment has been sought and denied. [Eff 10/26/01; am 05/10/03] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.252, 447.253)

§17-1739.1-8 Medicaid payments for other noninstitutional items and services not included in the Medicaid fee schedule. The following services shall be limited to billed charges not to exceed Medicare's upper limit of payment or the rate established by the department:

- (1) Hearing aids;
- (2) Home health agency services;
- (3) Outpatient hospital services;
- (4) Emergency room services;
- (5) Frames for eyeglasses;
- (6) Hearing devices shall be the actual claim charge or \$300, whichever is lower. Exceptions may be made for special models or modifications.
- (7) Clinic services (other than physician-based clinics); The types of clinics include government sponsored non-profit, and hospital-based clinics.
- (8) Teaching physicians shall be paid to the teaching fund, not to the physician;
- (9) Prescribed drugs shall be made as described in section 17-1739.1-11.
- (10) The Hawaii Medicaid program shall not pay more than the billed amount for any noninstitutional item or service or more than the amount permitted by federal law or regulation; and
- (11) Payments to a facility for non-emergency care rendered in an emergency room and to an emergency room physician for the screening and assessment of a patient who receives non-emergency care. [Eff 10/26/01;

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am 05/10/03] (Auth: HRS §346-59)
(Imp: 42 C.F.R. §§447.201, 447.304)

§17-1739.1-9 Payments for intra-state transportation and related services. (a) Payments for the following intra-state transportation and related services are based upon the Hawaii Medicaid fee schedule:

- (1) Payments for emergency air ambulance services;
- (2) Payments for emergency ground ambulance services;
- (3) Payments for non-emergency air and ground ambulance services. Air and ground ambulances must be authorized by the department; and
- (4) Payments for non-emergency transportation (e.g. handicabs, but not taxis).

(b) Except for a recipient who is a stretcher patient, payment for air transportation shall not exceed the inter-island air fare charged the other persons on the recipient's flight, or a contracted amount previously agreed upon between the airlines and the department for emergency chartered flights, whichever is lower. For transportation of a stretcher patient by the scheduled inter-island carrier, payment shall not exceed the air fare charged for four seats on the recipient's flight.

(c) A round trip air fare shall be paid for an attendant whose services are recommended by the attending physician or are required by the airline. Prior approval of the department's medical consultant is necessary, except in emergency situations, when the attending physician's authorization is sufficient, subject to the department's medical consultant's review.

(d) Payments for medical taxi services shall be by purchase order issued by the department and only on trips to or from a physician's office, clinic, hospital, or airport (for covered medical transportation) and the patient's home. Reimbursement for those services shall be further limited as follows:

- (1) No detours or side trips shall be permitted;

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- (2) The amount of payment shall be made on the basis of metered rates charged the public; and
- (3) Payments shall not include compensation for the driver's waiting time at the clinic, hospital, physician's office, or at the location of other providers of medical services.

(e) Lodging and meals for Medicaid patients or attendants authorized by the attending physician, in an emergency situation, or the department's medical consultant shall be paid through purchase orders to the providers issued by the department.

[Eff 10/26/01; am 05/10/03] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.201, 447.304)

§17-1739.1-10 Payments for out-of-state transportation and related services. (a) Payments shall be made for out-of-state transportation, meals and lodging when these services are authorized in accordance with section 17-1739.1-9.

(b) Out-of-state air transportation shall be paid by a purchase order made out to the airlines or travel agency.

(c) Ground transportation expenses, subject to subsection 17-1739.1-9(f), shall be allowed when these expenses are incurred by the recipient. Verification of ground transportation expenses shall be documented completely on the proper departmental form when reimbursement is requested.

(d) Payment for meals and lodging shall be the lesser of the per diem rate of \$100 a day or the actual charge for lodging plus a daily per diem of \$30 for meals.

(e) The \$30 per diem shall be prorated equally for three meals and shall begin with the first meal upon arrival at the specified destination and ending with the last meal prior to flight departure home.

[Eff 10/26/01] (Auth: HRS §346-59; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§447.201, 447.304)

§17-1739.1-11 Payment for drugs and related supplies. (a) The state medical assistance program shall determine reimbursement for the ingredient cost of prescription drugs using the following criteria:

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- (1) Single source drugs shall not exceed the lower of:
 - (A) The provider's invoice price;
 - (B) The provider's usual and customary charge to the general public; or
 - (C) The estimated acquisition cost (EAC).
- (2) Multiple source drugs shall not exceed the lower of:
 - (A) The provider's invoice price;
 - (B) The provider's usual and customary charge to the general public;
 - (C) The EAC;
 - (D) The federal upper limit (FUL) price; or
 - (E) The state maximum allowable cost (SMAC).
- (3) The FUL price shall not apply if the practitioner:
 - (A) Certifies in his or her own handwriting or by an electronic method compliant with national standard approved by the Centers for Medicare and Medicaid Services that a specific brand medication is medically necessary for a particular recipient. A check-off box is not acceptable but a notation of "brand medically necessary" or "do not substitute" is allowable; and
 - (B) Obtains prior authorization for medical necessity from the state medical assistance program. In such cases, the payment shall be according to the methodology in this section.
- (4) The State medical assistance program requires that the lower cost equivalent drug product be dispensed if available in the marketplace and substitution is not prohibited by part VI of chapter 328, Hawaii Revised Statutes, relating to drug product selection. The recipient may refuse lower cost drug products but must pay the entire cost of the higher price equivalent.
- (5) If a published WAC is unavailable for the medication and the provider does not submit documentation of the invoice price, then the medication and dispensing fee shall not be reimbursed.

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(b) The dispensing fee for prescription medications dispensed by a licensed pharmacy shall be:

- (1) \$5.00 (five and no/100 dollars) per prescription.
- (2) The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty (30) days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program.

(c) The Department may cover selected over-the-counter medications.

- (1) Reimbursement for over-the-counter medications shall be according to the methodology in subsection (a).
- (2) Reimbursement for over-the-counter drugs shall be limited to the over-the-counter drugs prescribed by a licensed practitioner and specifically designated by the medical assistance program. Over-the-counter drugs not specifically designated shall require prior authorization for medical necessity by the medical assistance program.
- (3) Under no circumstances shall the program pay more than the general public for the same prescription or item.

(d) The following conditions shall apply to payment for drugs dispensed by physicians and dentists from the physicians' and dentists' offices:

- (1) Physicians and dentists dispensing medications from the physicians' and dentists' offices shall be reimbursed at the EAC plus \$0.50 (fifty cents); and
- (2) If there is no pharmacy within five miles of the provider's office, special consideration for payment at the pharmacy rate may be made upon written request to the department's med-QUEST division administrator for approval.

(e) Payment for prescribed drugs dispensed to outpatients and patients of long-term care facilities shall be made only upon the submission of an itemized claim by the dispensing provider (Form 204), hardcopy or electronic media claim or via point-of-sale.

(f) Emergency calls by the pharmacist to the long-term care facility:

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- (1) Shall be paid up to a maximum of four calls for each one hundred beds in the facility at the time services are rendered, at \$25 (twenty-five and no/100 dollars) per emergency call. Any fraction of one hundred shall be prorated accordingly; and
- (2) Facilities with less than twenty-five beds at the time services are rendered may charge up to one full emergency call per month.
 - (A) An emergency call shall be one that cannot be delayed, i.e. non-routine call to the patient of a facility by the pharmacist in a life-threatening situation.
 - (B) All other services shall be handled during the pharmacist's routine visits whenever possible.
- (g) Payments for medical supplies shall be the lower of:
 - (1) The rate set by the department;
 - (2) Medicare's upper limit of payment; or
 - (3) The EAC for a medical supply. [Eff 10/26/01; am 05/10/03; am 05/05/05; am 04/12/13] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.331, 447.332, 447.333)

§17-1739.1-12 REPEALED. [R 04/12/13]

§17-1739.1-13 Drug use review (DUR) board. (a) An advisory drug use review board shall be appointed by the director of the department, and shall consist of:

- (1) The department's pharmacy consultant or medical consultant or both, shall serve as the drug use review coordinator(s);
 - (2) Four persons licensed and actively engaged in the practice of medicine in the state;
 - (3) Four persons licensed and actively practicing pharmacy in the state; and
 - (4) One person actively practicing as a medical service representative in the state.
- (b) The term of each drug use review board member shall be three years and overlapped in such a way that expiration of terms shall not cause a total membership change.

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(c) A quorum shall consist of five board members; at least one of the five must be a physician or pharmacist.

(d) The duties of the advisory drug use review board shall be to:

- (1) Meet when called by the chairperson;
- (2) Develop, review, and adapt criteria and standards for prospective and retrospective drug use review;
- (3) Make policy recommendations to the Hawaii medical assistance program in respect to confidentiality of patient related data, and all aspects of the drug use review program;
- (4) Decide on and monitor educational programs and interventions deemed appropriate based on potential therapeutic problems identified through the program; and
- (5) Determine the content and mix of educational programs and interventions for practitioners, designed to enhance the clinical appropriateness and cost effective use of prescription drugs with primary emphasis on therapeutic outcomes and quality of care.

(e) The actions of the drug use review board shall be:

- (1) Subject to the approval of the department;
- (2) Remain confidential within the department; and
- (3) Be communicated to the specific providers affected. [Eff 10/26/01] (Auth: HRS §346-14; P.L. 101-508) (Imp: 42 C.F.R. §§456.1, 456.3)

§17-1739.1-14 Medical payment involving third party liability. (a) The liability of a third party for the cost of the medical services shall be treated as a resource applicable to the cost of needed medical services when:

- (1) It has been verified that a legal obligation actually exists; and
- (2) The amount of the obligation may be determined within thirty days from the time of the recipient's need for medical care.

(b) No Medicaid payment may be made under a refund plan for that portion of cost for which a third party has been determined to be liable and reimbursement is forthcoming. An exception is

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Medicaid's agreement with Medicare on durable medical equipment processing.

(c) If a liability by an identified third party exists, the recipient shall be required to satisfy all conditions set forth by that third party to receive third party coverage, to the extent coverage is available, before Medicaid payment is allowed.

(d) When the existence or extent of third party liability is in question, medical assistance payments may be made:

- (1) In part, if the recipient has excess income and other assets; or
- (2) For the entire cost of the medical services, if the recipient assigns to the department in writing, the third party payment; provided that where third party policy prohibits assignment of payment, the recipient shall, in writing, agree to refund the department upon being paid by the third party. [Eff 10/26/01; am 02/07/05]
(Auth: OHRS §346-59) (Imp: 42 C.F.R. §§433.135 through 433.154, 447.20)

§17-1739.1-15 Timely claims payment. (a) The department shall pay ninety per cent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty days, and ninety-nine per cent of the clean claims within ninety days of the date of receipt.

(b) The department shall pay all other claims within twelve months of the date of receipt, except where:

- (1) Retroactive adjustments are paid to providers who are reimbursed under a retrospective payment system;
- (2) Claims are from providers under investigation for fraud or abuse; or
- (3) Payments are made in accordance with a court order, hearing decision, corrective action, or to extend benefits of these actions to others in the same situation as those directly affected.

(c) Prepayment and post-payment claims review shall be conducted for all claims to verify:

- (1) Eligibility and proper authorization of service;

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- (2) The number of visits and services for consistency with age, sex, and illness;
 - (3) That payment does not exceed reimbursement rates or limits; and
 - (4) Third party liability, if any.
- (d) Post-payment claims review shall meet the requirements dealing with fraud and utilization control.
- (e) The department shall provide any reports and documentation in compliance with this chapter and any conditions that the federal Centers for Medicare and Medicaid Services may require. [Eff 10/26/01; am 05/05/05] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.45)

§17-1739.1-16 Time limit for claims submittal and one year claim filing deadline waiver request.

(a) The provider shall submit all claims for payment within twelve months from providing care or services. No Medicaid payment shall be made for any claim submitted after this period except as allowed by subsections (c) and (d). For retroactive cases involving retroactive assistance, the twelve-month period for claim submittal shall start from the date of service or the date retroactive eligibility was determined, whichever is later. This subsection shall not apply to payment of deductibles and coinsurance for cases that are eligible for both Medicare and Medicaid in which the circumstances leading to a submittal of claim after twelve months are acceptable to Medicare's fiscal agent or carrier.

(b) In cases where the provider disputes the department's allowance or claim adjudication, a request for reconsideration of the payment amount or claim adjudication must be made within sixty days of the Medicaid payment or claim adjudication date. The Medicaid payment or claim adjudication date is the date on the remittance advice or the date on the explanation of benefit (EOB).

(c) A claim received after the twelve-month period shall only be accepted for consideration of payment if all of the following conditions are met:

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- (1) The department finds that the delay was caused by the provider's efforts to obtain coverage from Medicare or any other source or third party liability;
- (2) The provider filed a claim with Medicare or another source of third party liability on a timely basis, as determined by Medicare or the source of third party liability involved; and
- (3) The claim is received by the department or its Medicaid fiscal agent within six months of a final disposition of coverage by Medicare or the source of third party liability involved.

(d) In addition to the conditions stated in subsection (c), a claim for medical assistance payment that is received more than twelve months after the date of service by the department or its Medicaid fiscal agent, may, with the approval of the department, be accepted and processed in accordance with:

- (1) A court order;
- (2) An administrative hearing decision; or
- (3) As a corrective action to resolve a dispute.

The request shall be made in writing to the department and include a clear statement and documentation of the reason for the delayed filing of the claim.

(e) A request for payment of a claim that has been filed after the twelve-month deadline for claim submittal shall be made in writing to the department. The request shall include a clear statement and documentation of the reason(s) for the delayed filing of the claim.

(f) Providers may appeal the denial of a claim. [Eff 05/05/05] (Auth: HRS §346-59) (Imp: 42 C.F.R. §447.45)