

Connecticut Medical Assistance Program Refresher for Home Health Providers

Presented by

The Department of Social Services
& HP for Billing Providers

Training Topics

Home Health Agenda

- Fee Schedule Update
- Subsequent Client Claim Submission Review
- Prior Authorization Changes
- Timely Filing Requirements
- Third Party Other Insurance Claim Submission
- Medicare Cost Avoidance
- Program Resources
- Questions

Home Health Fee Schedule Updates

New Procedure Code

T1503 – Administration of medication, other than oral and/or injectable by a health care agency or professional, per visit.

- »Effective November 1, 2009
- »To be used when nursing care service is limited to the administration of medication by any method not included in the description of code T1502, e.g. eye drops, eardrops, patches, creams and suppositories
- »Prior authorization required when more than 2 visits per week or with any combination of S9123, S9124, T1502 and T1503
- »Reference Provider Bulletin PB 2009-34 for further details

Home Health Claim Submission Review

Subsequent Client Claim Submission

Multiple clients serviced in the same visit

- Same skilled nursing service (other than complex care)
 - First client primary (e.g. S9123)
 - All other clients (e.g. S9123 TT)
- Different skilled nursing services (other than complex care)
 - First client primary (S9123)
 - All other clients receiving same skill (S9123 TT)
 - First client receiving different skill (T1502 TT)
 - All other clients receiving this skill (T1502 TT)

Home Health Claim Submission Review cont.

Subsequent Client Claim Submission cont.

Multiple clients serviced in the same visit

- Home Health Aide Services
 - First client (T1004)
 - All other clients receiving same service (T1004)
- Skilled Nursing and Home Health Aide Services
 - First client primary (S9123)
 - All other clients receiving same skill (S9123 TT)
 - First client receiving Home Health Aide Services (T1004)
 - All other clients receiving Home Health Aide Services (T1004)

Home Health Claim Submission Review cont.

Subsequent Client Claim Submission cont.

Complex Nursing Care to more than one client

- Primary client (S9123 TG)
- Secondary client (S9123 TG TT)
- Third client (no claim can be submitted, no PA-provider maintains medical records. If primary client is in the hospital or no longer residing in the home at the time of the visit this client becomes primary.)
- Fourth client (no claim can be submitted, no PA-provider maintains medical records. If both primary and secondary clients are in the hospital or no longer residing in the home at the time of the visit this client becomes secondary.)

Prior Authorization

- Prior Authorization (PA) means the approval from the Department of Social Services (DSS), or a contracted agent of the Department of Social Services, for the provision of a service or the delivery of goods from the department before the provider actually performs the service or delivers the goods.
- Obtaining PA does not guarantee payment or ensure client eligibility. It is the responsibility of the provider to verify client eligibility for the appropriate date (s) of service.

Resources: Chapter 9 Prior Authorization Information

Prior Authorization for the Submission of Third Party Liability (TPL) Claims

- Providers are not required to obtain a PA prior to the service being rendered when the client has known other insurance which will cover the claim. If in doubt request prior authorization.
- A Prior Authorization Request Form and the Explanation Of Benefits (EOB) from the other insurance, in addition to clinical data may be submitted to the Department of Social Services (DSS) after the claim has been processed by the other insurance.
- The request will be forwarded to the Medical and Clinical Consultant team at DSS and PA will be authorized retroactively on a case by case basis depending on the information in the third party Explanation Of Benefits (EOB).
- The PA will be backdated to the date of service, if the service is medically necessary, appropriate and a covered benefit.

Prior Authorization Changes

Changes to Prior Authorization Requests

Providers will be able to request prior authorization for service combinations as indicated:

Nursing Care	Complex Nursing Care	Obstetrics Nursing Care	Medication Administration
S9123	S9123 TG	S9123 TH	T1502
S9124	S9124 TG TE	S9124 TH	T1502 TT
S9123 TT	S9123 TG TT	S9123 TH TT	T1503
S9124 TT	S9124 TG TE TT	S9124 TH TT	T1503 TT

Prior Authorization - Changes to Requests (cont.)

- Each combination (list) of services will be assigned a “list code”
- Providers will indicate a “list code” when requesting Prior Authorization
 - Providers will be able to submit claims for services in any combination on the “list code” up to the units authorized
 - Note: an RN must assess the Plan of Care every 60 days
- Benefits of requesting Prior Authorization via a “list code”
 - Less frequent change requests
 - Reduce claim denials due to no service authorization
 - Reduce rebilling after change of authorization has been completed

Prior Authorization – Medical Policy

Current Medical Policy requires Prior Authorization if:

- >2 nurse visits per week (Sun.-Sat.) for any combination of Skilled Nursing Services (S9123, S9123TT, S9124, S9124TT, T1502, T1502TT, T1503, T1503 TT).
- >14 hours per week (Sun.-Sat.) for Home Health Aide Services (T1004).
- >2 therapy services (PT/ST), per week, excluding initial evaluation (RCC 421/441).
- >1 therapy service (OT), per week, excluding initial evaluation (RCC 431).

Prior Authorization Changes cont.

Current Service Authorization

- Home Health services requested by a Home Health Agency are authorized based on the total plan of care for each procedure code within the span dates of service for which PA is requested.
- Providers, should request PA for all units of the procedure (s) to be serviced within the time frame requested.

Example: Client requires 3 units of S9123 per week for 6 weeks = 18 units of service. PA request should = 18 units.

– Provider should not deduct the 2 units currently paid today without regard to PA.

Prior Authorization – Claims Processing - Home Health

Current Claims Processing:

- Pays units up to the audit limit per week with or without Prior Authorization on file for the procedure and span dates of service of the claim.
- Pays first two units (Skilled nursing) per week without decrementing the PA file.
- Pays first 14 hours (Home Health Aide) per week without decrementing PA file.
- Pays first two units of therapy (PT/ST) services without decrementing the PA file.
- Pays first unit of therapy (OT) services without decrementing the PA file.

As PA is authorized for the total plan of care, providers must keep this in mind when querying their PA as to actual units available

Prior Authorization – Claims Processing - Home Health (cont.)

Future modifications to claims processing when a prior authorization is on file for Home Health Providers:

- Procedure code billed is on the PA file and the dates of service on the claim are within the PA span dates of service
 - All units will decrement the PA file. Claims will no longer pay up to the audit limit per week before decrementing the PA file.
- Procedure code billed is on the PA file and the dates of service on the claim are within the PA span dates of service, however, units available for the procedure code billed on the PA are less than billed on the claim
 - Units on the claim will pay up to the units available on the PA. Claim will not pay up to the audit limit per week prior to decrementing the PA file as it does today.

Prior Authorization – Claims Processing - Home Health (cont.)

- Procedure code billed is on the PA file and the dates of service on the claim are within the PA span dates of service, however, units for the procedure code billed on the PA are exhausted.
 - All units on the PA will deny. Claim will not pay up to the audit limit as it does today.
- Procedure code billed is not on the PA file and the dates of service on the claim are within the PA span dates of service
 - Procedure code will pay up to the audit limit per week as it does today as the procedure code billed is not on the authorized plan of care.

Prior Authorization – Claims Processing - Home Health (cont.)

Claims Processing Impact to Home Health Claims

- Current PA audits will be end dated based on a prior date of service (to be determined by DSS)
- New audits/Explanation of Benefit Codes (EOBs) will be established for the day after the old audit ended. For example:
 - 6230 “PA required for care plan” to replace 6229 “PA required for more than 2 nurse visits per week.”

Prior Authorization – Claims Processing - Home Health (cont.)

- Home Health claims for dates of service prior to the the new audit effective date with Prior Authorization on file for the procedure codes billed, will be reprocessed.
 - Claims which previously paid up to the audit limit per week without regard to PA will now decrement the PA file for those units.
 - Providers who may have over serviced for the span dates of service authorized will see denials at both the detail and claim level.

Prior Authorization – Claims Processing – Connecticut Home Care

Current Service Authorization

- Connecticut Home Care services requested by an Access Agency (CCCI, SWCAA, SCCAA) are authorized based on the total plan of care less the audit limit units per week for each procedure code within the span dates of service PA is requested.

Example: Client requires 3 units of S9123 per week for 6 weeks = 18 units of service. PA request should currently = 6 units. $18 - 12 (2 \text{ units} \times 6 \text{ weeks}) = 6 \text{ units}$.

Future Service Authorization

- Access Agencies should request PA for all units of the procedure (s) to be serviced within the time frame requested.

Example: Client requires 3 units of S9123 per week for 6 weeks = 18 units of service. PA request should = 18 units.

–Provider should not deduct the 2 units currently paid today without regard to PA.

Prior Authorization – Claims Processing –Connecticut Home Care (cont.)

Current Claims Processing:

- Pays units up to the audit limit per week with or without Prior Authorization on file for the procedure and span dates of service of the claim.
- Pays first two units (Skilled nursing) per week without decrementing the PA file.
- Pays first 14 hours (Home Health Aide) per week without decrementing PA file.
- Pays first two units of therapy (PT/ST) services without decrementing the PA file.
- Pays first unit of therapy (OT) services without decrementing the PA file.

Currently- As PA is authorized for the total plan of care less the audit limit per week providers must keep this in mind when querying their PA as to actual units used.

Prior Authorization – Claims Processing –Connecticut Home Care (cont.)

Claims Processing Impact to CHC Claims

- Current PA audits will be end dated based on a prior date of service (to be determined by DSS)
- New audits/Explanation of Benefit Codes (EOBs) will be established for the day after the old audit ended. For example:
 - 6230 “PA required for care plan” to replace 6229 “PA required for more than 2 nurse visits per week.”
- A future PA received date (to be determined by DSS) will be established to allow CHC providers time to change their process of requesting PA to include the allowed units per week on their PA requests.

Prior Authorization – Claims Processing –Connecticut Home Care (cont.)

- Claim dates of service prior to the new audit will
 - Process against the old audit established for the service billed
- Claim dates of service on or after the new audit will:
 - Process against the new audit established for the service billed
- Claim dates of service prior to the date established for the PA receipt date will:
 - Allow units without PA up to the audit limit.
- Claim dates of service on or after the date established for the PA receipt date will:
 - Decrement the PA file for all units authorized.

Timely Filing –System Enhancement

- Previously claims over one year old (fee for service) or 120 days (CTBHP) needed to be submitted on paper with attachments to support a timely filing override.
- Providers may now submit claims with dates of service over one year old (fee for service) or 120 days (CTBHP) via:
 - Electronic Claim Submission
 - 837 Transaction (Vendor)
 - 837 Transaction (Provider Electronic Solutions)
 - Web Claim Submission
 - Paper
- Claims will bypass the timely filing edits systematically based on the following criteria:

Timely Filing Requirements

Fee for Service Client claims will bypass timely filing if the following criteria is met:

- **Original claim with no TPL:**

- ICN Julian date is within 366 days from the detail through date (s) of service on the claim

- **Client eligibility file change:**

- Client eligibility has been added or updated where the ICN Julian date is within 366 days of the change and the claim date of service is between the effective dates of the change

- **Medicare and/or Other Insurance Payment:**

- OI or Medicare paid amount is greater than \$0.00 and the paid date is within 366 days of the ICN Julian date of the claim.
 - If multiple carriers and any one does not meet above criteria the claim will deny with EOB 512

Timely Filing Requirements cont.

- **Other Insurance denial:**

- OI denial date is within 366 days of the from date of service on the claim and within 366 days of the ICN Julian date.
 - If multiple carriers and any one of the date checks does not meet these criteria the claim will deny with EOB 512

- **Medicare denial:**

- Medicare (carrier code MPA or MPB) denial date on the claim is within 549 days of the from date of service on the claim and within 366 days of the ICN Julian date.

- **Prior claim history:**

- When paid or denied claim in history with same client, provider, billed amount, detail from and through date of service and RCC or RCC/Procedure code where ICN Julian date on the current claim is less than or equal to 366 days from the previous claims Remittance Advice (RA) date and the previous claim did not deny for timely filing.

Timely Filing Requirements cont.

- **Claim adjustments:**

- When the number of days between the paid date of the claim and the adjustment's ICN Julian date is less than 366 days.

Timely Filing Requirements cont.

- **Connecticut Behavioral Health Partnership (CTBHP)**

Client claims will bypass timely filing if the following criteria is met:

- **Original claim with no TPL:**

- 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, Revenue Center Code (RCC) or RCC/HCCPC (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.

Client Eligibility

- Eligibility

- DSS maintains and updates client eligibility information
 - Issues regarding client eligibility should be directed to the DSS Regional Office
 - Prior to providing a service providers are responsible for verifying client eligibility **on the date of service**
- Affiliated Computer Systems (ACS) enrolls clients and maintains MCO Charter Oak, HUSKY A and HUSKY B eligibility
- Issues regarding MCO eligibility should be directed to ACS at 1(800)-656-6684

Eligibility Verification

- Web Eligibility www.ctdssmap.com
- Provider Electronic Solutions Software
- HIPAA ASC X12N 270/271 Health Care Eligibility Remit Inquiry and Response
- Automated Voice Response System (AVRS)
 1-800-842-8440 or 860-269-2028

Eligibility Verification

- Eligibility Inquiry (not available to inactive providers)
 - Requires a combination of primary and secondary client identification (ID and Social Security Number (SSN); SSN and Date of Birth)
 - From and through dates of service

Important points to remember:

- Verify eligibility on the same day as services to be rendered, eligibility can change daily, even for HUSKY Managed Care Clients
- Providers can not verify future dates of service
- Providers must contact the Provider Assistance Center to verify client eligibility for dates of service greater than one year old
- Other insurance is also received from a verification inquiry
- Obtain the Inquiry Verification Number to use if claim denies as client ineligible on date of service.

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

Third Party Liability (TPL) Coverage

- Connecticut Medical Assistance Program providers must investigate the possibility that a client has other medical coverage and pursue payment from all other medical insurance plans.
- Providers can determine other insurance coverage by verifying client eligibility

TPL information on the client's eligibility file will be returned to the provider with the following data:

- **Carrier Code**
- **Carrier Name**
- **Policy Number**
- **Coverage Type**

Third Party Liability (TPL) Coverage cont.

- Discrepancies between the Department's third party liability information and what has been determined by the provider through their own health insurance verification process, should be communicated to the Department of Social Services (DSS).
- Health Management System Inc. (HMS)
 - DSS contractor for TPL related information
- Provider should contact HMS regarding TPL discrepancies to:
 - End date outdated coverage
 - Avoid the unnecessary denial of claims
 - Adding new coverage information
 - Cost avoid claim payment when other coverage exists

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
 - 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.)

HMS Confirmation of Request 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 providers may supply this information by mail or by e-mail at quality.dss@ct.gov.

Third Party Liability (TPL) Claim Submission

- **Connecticut Medical Assistance Program Institutional Other Insurance/Medicare Billing Guide**

- Determining Other Insurance Coverage
- Private Insurance as Primary Payer
- Billing Instructions for
 - Other Insurance Denial
 - Other Insurance Payment

- TPL Claim Submission Instructions for
 - Web
 - ASC X12N 837 Health Care Claim
 - Provider Electronic Solutions Software
 - UB-04

- Timely Filing Rules

Note: This guide will be incorporated in a new chapter 11 of your provider billing manual.

Home Health Medicare Cost Avoidance

Federal Medicaid regulations require the Department of Social Services (DSS) to cost avoid (deny) claims when a client has known Third Party Liability (TPL) coverage, including Medicare that is:

- Not indicated on the claim
- Indicated on the claim as partially paid or denied without an adjustment reason code or occurrence code (code 24 for OI denial on UB-04) and corresponding date of payment or denial

Previously DSS did not require providers to indicate why a Home Health Advanced Beneficiary Notice (HHABN) was being issued to a client who did not meet specific Medicare criteria for Home Health coverage.

Claim Submission Requirements

Claims for dually eligible clients who are traditional Medicare or Medicare Managed Care (A, B or A & B benefit eligible) and title 19 eligible, must contain:

- at least one HIPAA Adjustment Reason Code (150, 151 or 152)
- date the associated HHABN or MCO Notice of Medicare Non-Coverage (NOMNC) was issued

Note 1: This does not include Medicare clients who are State Funded CT Home Care eligible

Note 2: Home Health Aide services that are not hands on personal care services are not covered under Medicaid.

Home Health Agency Reasons to Issue Advanced Beneficiary Notice	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Code Description
Client determined to be not homebound; either at the start of care or after Medicare-covered services have been provided.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client receiving thirty-five (35) hours per week of Medicare-covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week.	151	Payment adjusted because the payer deems the information submitted does not support this many services
Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g. nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client's continued care determined to not be Medicare-coverable. CMS required Annual HHABN issued.	152	Payment adjusted because the payer deems the information submitted does not support this length of service.

Home Health Medicare Cost Avoidance

Effective for dates of service **April 1, 2010** Home Health claims for dually eligible clients that do not comply with the new Medicare Cost Avoidance requirements will:

–Deny with Explanation of Benefit Code (EOB) 2522 “Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of HHABN or NOMNC”

Claim Auditing – HHABN or NOMNC

Monthly TPL (other insurance audit) will include:

- Random selection of claims containing at least one of the HIPAA Adjustment Reason Codes (150, 151, 152)
- Providers will be required to submit a copy of the original signed and dated HHABN or NOMNC associated with the selected claim
 - Providers may use either the HHABN or NOMNC when submitting claims for clients with Medicare Managed Care.

Claim Auditing cont.

Claims with an HHABN or NOMNC with an issue date different from the signature date may be recouped.

- When a home health agency cannot deliver a HHABN or NOMNC timely and in-person to the client or client's authorized representative the home health agency would be required to demonstrate it delivered proper notice by either telephone contact, secure fax machine, or internet e-mail.
- Agency would be required to produce documentation to support the contact was made in a timely manner.

TPL Claim Submission - ASC X12N 837 I Health Care Claim

Loop	Segment	Description
2320	SBR	Other Subscriber Information
2320	CAS	Claim Adjustment
2320	AMT	Coordination of Benefits Payer Paid Amount
2320	DMG	Other Subscriber Demographic Information
2320	OI	Other Insurance Coverage Information
2330A	NM1	Other Subscriber Name
2330A	N3	Other Subscriber Address
2330A	N4	Other Subscriber City, State, Zip Code
2330A	REF	Other Subscriber Secondary Information
2330B	NM1	Other Payer Name
2330B	NM109	Other Payer Primary Identifier - Enter the Connecticut Medical Assistance Program Carrier Code. These code values can be found at http://www.ctdssmap.com-Information-Publications-Provider Manuals Chapter 5 .
2330B	DTP	Claim Paid Date
2330C	NM1	Other Payer Patient Information
2330C	REF	Other Payer Patient Identification
2430	SVD	Line Adjudication Information
2430	CAS	Line Adjustment Information
2430	DTP	Line Adjudication Date

Electronic Claim Submission Format

Loop	Segment	Position	Description
2320	CAS	01	Claim Adjustment Group code = CO (claim header)
2320	CAS	02	Adjustment Reason Code = 150, 151, 152 (claim header)
2430	CAS	01	Claim Adjustment Group code = CO (claim detail)
2430	CAS	02	Adjustment Reason Code = 150, 151, 152 (claim detail)
2330B	DTP	03	HHABN or NOMNC issue date (claim header)
2430	DTP	03	HHABN or NOMNC issue date (claim detail)

Web Claim Submission

The screenshot shows a web form for Medicare claim submission. At the top left, a box labeled 'TPL' is highlighted with a red rectangle. Below this is a table with columns: Code, Plan Name, Policy Number, Paid Amount, Paid Date, Relationship, Last Name, First Name, MI, and Date of Birth. The first row shows 'A MPA MEDICARE PART A' with a paid amount of '\$0.00' and date '02/12/2010'. The second row shows '060 BC OF CONNECTICUT' with a paid amount of '\$0.00' and date '08/13/2009'. Below the table is a form for entering new record data. Fields include: Client Carriers (Other), Carrier Code* (MPA), Plan Name (MEDICARE PART A), Policy Number, Paid Amount* (\$0.00), Paid Date* (02/12/2010), Relationship (Self), Last Name (CAREY), First Name, MI (BABYC), Date of Birth (01/20/2007), Adjustment Reason Code (151), and Adjustment Amount (\$140.00). A red arrow points from the 'Date of Birth' field to a text box on the right that says 'Date of HHABN or NOMNC'. Another red arrow points from the 'Adjustment Reason Code' field to a text box at the bottom left that says 'HIPAA Adjustment Reason Code indicating reason HHABN or NOMNC was issued.'. A third red arrow points from the 'add' button to a text box at the bottom right that says 'Click add then enter Medicare data in the TPL section of your web claim'.

Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
A	MPA	MEDICARE PART A	\$0.00	02/12/2010	Self	CAREY	BABYC		01/20/2007
060	BC OF CONNECTICUT	0001112334	\$0.00	08/13/2009					

Type data below for new record.

Client Carriers: Other
Carrier Code*: MPA [Search] Relationship: Self
Plan Name: MEDICARE PART A Last Name: CAREY
Policy Number: First Name, MI: BABYC
Paid Amount*: \$0.00 Date of Birth: 01/20/2007
Paid Date*: 02/12/2010
Adjustment Reason Code: 151 [Search] [Search] [Search]
Adjustment Amount: \$140.00 \$0.00 \$0.00

Date of HHABN or NOMNC

HIPAA Adjustment Reason Code indicating reason HHABN or NOMNC was issued.

Click add then enter Medicare data in the TPL section of your web claim

Medicare Cost Avoidance - Provider Electronic Solutions

837 Institutional Outpatient

Total Charge 0.00 OI Amount .00 Billed Amount .00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | **Header5** | OI | Service

Other Insurance Indicator **Y** Crossover Indicator **N**

Delay Reason Code

Change indicator to Y to populate OI tab

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
000000001	CLIENT	MARY	.00		R

Add
Copy
Delete
Undo All
Save
Find...
Print
Close

Provider Electronic Solutions

837 Institutional Outpatient

Total Charge 150.00 OI Amount .00 Billed Amount 150.00 Services 1

Header 1 | Header 2 | Header 3 | Header 4 | Header 5 | OI | Service

Release of Medical Data Y Benefits Assignment Y
Claim Filing Ind Code MA Adjustment Group Cd CO
Reason Codes/Amts: 1 151 150.00 2 .00
Paid Date/Amount 02/12/2010 .00 3 .00

Policy Holder
Group # Group Name Carrier Code MPA
Last Name CLIENT First Name MARY

Srv #	Carrier Code	Group #	Group Name	Last Name
1	MPA			CLIENT

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
000000001	CLIENT	MARY	.00		R

Issue date of HHABN or NOMNC

HIPAA Adjustment Reason Code Associated with the HHABN or NOMNC

Buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, Close

Medicare Cost Avoidance - UB-04 Paper Claim Format

3a PAT. CNTL #							4 TYPE OF BILL	
b. MED. REC. #								
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM			7 THROUGH			
		c	d	e				
24 ODES		25	26	27	28	29 ACDT STATE	30	
							151	



Enter Adjustment Reason Code 150, 151 or 152 associated with the reason the HHABN or NOMNC was issued.

UB-04 Paper Claim Format cont.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MPA N/A 02/12/2010					



Enter the date the HHABN or NOMNC was issued for the Adjustment Reason Code indicated in field 30.

Medicare Cost Avoidance Claim Denials

Edit 2522 – Bill Medicare first or provide appropriate adjustment reason code and date of HHABN or NMNOC.

Edit will set if client has Medicare A, B or A & B and:

- Adjustment reason code associated with MPA or MPB is other than 150, 151 or 152
- Date of HHABN or NOMNC is missing from the claim
- Claim filing indicator associated with MPA or MPB is MC.
(loop 2320 Other subscriber information –SBR 09 based on payer in 2330B)

Resources

- Connecticut Medical Assistance Program Web site www.ctdssmap.com
 - All Formats
 - Institutional Other Insurance/Medicare Billing Guide
 - » From the home page > Publications > Claims Processing Information > *Institutional Other Insurance/Medicare Billing Guide*
 - » From the home page > Publications > Provider Manuals > Chapter 11 *Institutional Other Insurance/Medicare Billing Guide (future location of this guide)*
 - Electronic Claim Format
 - Implementation Guide
 - » From the home page > Trading Partner Documents > EDI Documents > *Implementation Guide*
 - Web Claim Submission
 - Instructions for submitting Institutional claims
 - » From your Provider Secure Web Account home page > claims > Institutional > *Instructions for submitting Institutional claims*

Resources cont.

- Connecticut Medical Assistance Program Web site www.ctdssmap.com cont.
 - Provider Electronic Solutions Billing Instructions
 - From the home page > Trading Partner > Provider Electronic Solutions Billing Instructions > Outpatient/Home Health > *HP Provider Electronic Solutions Billing Instructions*
 - Home Health Paper Claim (UB-04) Instructions
 - From the home page > Publications > Provider Manuals > Chapter 8 > select Home Health > view chapter 8 > *Home Health Services Claim Submission Instructions*

Resources cont.

- 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)
- EDI Help Desk
 - Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
 - 1-800-688-0503 (in-state toll free)
 - (860) 269-2026 (local to Farmington, CT)

Connecticut Medical Assistance Program Refresher Workshop for Home Health Providers

Time for Home Health Questions