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Elimination of Paper Claims FAQ

ATTENTION PROVIDERS: This Frequently Asked Question (FAQ) document has been developed to provide answers to commonly asked questions regarding Provider Bulletin PB16-31 - Elimination of Paper Claims Notification, which was recently published. This document is intended to assist providers, but is not an all-inclusive document. Further information may be found in Chapter 5, Chapter 8 and Chapter 11 of the Provider Manuals. The Provider Manual chapters may be accessed by going to www.ctdssmap.com: 1) select Information and then 2) Publications. If your question is not answered by reviewing these documents, please call the Provider Assistance Center at 1-800-842-8440.

FAQ

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Q: Are there are any exceptions to this requirement?

A: Yes. Claims submitted by Out-of-state (OOS) providers or claims submitted for an edit override, such as timely filing, can be submitted via a paper claim. Please note: with the exception of Medicare crossover claims and commercial insurance attachments needed to override timely filing, no other attachments are required.

Q: What is the electronic claim attachments process for this update?

A: CT Medicaid does not currently require a claim attachment to process an electronic claim.

Q: What is the process for appeals and corrected claims?

A: Adjusted claims should be submitted electronically. Please note that providers have one (1) year* from the date of the most recent remittance advice (RA) indicating a denial to resubmit the claim, provided the denial was not for timely filing to make an adjustment to increase units.

*Please note: Providers have 120 days to resubmit for HUSKY A and B Behavioral Health services.

If an adjustment to increase payment is made after the one (1) year deadline, then the entire claim will be denied for timely filing and the money will be recouped.

Claim adjustments resulting in a decreased payment can be made at any time regardless of the original paid date.

For instructions specific to Behavioral Health claims please see chapter 5 of the Provider Manuals.

Q: Does this apply to both participating and non-participating providers?

A: CT Medicaid only pays participating providers. Non-participating provider claims will be denied regardless of how the claim is submitted.

Q: What is the process for institutional and professional claims?

A: All claims must be submitted electronically. The instructions for claims can be found at www.ctdssmap.com in the Internet Claims Submission FAQ found here. Please see information regarding exceptions above.

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Q: Is re-enrollment required? Or enrollment for providers who have not enrolled in e-claims?

A: No, re-enrollment is not required to become an electronic biller. For information on electronic billing options, providers should review Provider Bulletin 2016-31. Additional resources can be found at www.ctdssmap.com in Provider Manuals Chapters 5, 6, 8 and 11, and at the Internet Claims Submission FAQ which can be found by going to 1) Publications, 2) Claims Processing Information and then 3) Internet Claims Submission FAQ.

Q: Is the payer ID staying the same?

A: There are no changes to the electronic claim submission process. For those exceptions, the billing address can be found in the applicable Provider Manual, Chapter 1.

Q: For providers who can still submit paper claims, what is the address they should be sent to?

A: The appropriate mailing address for each submission type can be found at www.ctdssmap.com in Chapter 1 of the Provider Manuals.

Q: Are tertiary claims going to be accepted on paper?

A: No, tertiary claims should be submitted electronically. For further information regarding tertiary claims, please review the Provider Manual, Chapter 11.

Q: What are your plans in regards to attachments (paper, fax, etc.)? Should these be mailed, faxed? What is the address/number this should be sent to?

A: CT Medicaid does not require any attachments to process an electronic claim.

B: Sterilization/hysterectomy consent forms do not need to be attached to the claim for processing and should be mailed separately to Hewlett Packard Enterprise.

Q: Do you accept the ANSI 275 attachment process?

A: CT Medicaid does not require any attachments to process an electronic claim.

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Q: What will happen if a paper claim is received at Hewlett Packard Enterprise on or after October 1, 2016?

A: The paper claim will be returned to the provider's billing address that was submitted on the claim.

Q: I currently submit paper claims, what are my options?

A: Providers are encouraged to check with their claim vendors in order to begin preparing for this transition by ensuring that all claims are submitted to Hewlett Packard Enterprise electronically, using the ASC X12N 837 Health Care Claim or through the Provider Secure Web Portal at www.ctdssmap.com.

Q: Will there be any training offered to providers?

A: Yes, Hewlett Packard Enterprise will offer a number of Refresher Provider Workshops and Web Claim Submission training sessions over the summer months. Invitations will be sent to providers as the dates become available. As always, providers are encouraged to check the Provider Training page to review what Provider Workshops are currently available for providers. To access the Provider Training page, please click on the following link:

Provider Training