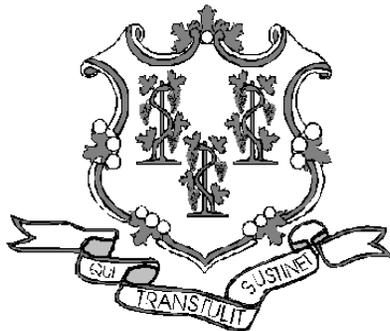


Behavioral Health Professional Refresher Workshop

Presented by
The Department of Social Services
& HP



Training Topics

- **Provider Bulletins**
- **Provider Fee Schedule**
- **Policy Changes**
- **Web Claim Inquiry**
- **Web Claim Submission**
- **Third Party Liability (TPL)**
- **Dual Eligible / Medicare Prime**
- **Frequent Claim Denials**
- **ICD-10**
- **Time for Questions**



Provider Bulletins

Provider Bulletins

- Access the Publications page via our Web site www.ctdssmap.com and select “Publications” from either the Information box on the left hand side of the home page or from the “Information” drop-down menu.
- The Bulletin Search menu allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type.
 - When searching by title, you can search by any word as long as that word is in the title of the bulletin.
- Searches by year and number are based on the Provider Bulletin number, not the policy transmittal number.



Provider Bulletins

Provider bulletin search by Year "14" and Number "29" to pull up a specific bulletin.

Home Information Provider Trading Partner Pharmacy Information

home publications links hipaa

Bulletin Search

Year 14 Provider Type

Number 29 Title

search

clear

Search Results

Bulletin Number	Title	Published Date
PB14-29	Newly Eligible Clients under the Affordable Care Act (Part III)	05/01/2014

- Provider bulletins numbers are located on the actual document.

 **Connecticut Department of Social Services**
Medical Assistance Program
www.ctdssmap.com

Provider Bulletin PB14-29
May 2014

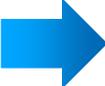
TO: All Providers

RE: Newly Eligible Clients under the Affordable Care Act (Part III)



Provider Bulletins

Provider bulletin search by Year "14" and Provider Type "Behavioral Health Clinician" to pull up all the bulletins for 2014 pertaining to Behavioral Health Clinicians and Psychologists.



Bulletin Search

Year Provider Type

Number Title

Search Results

Bulletin Number	Title	Published Date
PB14-45	Connecticut Medical Assistance Program Provider Satisfaction Survey	07/08/2014
PB14-39	Expansion of Coverage Provided by Licensed Behavioral Health Clinicians in Indep...	06/17/2014
PB14-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedul...	05/21/2014
PB14-35	Expedited Medicaid Eligibility Processing for Individuals with Medical Emergenci...	05/11/2014
PB14-29	Newly Eligible Clients under the Affordable Care Act (Part III)	05/01/2014
PB14-20	**Updated** Implementation of the ICD-10 Code Sets	04/13/2014
PB14-15	Newly Eligible Clients under the Affordable Care Act (Part II)	03/10/2014
PB14-02	Psychologist Fee Schedule Update	01/14/2014
PB14-01	Newly Eligible Clients under the Affordable Care Act	01/02/2014



Provider Bulletins

Provider Bulletin 2014-02 "Psychologist Fee Schedule Update"

- Effective for dates of service January 1, 2014 and forward, the Department of Social Services added Current Procedural Terminology (CPT) code 96116 to the psychologist fee schedule.
- Prior authorization is not required.
- To view the fee schedule, from the Web site www.ctdssmap.com go to "Provider", then to "Provider Fee Schedule Download", click on "I Accept" scroll to Psychologist and click on the PDF link.



Fee Schedule

- Prior authorization requirements and list of covered services and fee can be accessed under the fee schedule on the Web site at www.ctdssmap.com.
- Prior Authorization (PA) from the Connecticut Behavioral Health Partnership is required for these services.
- You can also refer to the Web site www.ctbhp.com for PA guidelines under “For Providers” and select covered services.
 - Under Authorization Schedule select your provider type based on Independent – Group Practitioners.
 - Independent-Group Practitioners – PhD, PsyD
 - Independent-Group Practitioners – LCSW, LMFT, LPC, LADC



Fee Schedule

- Psychologists fee schedule at www.ctdssmap.com



Procedure	Description	Mod1	Rate Type	Max Fee	Effective	End Date	PA
Psychologist							
For all HUSKY Health Benefit Plans T1016 is only payable for clients under							
the age of 19							
90785	PSYTX COMPLEX INTERACTIVE		DEF	3.13	1/1/2013	12/31/2299	Y
90791	PSYCHIATRIC DIAGNOSTIC EV		DEF	125.38	1/1/2013	12/31/2299	Y
90832	PSYTX PT&/FAMILY 30 MINUT		DEF	52.28	1/1/2013	12/31/2299	Y
90834	PSYTX PT&/FAMILY 45 MINUT		DEF	76.64	1/1/2013	12/31/2299	Y
90837	PSYTX PT&/FAMILY 60 MINUT		DEF	114.91	1/1/2013	12/31/2299	Y
90846	FAMILY PSYCHOTHERAPY (WIT		MPH	75.62	1/1/2012	12/31/2299	Y
90847	FAMILY PSYCHOTHERAPY (CON		MPH	93.16	1/1/2012	12/31/2299	Y
90849	MULTIPLE-FAMILY GROUP PSY		MPH	27.42	1/1/2012	12/31/2299	Y
90853	GROUP PSYCHOTHERAPY (OTHE		MPH	29.01	1/1/2012	12/31/2299	Y
90875	PSYCHOPHYSIOLOGICAL THERA		MPH	65.82	1/1/2012	12/31/2299	Y
90876	PSYCHOPHYSIOLOGICAL THERA		MPH	95.23	1/1/2012	12/31/2299	Y
90880	HYPNOTHERAPY		MPH	96.93	1/1/2012	12/31/2299	Y
90887	INTERPRETATION OR EXPLANA		MPH	69.95	1/1/2012	12/31/2299	Y
96101	Psycho testing by psych/p		MPH	75.05	1/1/2012	12/31/2299	Y
96105	ASSESSMENT OF APHASIA (IN		DEF	66.41	1/1/2008	12/31/2299	
96110	DEVELOPMENTAL SCREEN		MPH	15.3	1/1/2012	12/31/2299	
96111	DEVELOPMENTAL TEST EXTEND		MPH	74.15	1/1/2012	12/31/2299	
96116	Neurobehavioral status ex		DEF	51.56	1/1/2008	12/31/2299	
96118	Neuropsych tst by psych/p		MPH	98.12	1/1/2012	12/31/2299	Y
96150	ASSESS HLTH/BEHAVE INIT		DEF	12.29	1/1/2008	12/31/2299	
96151	ASSESS HLTH/BEHAVE SUBSEQ		DEF	11.91	1/1/2008	12/31/2299	
96152	INTERVENE HLTH/BEHAVE IND		DEF	11.3	1/1/2008	12/31/2299	
96153	INTERVENE HLTH/BEHAVE GRO		DEF	2.76	1/1/2008	12/31/2299	
96154	INTERV HLTH/BEHAV FAM W/P		DEF	11.11	1/1/2008	12/31/2299	
96155	FAMILY (WITHOUT THE PATIE		DEF	11.74	1/1/2008	12/31/2299	
99406	BEHAV CHNG SMOKING 3-10 M		MPH	6.43	1/1/2012	12/31/2299	
99407	BEHAV CHNG SMOKING > 10 M		MPH	17.56	1/1/2012	12/31/2299	
T1016	CASE MANAGEMENT; EACH 15		MPH	12.75	1/1/2012	12/31/2299	
Please contact Value Options at 1-877-552-8247 for all prior authorizations							
Codes 96150-96155 are payable only for non-behavioral health diagnoses (those							
not in the range 291-316)							
Procedure code 96116 payable effective 01/01/2014							



Fee Schedule

- From www.ctbhp.com Web site, select “For Providers”, then “Covered Services” then click on the link for CT BHP Proposed Fees/Rates.

The screenshot shows the VALUEOPTIONS CONNECTICUT website. The navigation menu on the left includes: Home, Provider Home, Bulletins, **Covered Services** (highlighted with a red arrow), Enhanced Care Clinics, Forms, Level of Care Guidelines, Provider Manual, Residential Care Team, Events/Trainings/Publications, Find a Provider, and Recovery. The main content area is titled 'Provider Covered Services' and contains two sections: 'Covered Services/Fees' and 'Authorization Schedule'. The 'Covered Services/Fees' section lists 'CT BHP Covered Services' (pointed to by a red arrow) and 'NEW: HUSKY B Client Cost-Share Services'. The 'Authorization Schedule' section lists various service providers, including 'Independent-Group Practitioners - PhD, PsyD' (pointed to by a red arrow).



Fee Schedule

- Behavioral Health Clinicians fee schedules
- Accessing Behavioral Health Clinicians fee schedule:
 - From the Web site www.ctdssmap.com go to “Provider”, then to “Provider Fee Schedule Download”, click on “I Accept” scroll to Behavioral Health Clinicians and click on the PDF link.
- Behavioral health clinicians can only bill for those services that are on their fee schedule and which they personally provide.



Fee Schedule

- Behavioral Health Clinicians fee schedules

Behavioral Health Clinician							
For all HUSKY Health Benefit Plans T1016 is only payable for clients under							
_____ the age of 19							
Procedure	Description	Mod1	Rate Type	Max Fee	Effective I	End Date	PA
90785	PSYTX COMPLEX INTERACTIVE		DEF	2.58	1/1/2013	12/31/2299	Y
90791	PSYCHIATRIC DIAGNOSTIC EV		DEF	103.25	1/1/2013	12/31/2299	Y
90832	PSYTX PT&/FAMILY 30 MINUT		DEF	43.06	1/1/2013	12/31/2299	Y
90834	PSYTX PT&/FAMILY 45 MINUT		DEF	63.12	1/1/2013	12/31/2299	Y
90837	PSYTX PT&/FAMILY 60 MINUT		DEF	94.63	1/1/2013	12/31/2299	Y
90846	FAMILY PSYCHOTHERAPY (WIT		MPH	62.28	1/1/2012	12/31/2299	Y
90847	FAMILY PSYCHOTHERAPY (CON		MPH	76.72	1/1/2012	12/31/2299	Y
90849	MULTIPLE-FAMILY GROUP PSY		MPH	22.58	1/1/2012	12/31/2299	Y
90853	GROUP PSYCHOTHERAPY (OTHE		MPH	23.89	1/1/2012	12/31/2299	Y
90875	PSYCHOPHYSIOLOGICAL THERA		MPH	54.2	1/1/2012	12/31/2299	Y
90876	PSYCHOPHYSIOLOGICAL THERA		MPH	78.43	1/1/2012	12/31/2299	Y
90880	HYPNOTHERAPY		MPH	79.83	1/1/2012	12/31/2299	Y
90887	INTERPRETATION OR EXPLANA		MPH	57.6	1/1/2012	12/31/2299	Y
96110	DEVELOPMENTAL SCREEN		MPH	12.6	1/1/2012	12/31/2299	
96111	DEVELOPMENTAL TEST EXTEND		MPH	61.06	1/1/2012	12/31/2299	
99406	BEHAV CHNG SMOKING 3-10 M		MPH	5.29	1/1/2012	12/31/2299	
99407	BEHAV CHNG SMOKING > 10 M		MPH	14.46	1/1/2012	12/31/2299	
T1016	CASE MANAGEMENT; EACH 15		MPH	10.5	1/1/2012	12/31/2299	
Please contact Value Options at 1-877-552-8247 for all prior authorizations							



Policy Change

- **Provider Bulletin 2014-39** "Expansion of Coverage Provided by Licensed Behavioral Health Clinicians in Independent Practice."
- Effective July 1, 2014, behavioral health assessment and treatment services provided by the following independent practitioners will be reimbursable for all HUSKY Health clients, regardless of the age of the client:
 - Licensed Psychologists
 - Licensed Clinical Social Workers (LCSWs)
 - Licensed Marital and Family Therapists (LMFTs)
 - Licensed Professional Counselors (LPCs)
 - Licensed Alcohol and Drug Counselors (LADCs)



Policy Change

- **Provider Bulletin 2014-39** "Expansion of Coverage Provided by Licensed Behavioral Health Clinicians in Independent Practice ."
- The policy change expands coverage for the HUSKY C and HUSKY D populations, who were previously able to obtain services from these independently practicing professionals only up to age 21.
- Targeted case management for children with a behavioral health disorder who are transitioning from an institutional setting, billed using CPT code T1016, remains available only for individuals under age 19.



Policy Change

Developmental and Behavioral Health Screens (CPT 96110)

- Please note while the Department encourages behavioral health clinicians, behavioral health clinics, psychiatrists and psychiatric APRNs to utilize the U3 and U4 modifiers, as applicable, use of the modifiers **is not** a requirement for claims submission and CPT code 96110 will not deny if U3 or U4 is not submitted.
- Modifier U3 should be used with CPT code 96110 when a developmental or BH screen results in a positive screen. Positive screens are defined based on the scoring criteria for the specific screening tool used.



Policy Change

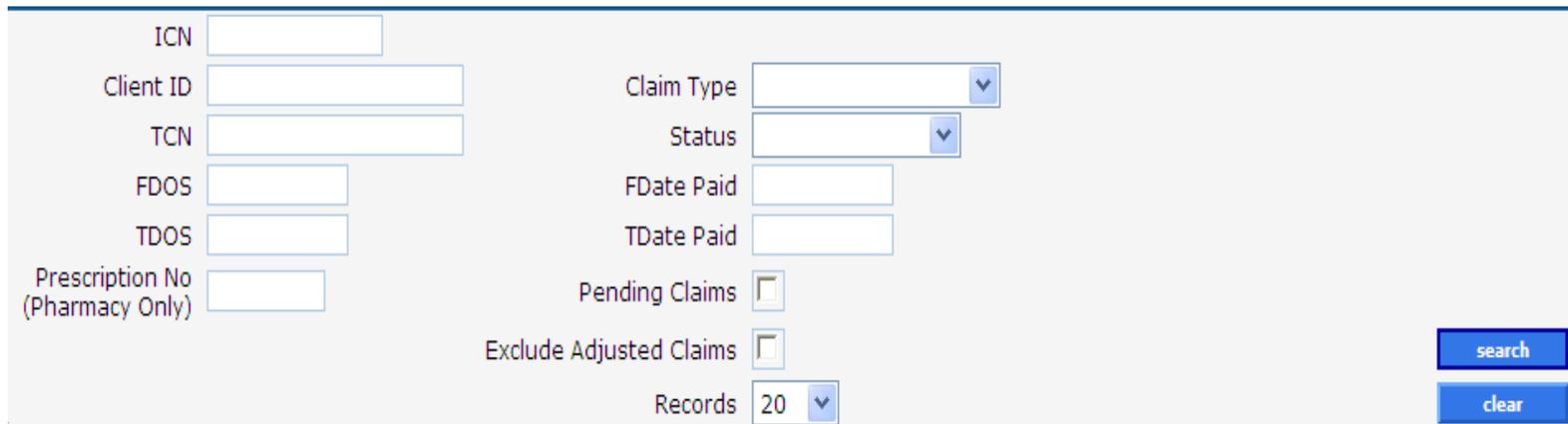
Developmental and Behavioral Health Screens (CPT 96110)

- Modifier U4 should be used with CPT code 96110 when a developmental or BH screen results in a negative screen. Negative screens are defined based on the scoring criteria for the specific screening tool used.
- The Department is implementing the use of modifiers U3 and U4 with CPT code 96110 in an effort to not only track the number of HUSKY Health members under the age of 18 who receive a developmental or BH screen in primary care settings, but to also track the number of positive versus negative screens and, when appropriate, subsequent referral for additional assessment or follow-up care.



Web Claim Inquiry

- At the claims menu select claims inquiry to view claims processed regardless of the submission method.
- Search by:
 - Internal Control Number (ICN)
 - Client ID and date of service (no greater range than 93 days)
 - Date of payment (no greater range than 93 days)
 - Pending claims



The screenshot shows a search form for claim inquiries. It includes several input fields and checkboxes. On the left side, there are fields for ICN, Client ID, TCN, FDOS, TDOS, and Prescription No (Pharmacy Only). On the right side, there are dropdown menus for Claim Type and Status, and input fields for FDate Paid and TDate Paid. Below these are checkboxes for Pending Claims and Exclude Adjusted Claims. At the bottom right, there is a dropdown for Records (set to 20) and two buttons labeled 'search' and 'clear'.



Web Claim Submission

Claim submission – Professional

Home Information Provider Trading Partner ConnPACE Pharmacy Information **Claims** Eligibility Prior Authorization Hospice Trade Files MAPIR Messages Account

home claim inquiry **professional** institutional dental

Quick Links

- [Internet Claims Submission FAQ](#)
- [Instructions for submitting Professional claims](#)
- [Claim Resolution Guide](#)

Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	008000008 MCD	To Date	<input type="text"/>
AVRS ID	008000008	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	<input type="text"/> \$0.00
First Name, MI	<input type="text"/>	Total Paid	<input type="text"/> \$0.00
Date of Birth	<input type="text"/>	TPL Amount	<input type="text"/> \$0.00
Patient Account #	<input type="text"/>	CoPay Amount	<input type="text"/> \$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	<input type="text"/> No
Referring Physician	<input type="text"/> [Search]	837 Version	<input type="text"/> 5010
Accident Related	<input type="text"/> No		
Accident Date	<input type="text"/>		

Accident Related Causes

Auto Accident Another Party Responsible Employment Related Other Accident



Web Claim Submission

Claim submission – Professional (Cont.)

Diagnosis								
Diag-Sequence	Diagnosis	Description						
Code Set	ICD 9							
Principal	<input type="text"/>	[Search]	Other 1	<input type="text"/>	[Search]	Other 2	<input type="text"/>	[Search]
Other 3	<input type="text"/>	[Search]	Other 4	<input type="text"/>	[Search]	Other 5	<input type="text"/>	[Search]
Other 6	<input type="text"/>	[Search]	Other 7	<input type="text"/>	[Search]	Other 8	<input type="text"/>	[Search]
add more								

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1			1.00	\$0.00		\$0.00

Type data below for new record.

Item	<input type="text" value="1"/>	Status	<input type="text"/>
From DOS*	<input type="text"/>	Emergency Indicator	No
To DOS*	<input type="text"/>	Pregnancy	Not pregnancy Related
Procedure*	<input type="text"/> [Search]	EPSDT Referral	None
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	No
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	\$0.00
Units*	<input type="text" value="1.00"/>	CoPay Amount	\$0.00
Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	<input type="text" value="\$0.00"/>	Medicare Calc Allowed Amt	\$0.00
Rendering Physician	<input type="text"/>	Medicare Paid Amount	\$0.00
Diagnosis Code Pointer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Medicare Deductible Amount	\$0.00
National Drug Code	<input type="text"/>	Medicare Coinsurance Amount	\$0.00
NDC Quantity	<input type="text" value="0"/>		
NDC Unit of Measurement	<input type="text"/>		

[delete](#) [add](#)



Web Claim Submission

- Provider must bill using modifiers identified in Provider Bulletin 2005-79 on all claims for all client coverage groups.

Provider Type / Specialty	Modifier
License Clinical Social Worker (LCSW)	AJ
Licensed Marital and Family Therapists (LFMT)	HO
Licensed Professional Counselors (LPC)	HO
Licensed Alcohol and Drug Counselors (LADC)	HO
Psychologists	N/A



Web Claim Submission - TPL

- Medicaid is the Payer of last resort. The three digit Carrier Code of the Other Insurance (OI) is required to be submitted on the claim when OI is primary.
 - The three digit code can be found on the client eligibility verification screen under TPL.
 - It can also be found on the claim submission screen under the TPL panel in the “[Client Carriers](#)” field.
- Other Insurance billing guides are located Web site www.ctdssmap.com; under publications, scroll to provider manual chapter 11 and select “Professional Other Insurance/Medicare Billing Guide”.



Web Claim Submission - TPL

- TPL payment of \$100.00 from carrier code 060 with a paid date of 07/01/2014.

TPL									
Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
A 060	BC/BS OF CONNECTICUT		\$0.00						

Type data below for new record.

Client Carriers

Carrier Code* [Search] Relationship

Plan Name Last Name

Policy Number First Name, MI

Paid Amount* Date of Birth

Paid Date*

Adjustment Reason Code [Search] [Search] [Search]

Adjustment Amount



Dual Eligible / Medicare Prime

- Dual Eligible is when a client is eligible for Medicare and Medicaid. Medicaid is always the payer of last resort and claims must be submitted to Medicare first for Medicare eligible services.
- Medicare refers to traditional Medicare and Medicare HMOs.
- As of July 1, 2014 behavioral health clinicians claims will now be considered for reimbursement even if the behavioral health clinician cannot enroll in Medicare.
- If Medicare is prime and makes a payment we will pay co-insurance and/or deductible up to your Medicaid rate. If Medicare's payment is greater than or equal to your Medicaid rate, Medicaid will pay zero.



Web Claim Submission – Medicare Payment

- To indicate a Medicare payment, the Medicare Crossover field on the Professional Claim panel must indicate Yes.
- Each claim detail must contain the following:
 - Medicare Paid Date
 - Medicare Calculated Allowed Amount
 - Medicare Paid Amount
 - If Medicare allows services, but pays zero enter \$0.00
 - Medicare Deductible Amount
 - Medicare Coinsurance Amount



Web Claim Submission – Medicare Payment

Home Information Provider Trading Partner Pharmacy Information **Claims** Eligibility Prior Authorization Hospice Trade Files MAPIR Messages Account

home claim inquiry **professional** institutional dental claim history for specific services

Quick Links

- [Internet Claims Submission FAQ](#)
- [Instructions for submitting Professional claims](#)
- [Claim Resolution Guide](#)

Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	008000008 MCD	To Date	<input type="text"/>
AVRS ID	008000008	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	<input type="text"/> \$0.00
First Name, MI	<input type="text"/>	Total Paid	<input type="text"/> \$0.00
Date of Birth	<input type="text"/>	TPL Amount	<input type="text"/> \$0.00
Patient Account #	<input type="text"/>	CoPay Amount	<input type="text"/> \$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	Yes <input type="text"/> 
Referring Physician	<input type="text"/> [Search]	837 Version	5010 <input type="text"/>
Accident Related	No <input type="text"/>		
Accident Date	<input type="text"/>		



Web Claim Submission – Medicare Payment

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1	07/14/2014	07/14/2014	90834	1.00	\$100.00	\$0.00

Type data below for new record.

Item	<input type="text" value="1"/>	Status	<input type="text"/>
From DOS*	<input type="text" value="07/01/2014"/>	Emergency Indicator	<input type="text" value="No"/>
To DOS*	<input type="text" value="07/01/2014"/>	Pregnancy	<input type="text" value="Not pregnancy Related"/>
Procedure*	<input type="text" value="90834"/> [Search]	EPSDT Referral	<input type="text" value="None"/>
Modifiers	<input type="text" value="AJ"/> [Search] <input type="text"/> [Search]	Family Planning	<input type="text" value="No"/>
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	<input type="text" value="\$0.00"/>
Units*	<input type="text" value="1.00"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Facility Type Code*	<input type="text" value="11"/> [Search]	Medicare Paid Date*	<input type="text" value="07/14/2014"/>
Charges*	<input type="text" value="\$100.00"/>	Medicare Calc Allowed Amt	<input type="text" value="\$75.00"/>
Rendering Physician	<input type="text" value="123456789"/> [Search]	Medicare Paid Amount	<input type="text" value="\$50.00"/>
Referring Provider	<input type="text"/> [Search]	Medicare Deductible Amount	<input type="text" value="\$10.00"/>
Ordering Provider	<input type="text"/> [Search]	Medicare Coinsurance Amount	<input type="text" value="\$15.00"/>
Diagnosis Code Pointer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
National Drug Code	<input type="text"/>		
NDC Quantity	<input type="text" value="0"/>		
NDC Unit of Measurement	<input type="text"/>		

delete add



Dual Eligible / Medicare Prime

- If Medicare does not cover services due to the fact that behavioral health clinicians cannot enroll in Medicare, Medicaid will still consider your claim for processing.
- If the provider cannot get a denial Explanation of Medicare Benefits (EOMB), the provider should receive a letter from Medicare/CMS stating they are not eligible to enroll in Medicare and letter must be dated within one year from the date of service on the claim.
- To request this letter, providers must submit a request in writing to National Government Services (NGS) at PO Box 7052, Indianapolis, Indiana 46207-7052.



Dual Eligible / Medicare Prime

- In lieu of the Medicare 'Not Eligible To Enroll' denial letters for behavioral health clinicians providers requested through NGS, providers may submit a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation.
- The list is documented in the Medicare Provider Integrity Manual, Publication # 100-8, under Chapter 15, Section 15.4.8 which is located on the CMS Web site, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf>.
 - A copy of this page must be stored in the client's file for audit purposes and does not need to be submitted with the claim to HP.



Web claim submission – Medicare Denial

- To indicate a Medicare denial, the Medicare Crossover field on the Professional Claim panel must indicate No.
- The TPL panel must contain the following:
 - Enter MPB for Medicare Part B in the Carrier Code field.
 - Zero should remain in the Paid Amount field.
 - In the Paid Date field enter one of the following:
 - Enter the Medicare denial date.
 - Date of the Medicare letter.
 - The print date of the Medicare CMS Web page documenting the list of provider not eligible.



Web claim submission – Medicare Denial

Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	008000008 MCD	To Date	<input type="text"/>
AVRS ID	008000008	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	\$0.00
First Name, MI	<input type="text"/>	Total Paid	\$0.00
Date of Birth	<input type="text"/>	TPL Amount	\$0.00
Patient Account #	<input type="text"/>	CoPay Amount	\$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	No <input type="text"/>
Referring Physician	<input type="text"/> [Search]	837 Version	5010 <input type="text"/>
Accident Related	No <input type="text"/>		
Accident Date	<input type="text"/>		



Web claim submission – Medicare Denial

TPL									
Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
A	MPB	MEDICARE PART B	\$0.00						

Type data below for new record.

Client Carriers	Other ▾	Relationship	<input type="text"/>
Carrier Code*	MPB [Search]	Last Name	<input type="text"/>
Plan Name	MEDICARE PART B	First Name, MI	<input type="text"/>
Policy Number	<input type="text"/>	Date of Birth	<input type="text"/>
Paid Amount*	\$0.00		
Paid Date*	07/14/2014		

Adjustment Reason Code [Search] [Search] [Search]

Adjustment Amount \$0.00 \$0.00 \$0.00



Most Frequent Claim Denials

- **EOB 4801** "Procedure not covered. Check: Prior Authorization, FTC, Referring Provider, Quantity Restrictions."
- Cause
 - The procedure billed is not permitted to be paid to the billing provider on the date of service.
- Resolution
 - If the procedure billed is not a covered procedure on the provider's fee schedule for the date of service, the service is not payable.
 - If the procedure billed is present on the provider's fee schedule, contact the Provider Assistance Center to request an update to the procedure code in question.



Most Frequent Claim Denials

- **EOB 4140** "The Services Submitted are not Covered Under the Client's Benefit Plan" and **EOB 4250** "No Reimbursement Rule for the Associated Provider Type/Provider Specialty."
- The provider should verify client eligibility to determine if services are covered for their provider type and specialty.
- If the services are covered under client's benefit plan, client eligibility could have been updated at some point.
 - Providers should re-submit the claim for processing.
 - If the claim still denies, the provider will need to contact the Provider Assistance Center (PAC) to review the claim.



ICD-10

ICD-10 Changes Delayed

- On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9 through September 30, 2015.
- DSM diagnosis codes will not be accepted for dates of services on or after October 1, 2015. All providers must use ICD-10 codes on their claims.



ICD-10

ICD-10 Consists of Two Parts:

- ICD-10-CM: The clinical modification diagnosis classification system was developed by the World Health Organization (WHO) and the National Center for Healthcare Statistics (NCHS) for use in all U.S. health care treatment settings. (The CM codes increase from 13,000 to 68,000-plus in the ICD-10-CM code set.)
- ICD-10 codes must be used on all HIPAA transactions professional claims with dates of service (DOS) on or after the ICD-10 implementation date.
- On **October 1, 2015** the ICD-9 code set used to report medical diagnosis will be replaced by ICD-10 code sets.



ICD-10

ICD-10 Changes Delayed

- The transition to ICD-10 is required for all providers, payers and vendors.
- Do make it a point to refer to the **ICD-10 Implementation Information Important Message** from the home page of our Web site www.ctdssmap.com frequently to keep abreast with the most recent ICD-10 developments.



Training Session Wrap Up

- Where to go for more information:
 - www.ctdssmap.com
 - www.ctbhp.com
- For questions on authorizations and the authorization processing contact:
 - Value Options 1-877-552-8247
- For questions on claim and enrollment questions you can contact:
 - HP Provider Assistance Center (PAC) 1-800-842-8440
Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays.



Time for Questions

Questions & Answers

