

Behavioral Health Professional Refresher Workshop

Presented by

The Department of Social Services
& HP for Billing Providers



Training Topics

- **Client Eligibility**
- **Automated Voice Response System Updates**
- **Web Claim Inquiry**
- **Web Claim Submission**
- **Third Party Liability Update Procedures**
- **Timely Filing Guidelines**
- **HUSKY B Co-pays**
- **Most Frequent Claim Denials**
- **Questions**



Client Eligibility Verification

Valid Search Combinations

- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text" value="STAMP"/>	From DOS*	<input type="text" value="11/19/2009"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="POSTAGE"/>	<input type="text"/>	To DOS* <input type="text" value="11/19/2009"/>
Birth Date	<input type="text" value="10/10/1950"/>				
					<input type="button" value="search"/>
					<input type="button" value="clear"/>

Client Eligibility Reference Guide

- To access the Client Eligibility Reference Guide, the following steps apply:
 1. Go to the Public Web site at www.ctdssmap.com, navigate to the Information page and select Publications on the drop down.
 2. Scroll down the Information page to the Claims Processing Information Panel.
 3. Select the Eligibility Response Quick Reference Guide.

Client Eligibility Reference Guide

- Client Eligibility Responses:
 - Client Population
 - Program Benefits
 - Prior Authorization Request
 - Claims

Automated Voice Response System (AVRS)

Provider Assistance Center (PAC) Menu Options

1. Self Service Option
 - AVRS ID and Personal Identification Number (PIN)
 - Self Service Menu Options
2. Claim & Enrollment Assistance
 - Assistance Menu Options
3. Technical Assistance
 - Technical Menu Options

PB 10-43 – Upcoming Changes to the Automated Voice Response System Menu Options - Provides a list of the options under each menu selection.

Claim Inquiry

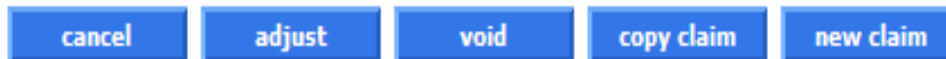
- View claims processed regardless of the submission method
- Search by:
 - Internal Control Number (ICN)
 - Client ID and date of service (no greater range than 93 days)
 - Date of payment (no greater range than 93 days)
 - Pending claims
 - Exclude adjusted claims
- Records – allows view of up to 100 claims per page

ICN	<input type="text"/>	Claim Type	<input type="text"/>
Client ID	<input type="text"/>	Status	<input type="text"/>
TCN	<input type="text"/>	FDate Paid	<input type="text"/>
FDOS	<input type="text"/>	TDate Paid	<input type="text"/>
TDOS	<input type="text"/>	Pending Claims	<input type="checkbox"/>
Prescription No (Pharmacy Only)	<input type="text"/>	Exclude Adjusted Claims	<input type="checkbox"/>
		Records	20 <input type="text"/>
			<input type="button" value="search"/>
			<input type="button" value="clear"/>

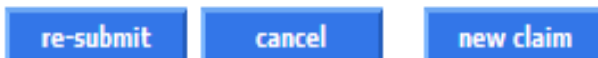
Claim Inquiry Search Results

Web Claim function buttons

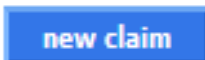
Paid claim



Denied claim



Suspended claim




Web Claim Submission

- Submit claims to HP directly from their secure Provider Web site.
- Receive immediate response
 - Pay
 - Deny
 - Suspend
- At the claims menu select the type of claim you wish to submit from the dropdown
 - Professional
 - Institutional
 - Dental



Web Claim Submission



**CONNECTICUT DEPARTMENT
OF SOCIAL SERVICES**
-- Caring for Connecticut --

Help
Friday, July 02, 2010

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

home claim inquiry **professional** institutional dental

Quick Links

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

Professional Claim

Billing Information	Service Information
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"/>	
Last Name <input type="text"/>	
First Name, MI <input type="text"/>	
Date of Birth <input type="text"/>	Total Charges <input type="text"/> \$0.00
Patient Account # <input type="text"/>	Total Paid <input type="text"/> \$0.00
Referring Physician <input type="text"/> [Search]	TPL Amount <input type="text"/> \$0.00
Accident Related <input type="text" value="No"/>	CoPay Amount <input type="text"/> \$0.00
Accident Date <input type="text"/>	Medicare Crossover <input type="text" value="No"/>

Accident Related Causes

- Auto Accident ☐
- Another Party Responsible ☐
- Employment Related ☐
- Other Accident ☐

Web Claim Submission

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	No <input type="button" value="v"/>
To DOS*	<input type="text"/>	Pregnancy	Not pregnancy Related <input type="button" value="v"/>
Procedure*	<input type="text"/> [Search]	EPSDT Referral	None <input type="button" value="v"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	No <input type="button" value="v"/>
	<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"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	<input type="text" value="\$0.00"/>	Medicare Allowed Amount	<input type="text" value="\$0.00"/>
Rendering Physician	<input type="text"/> [Search]	Medicare Paid Amount	<input type="text" value="\$0.00"/>
Diagnosis Code Pointer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Medicare Deductible Amount	<input type="text" value="\$0.00"/>
National Drug Code	<input type="text"/>	Medicare Coinsurance Amount	<input type="text" value="\$0.00"/>
NDC Quantity	<input type="text" value="0"/>		
NDC Unit of Measurement	<input type="text"/>		

Web Claim Submission

Claim Status Information

Claim Status PAID

Claim ICN 2210182600002

Paid Date 07/01/2010

Paid Amount \$83.26

Applied Income \$0.00

Client Contribution \$0.00

Charter Oak Coinsurance \$0.00

Charter Oak Deductible \$0.00

EOB Information

Detail Number	Code	Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
1	9001	REIMBURSEMENT REDUCED BY THE CLIENT'S CO-PAYMENT AMOUNT.

cancel

adjust

void

copy claim

new claim

Third Party Liability

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. You can find the Carrier Code:

- Client eligibility verification through the Provider secure Web site www.ctdssmap.com; refer to example 1.



Third Party Liability

Example 1:

[Home](#) [Information](#) [Provider](#) [Trading Partner](#) [ConnPACE](#) [Pharmacy Information](#) [Claims](#) [Eligibility](#) [Prior Authorization](#) [Trade Files](#) [Messages](#) [Account](#)

Valid Search Combinations

- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date

Eligibility Verification Request

Client ID Last Name From DOS* 07/09/2010
SSN First Name, MI To DOS* 07/09/2010
Birth Date

searchclear

Eligibility Verification Response

Verification Number 1019000SYM
Response Text Client is eligible

Client Information

Client ID Last Name
SSN ###-##-#### First Name, MI
Birth Date
Gender M

Benefit Plan

Service Information	Effective Date	End Date
Katie Becket Waiver	07/09/2010	07/09/2010
Medicaid Services	07/09/2010	07/09/2010

TPL

Carrier Code	Carrier Name	Policy Number	Policy Holder	Coverage Type	Effective Date	End Date
892	BC/BS OF ILLINOIS			Long Term Care	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Dr-Anesthesia	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Dr-Diagnosis X-Ray and Laboratory	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Hospitalization Inpatient	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Dr-Surgical	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Dr-Major Medical	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Hospital Outpatient	07/09/2010	07/09/2010
892	BC/BS OF ILLINOIS			Dr-Physician	07/09/2010	07/09/2010

Managed Care Provider

*** No rows found ***

Lockin


*** No rows found ***

Medicare

*** No rows found ***

CT interChange MMIS

/// 14



Third Party Liability cont.

Additional ways to find the carrier code:

- Verify eligibility via Automated Voice Response System
Toll free 1–800–842-8440 or locally in the Farmington, CT area at (860) 269-2028.
- From the Web site www.ctdssmap.com, click on Information → Publications → Carrier Listing under Chapter 5 of the Provider Manual.

Third Party Liability Update

To correct or update Third Party Liability (TPL) information:

- Obtain TPL forms
 - Print out form located on Web site at www.ctdssmap.com under Information → Publications → Forms → Other Forms → TPL Information Form.
 - Call Health Management System, Inc. (HMS) 1-866-277-4271. HMS staff will mail or fax the form to the provider.
 - E-mail request to ctinsurance@hms.com and form will be e-mailed back to provider.
- Submit completed forms
 - Mail to HMS
 - Fax to HMS with HIPAA compliant letter to 1-214-560-3932
 - Scan completed forms and submit through e-mail to ctinsurance@hms.com



Third Party Liability Update cont.

To correct or update Third Party Liability (TPL) information:

HMS contacts the provider either by telephone or in writing with the results within 45 days of receipt of the TPL information.

If providers are having difficulties with this process or want to suggest changes to this process, they may supply this information by e-mail at quality.dss@ct.gov or mail to:

Department of Social Services
Division of Fraud and Recoveries
25 Sigourney Street
Hartford, CT 06106-5033



Timely Filing Requirements

Previously claims that denied for timely filing Explanation of Benefits (EOB) codes 555 "Claim is past behavioral health timely filing guidelines" needed to be submitted on paper with attachments to support a timely filing override.

Providers may now submit claims with dates of service over 120 days (CTBHP) electronically, using Web claim submission or on paper without attachments.

Timely Filing Requirements cont.

Connecticut Behavioral Health Partnership (CTBHP) Claims will bypass timely filing EOB 555 "Claim is past behavioral health timely filing guidelines."

- Original claim:
 - Detail through dates of service on the claim is within 120 days prior to the ICN Julian date.
- Claim History:
 - Adjudicated claim for same client, provider, billed amount, detail from and through date of service, Procedure code where the ICN Julian date on the current claim is less than or equal to 120 days from the previous claims Remittance Advice date and the previous claim did not deny for timely filing.

HUSKY B Co-pays

Covered Services Table list is available on CT Medical Assistance Program Web site or CT Behavioral Health Partnership (CT BHP) Web site.

- CT Medical Assistance Program Web Site.
 - www.ctdssmap.com, select provider,
 - Select Provider Fee Schedule Download,
 - Accept disclaimer, click “I Accept” button,
 - Click Behavioral Health Partnership PDF format,
 - Scroll to page 17 of the fee schedule; Exhibit D-Covered Services Table list the codes that will apply a co-pay.

HUSKY B Co-pays

- CT Behavioral Health Partnership (CT BHP) Web site.
 - www.ctbhp.com select For Providers,
 - Scroll down and select Covered Services/Fees,
 - Click on HUSKY B Client Cost-Share Services link.

EOB 9001 “Reimbursement reduced by the client’s co-payment amount” will post to your claims to identify Co-Pay amounts for HUSKY B clients.



Most Frequent Claim Denials

- EOB 2017 “Service is included in MCO coverage”

Claims should be verified to determine if they should be processed by HP or the MCO (Managed Care Organization).

- Verify client eligibility to determine if client is enrolled in a managed care organization.
 - If yes, and it is a medical claim, submit the claim to the client’s MCO.
 - If yes, and it is a behavioral health claim, you will need to resolve any Prior Authorization requirements. Once Prior Authorization is in place, EOB 2017 may also be corrected at the same time.
 - If no, client eligibility could have been updated at some point. Re-submit the claim to the appropriate responsible party according to the client eligibility reference guide.

Most Frequent Claim Denials

- EOB 3003 "Prior Authorization is Required for Payment of this Service."
 - Providers need to check the PA inquiry on the Web site to verify if there is an Authorization on file.
 - If Prior Authorization is not on our Web site, you might need to contact CTBHP.
 - If Prior Authorization is on the provider secure Web site:
 - Verify the Prior Authorization effective and end dates with the dates of service being billed.

Most Frequent Claim Denials

- EOB 2504 “Bill private carrier first”
 - The provider should verify client eligibility to identify the client’s Third Party Liability (TPL) coverage through the secure Web site at www.ctdssmap.com.
 - If the client has other insurance, the provider needs to submit to the primary carrier first and then to Medicaid as the secondary carrier.
 - If the claim was submitted to the primary carrier, the claim to HP must contain the same other insurance carrier code as returned in the client eligibility response, the amount paid, if any and the date the other insurance paid/denied the claim.

Most Frequent Claim Denials

- EOB 4140 "The Services Submitted is 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 provider type and specialty.
- If 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 or verify by calling the provider assistance center (PAC).



Training Session Wrap Up

- Where to go for more information
www.ctdssmap.com
- HP Provider Assistance Center (PAC):
Monday through Friday, 8 a.m. to 5 p.m.
(EST), excluding holidays:
1-800-842-8440 (in-state toll free)
(860) 269-2028 (local to Farmington, CT)



Time for Questions

- Questions & Answers

