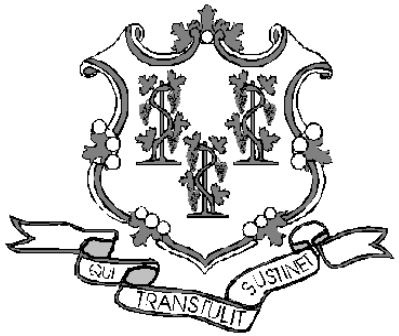
Connecticut Department of Social Services

Caring for Connecticut



Behavioral Health Professional Refresher Workshop

Presented by

The Department of Social Services

& HP for Billing Providers

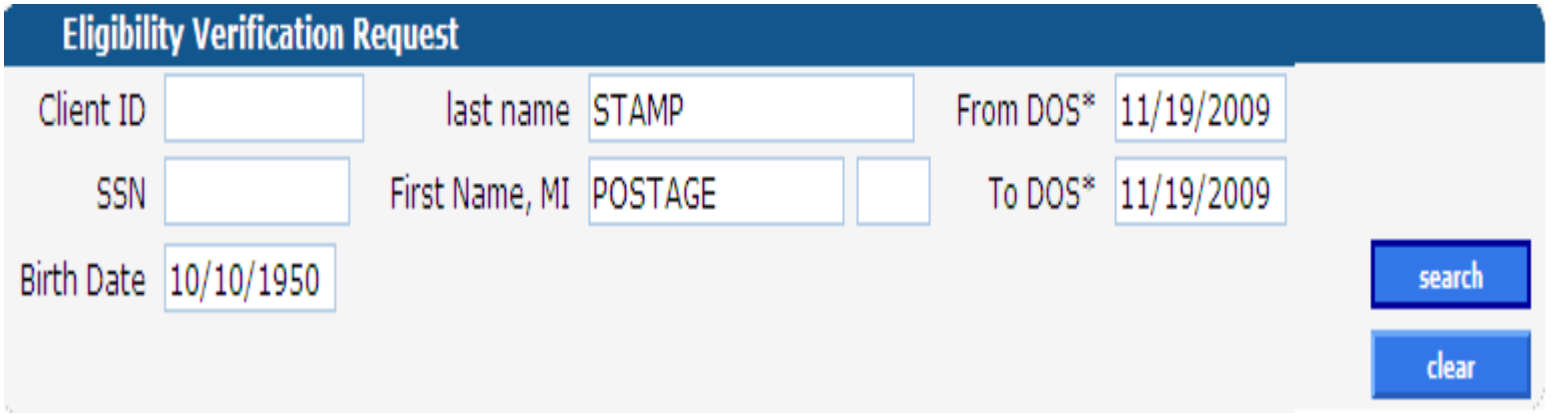
Training Topics

- **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



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

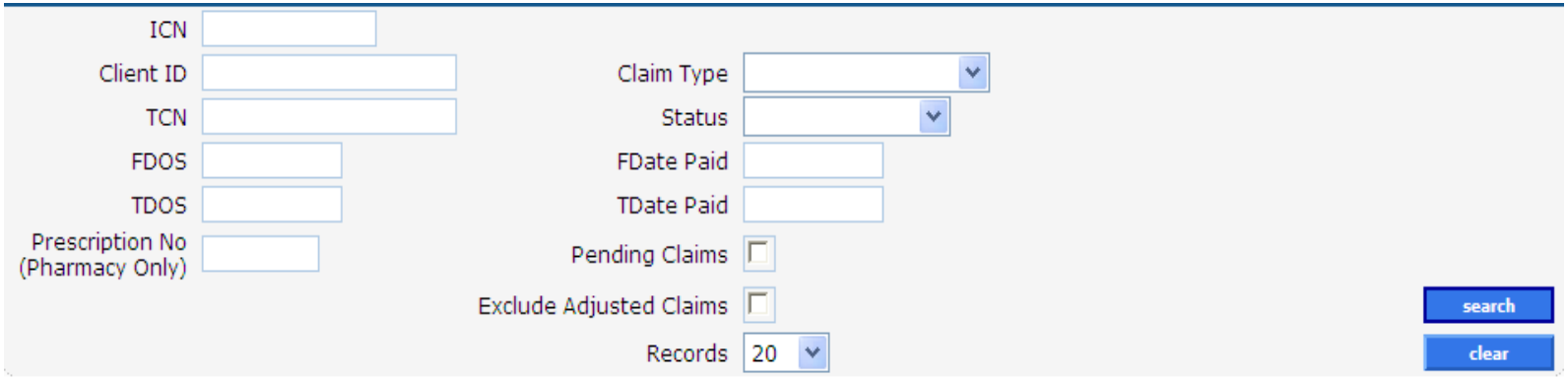
PB 10-43 – Upcoming Changes to the Automated Voice Response System Menu Options - Provides a list of the options under each menu selection.

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



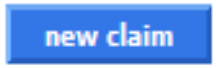
Claim Inquiry Search Results

Web Claim function buttons

Paid claim

Denied claim

Suspended claim



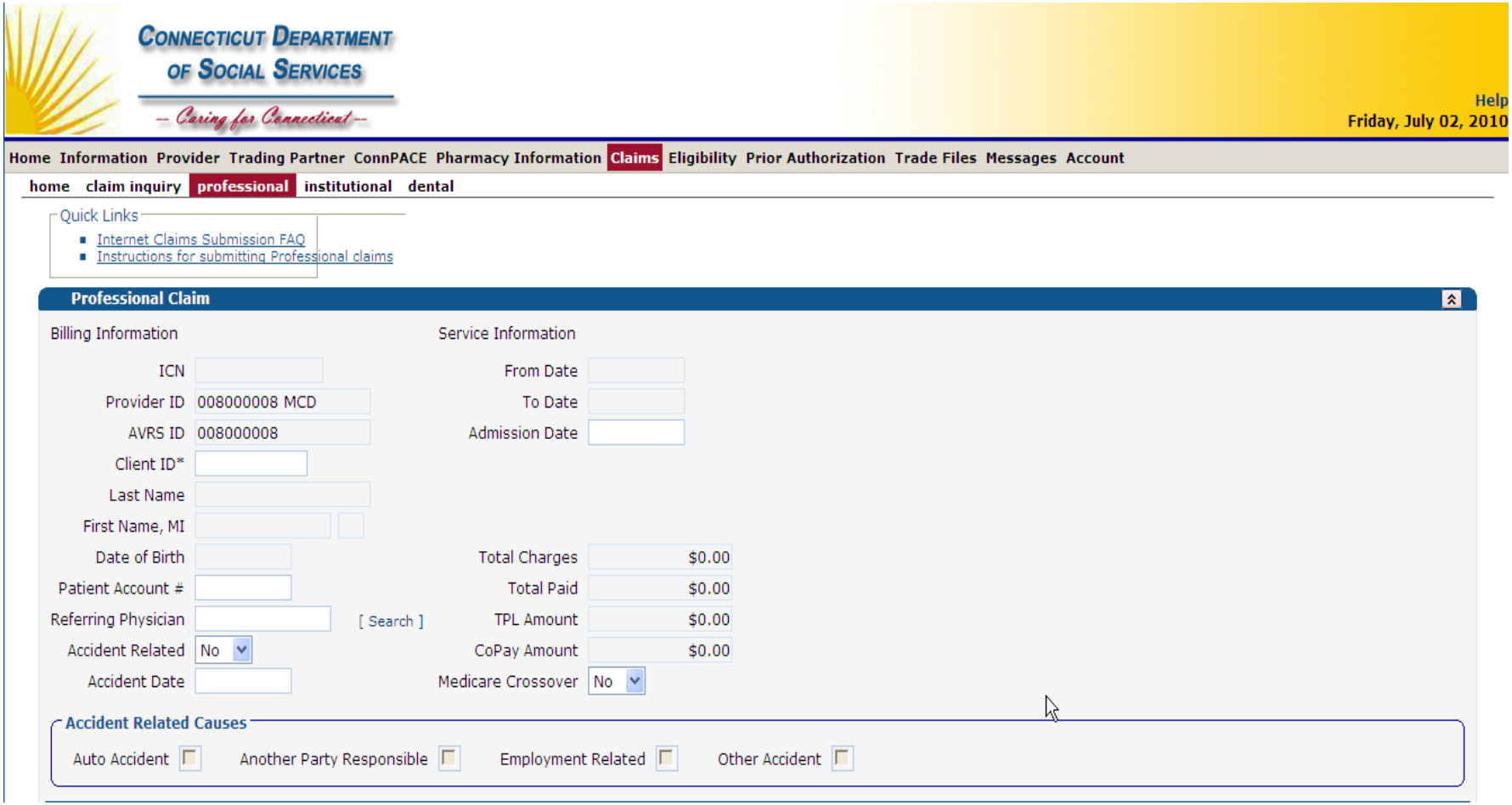
Web Claim Submission

- Submit claims to HP directly from their secure Provider Web site.

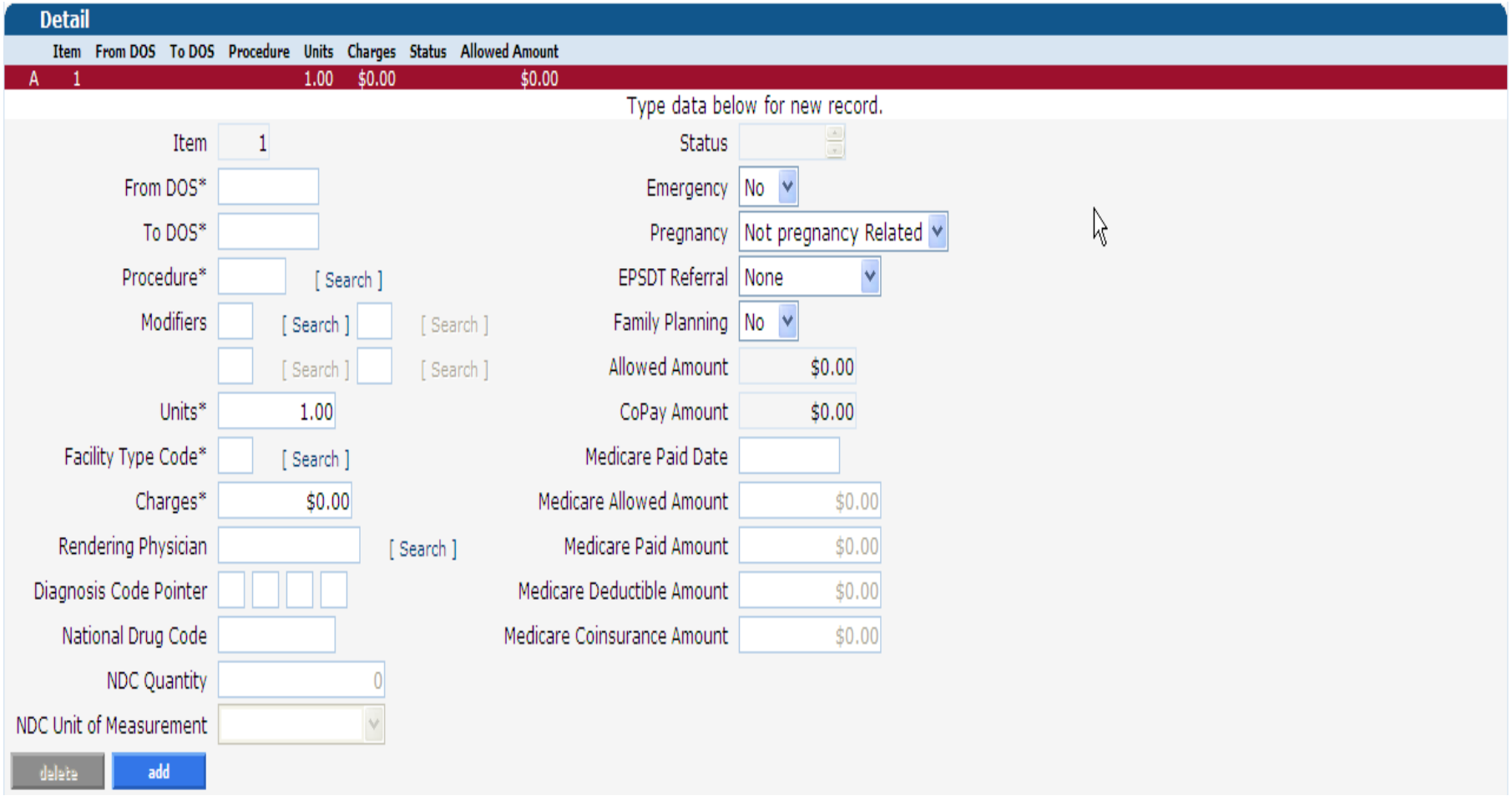
- Receive immediate response
  - Pay
  - Deny
  - Suspend

- At the claims menu select the type of claim you wish to submit from the dropdown
  - Professional
  - Institutional
  - Dental

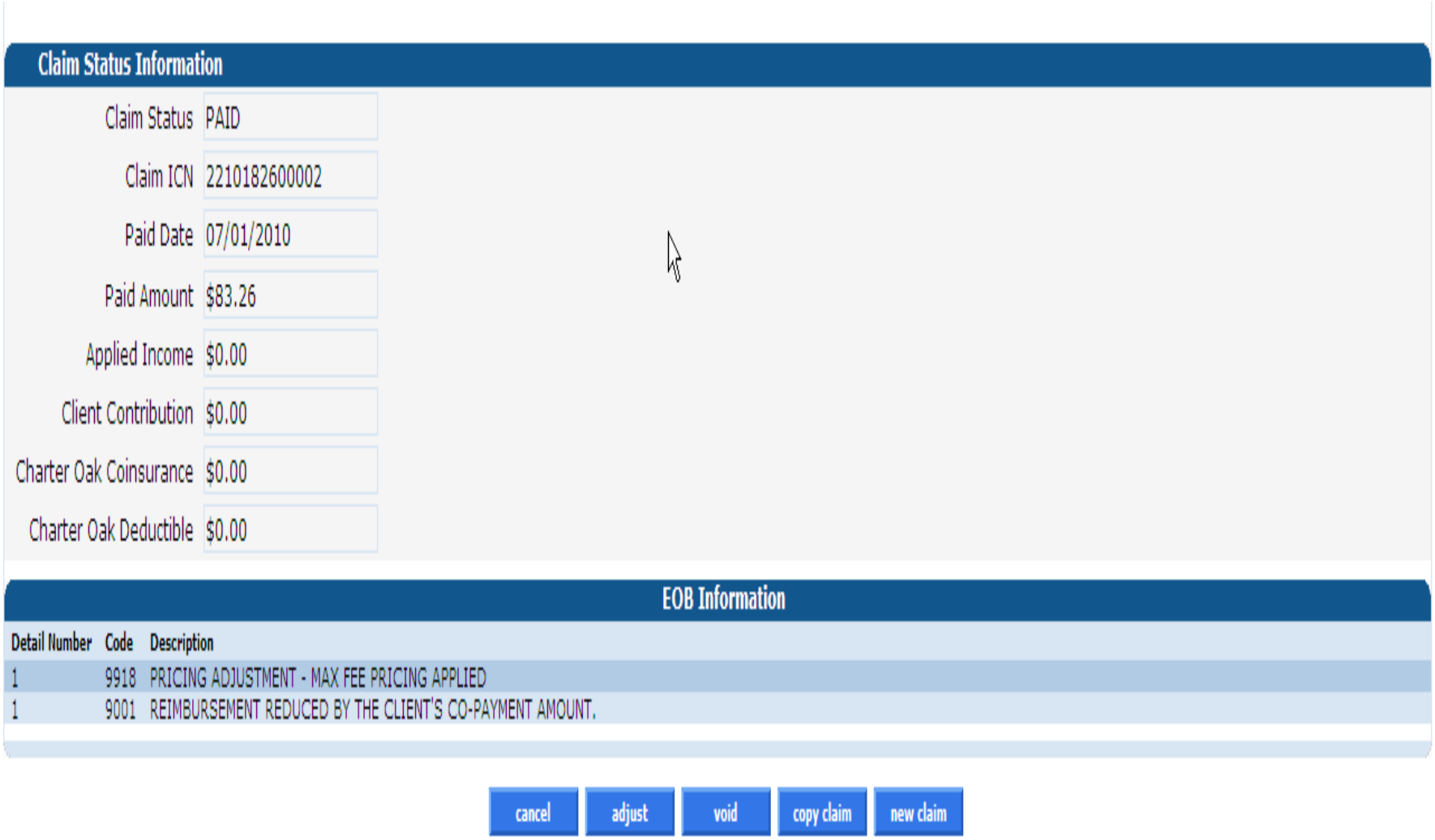
Web Claim Submission



Web Claim Submission



Web Claim Submission



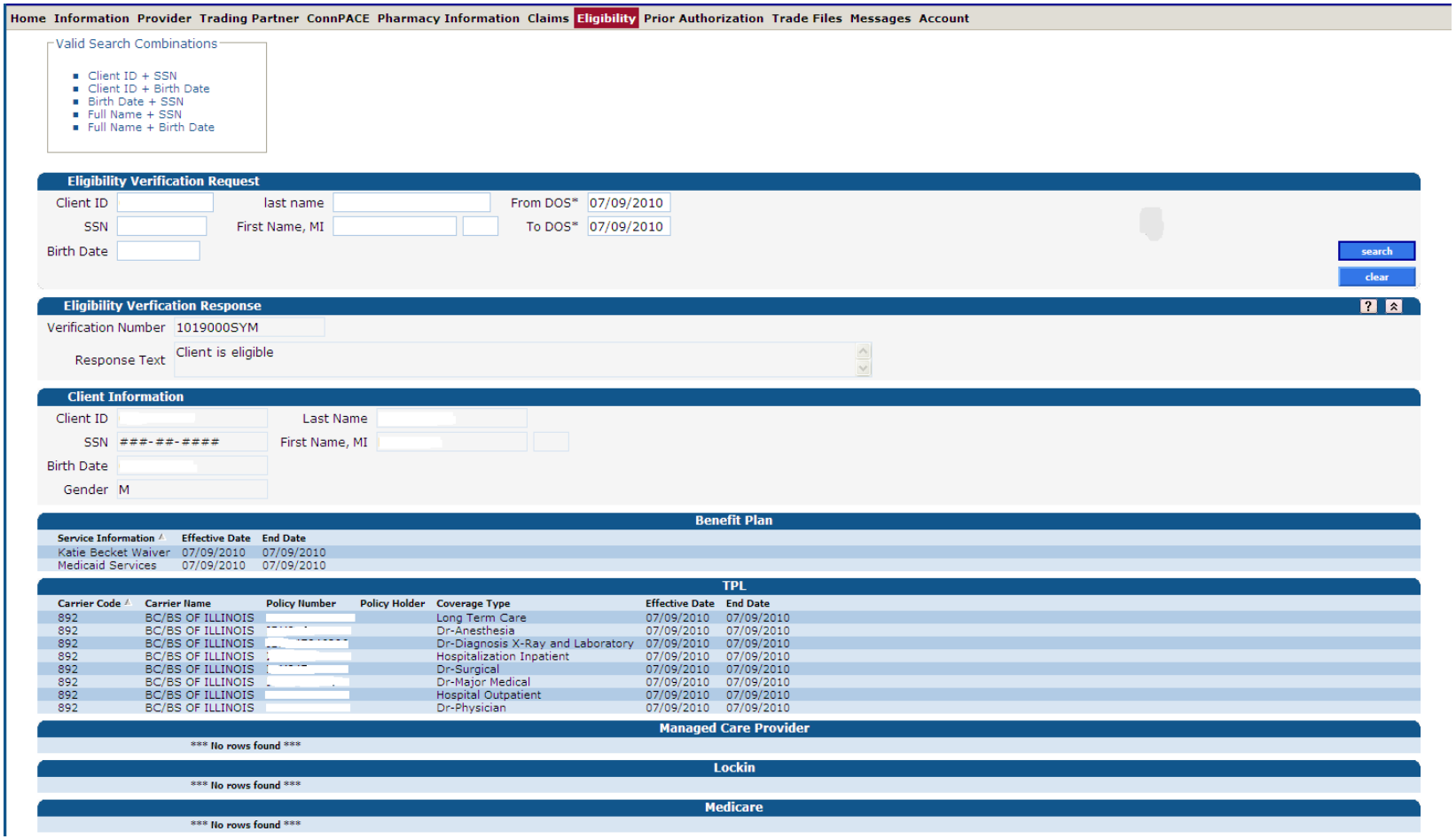
Third Party Liability

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:



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