Training Topics

- **Prior Authorizations**
- **Claim Submission Updates**
- **HIPAA 5010 Requirements**
- **Claim Resolution Guide**
- **Questions**

Prior Authorizations

Inpatient Medical Admissions

- Effective May 1, 2012, Community Health Network of CT (CHNCT), will begin offering acute care hospitals the ability to submit medical inpatient authorization requests for HUSKY Health and Charter Oak Health Plan clients online via a secure authorization portal, Clear Coverage.

- You can access the Clear Coverage Online Authorizations portal beginning on May 1, 2012 by visiting www.huskyhealth.com and setting up a user account for your hospital.

- Hospitals may continue to submit authorization to CHNCT by phone at 1-800-440-5071 or Fax 1-203-265-3994.

Prior Authorizations

Inpatient admissions change from Medical to Psychiatric or Psychiatric to Medical

- If the client is admitted with a primary medical diagnosis and then is subsequently admitted to a psychiatric unit, the initial authorization from CHNCT will cover the entire inpatient admission.
  - ➢You need to remember if you are splitting the claim for processing, the admit date on both claims must reflect the first date of the inpatient admission.

- If the client is admitted with a primary behavioral health diagnosis and then is subsequently admitted to a medical unit, the provider will need to contact CT BHP to handle the authorization for the entire stay and claims are to be submitted to HP for processing.

Prior Authorizations

Outpatient Hospital Rehabilitation Therapy

- Effective May 1, 2012 authorization requests for outpatient hospital therapy will no longer be accepted by HP.

- Provider must submit requests to CHNCT via either:

1. Clear Coverage Online Portal.
2. Fax at (203) 265-3994 utilizing the Authorization Request Form, which can be found online at www.huskyhealth.com. Click on “For Providers”, then click Benefits and Authorizations and select the Authorization Request Form.
3. Phone at 1-800-440-5071 Monday through Friday from 8am – 7pm.

Prior Authorizations

Outpatient Radiology Services

- For dates of service June 1, 2012 and forward non-emergent advanced imaging and nuclear cardiology services performed in an outpatient setting will require Prior Authorizations (PA).

- PA can be obtained by provider portal via www.huskyhealth.com and selecting the hyperlink to caretocare.com.

- Hospitals can also request PA by faxing the authorization to Care to Care (CtC) at 1-888-931-2468.

Prior Authorizations

Outpatient Radiology Services

- When faxing a PA request, providers should use the Advanced Imaging Prior Authorization Request Form located on the provider portal via www.huskyhealth.com. From the home page log-in to the secure provider portal through the "For Providers" link. After log-in is complete select "Forms".

- Authorizations must be obtained prior to the performance of any of the procedures requiring PA. Authorizations are valid for 30 days from the date of approval. Failure to obtain authorization will result in a denial of claims.

- Revenue center codes (RCC) 35X, 404 and 61X will always require PA.

Prior Authorizations

Outpatient Radiology Services

- Revenue center code 34X in combination with any of the following CPT codes (78451-78454, 78466, 78468-78469, 78472-78473, 78481, 78483, 78494 and 78496) requires PA.

- RCC code 34X with any other CPT codes will not require a PA.

- Hospitals requesting PA need to request CPT code and number of units. The PA system will automatically assign the appropriate RCC to the authorization based on the grid in provider bulletin 2012-18 “Important Changes to Radiology Services.”

Prior Authorizations

Hospital Outpatient Psychiatric Services

- Effective immediately hospitals should stop requesting authorization for RCC 513 for dates of service on or after January 1, 2012.

- The department is discontinuing the use of general psychiatric services code 513 and replacing it with the more specific RCCs 914-916 and 919.

- Hospitals do not need to take any action to modify existing authorizations for routine hospital outpatient psychiatric services. Authorizations will automatically include RCC 914-916 and 919.

Prior Authorizations

Hospital Outpatient Psychiatric Services

- The department is not changing how it defines or how providers should authorize the following RCCs:
  - 900-901, 905-907, 913 and 918.

- To access PA requirements, please go to www.ctbhp.com. From the web page, select “For Providers”, then select “Covered Services”. From that page under Authorization Schedule select “General and Psychiatric Hospitals.”

Prior Authorizations

Third Party Liability and/or Medicare

- For clients who have other insurance, hospitals are required to following the same PA procedures for those who do not have other insurance.

- For clients that are duel eligible with Medicare or Medicare HMO (Commercial Medicare), a PA will not be required if Medicare approves the service as the primary payer.

Claim Submission Updates

Outpatient Radiology Services

- For dates of service June 1, 2012 and forward the field name “admit source” will be required for the claim to pay for outpatient radiology services.

- Please refer to Provider Manual Chapter 8 under the www.ctdssmap.com Web site under publications then scroll to provider manual for a list of valid admit source codes.

- Advanced imaging and nuclear cardiology procedures performed as part of an emergency room visit will not require prior authorization.
  - Admission source of “7” must be entered in the appropriate field on the claim for processing without PA.

Claim Submission Updates

Outpatient Radiology Services

- Hospitals billing RCC codes 34X, 35X, 404 and 61X must be submitted with a CPT code and number of units to avoid claim denials.

- For RCC and CPT combinations, please refer to provider bulletin 12-18. If you bill the wrong RCC or CPT combination, the service will deny.

  - For example: CPT 70450 corresponds to RCC 35X, if you bill it with RCC code 61X, the service will deny.

- RCC 34X will pay without a PA on CPT codes not listed in provider bulletin 12-18, but you are still required to bill a valid CPT code on your claim.

Claim Submission Updates

Outpatient Radiology Services

- The admit source on outpatient radiology claims should be entered in the field identified below:
  - UB-04 paper claim submissions
    - Field 15
  - Web Claim Submission through the Provider secure Web site at www.ctdssmap.com
    - Admit Source
  - 837I Health Care Format
    - Admit source must be entered in Loop 2300, Segment CL.

Claim Submission Updates

Provider Preventable Conditions (PPCs) Reporting Requirements

- Outpatient hospital providers specifically because of the ACA mandate that Medicaid will not pay for PPC that are erroneous provided by a hospital outpatient department.

- Hospitals are also instructed to report erroneous surgeries to the Department. The outpatient hospital claims must be submitted with one of the following ICD-9-CM diagnosis code:

Claim Submission Updates

Provider Preventable Conditions (PPCs) Reporting Requirements

- E876.5 - Performance of wrong operation (procedure) on correct patient (existing code).
- E876.6 - Performance of operation (procedure) on patient not scheduled for surgery.
- E876.7 – Performance of correct operation (procedure) on wrong side/body part.

- If an outpatient hospital claim is submitted with one of the above diagnosis code, the claim will deny with Explanation of Benefit (EOB) code 721 “Diagnosis Not Covered – Other Provider Preventable Conditions.”

Claim Submission Updates

Hospital Outpatient Psychiatric Services (RCC 513)

- Effective for dates of services on or after January 1, 2012, RCC 513 will no longer be reimbursable.

- The Department has discontinued the use of the general psychiatric service code and replacing it with more specific RCCs codes.
  - RCC 914, 915, 916 for individual, group and family therapy respectively and RCC 919 for medication management services only.

- Hospitals will be required to re-submit previously processed claims using the more specific RCC for these dates of service.

Claim Submission Updates

Hospital Outpatient Surgery Claims

- Due to the HIPAA 5010 implementation, when submitting outpatient surgical claims you are no longer required to submit ICD9 surgical procedure codes.

- When submitting in the HIPAA 5010 version for all claim submission types (837I, Web or paper) you will now be required to bill a surgery CPT code (10000-69999 excluding 36415) on your claim.

- The surgery CPT code on outpatient surgery claims should be entered in the field identified below:
  - UB-04 paper claim submission - field 44 – HCPCS/ Rate
  - Web claim submission – HCPCS/Rates
  - 837I Health Care Format – Loop 2400 Segment SV2

Claim Submission Updates

Hospital Outpatient Surgery Claims

- If you bill multiple CPT codes, you will need to lump charges under the first RCC code and enter zero charge in the second RCC line.

- If you bill an operating provider without a CPT code, your claim will deny with Explanation of Benefit (EOB) code 365 “ Principal Procedure Date is invalid or Principal Procedure Code is Missing”.

Claim Submission Updates

Timely Filing Guidelines

- HUSKY C and HUSKY D for all claims (Medical, dental, behavioral health) the timely filing guidelines will be 365 days.

- HUSKY A, HUSKY B and Charter Oak non-behavioral health services the timely filing guidelines will be 365 days.

- HUSKY A, HUSKY B and Charter Oak behavioral health services timely filing will be 120 days

* DSS is reviewing provider manual chapter 5 and updates will be posted shortly.

HIPAA 5010 Requirements

- The cutover date for 5010 837I electronic claims submission is May 1, 2012. Starting May 1, 2012 any inpatient, outpatient or crossover claims submitted in the 4010 version will deny with EOB code 617, “Invalid Claim Version – Submit in new HIPAA 5010.”

- Any claims submitted to HP must bill with a valid taxonomy and 9 digit zip code.

- On inpatient admissions, you can no longer bill with a Present on Admission (POA) indicator as a “1”, the POA indicator must be either “Y”, “N” “U” or blank.

* A POA indicator left blank will only be valid when submitted with a diagnosis code on the POA exemption list.

HIPAA 5010 Requirements

HIPAA 5010 Explanation of Benefit (EOB) Codes

- EOB 1906 “Header billing provider’s taxonomy is not valid or EOB 1912 “Billing provider’s taxonomy is missing”
  - Change the taxonomy to the correct taxonomy as submitted on the provider’s enrollment application, correct all other errors and resubmit the claim.
  - The Billing Provider Taxonomy is submitted in loop 2000A segment PRV03 of the ASC X12N HIPAA 837I format.
  - Provider taxonomy can be found on the remittance advice in the upper left hand corner or on the left hand corner when you sign into your secure account on the www.ctdssmap.com Web site.

Claim Resolution Guide

Provider Manual Chapter 12 – Claim Resolution Guide

- This guide lists commonly posted Explanation of Benefit (EOB) codes and provides a brief explanation of the reason why claims were either suspended or denied.

- This guide provides a detailed description of the cause of each EOB and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.

- This guide also provides tips to assist providers to where they need to go to find additional information to help on correcting their claims.

Claim Resolution Guide

EOB 3004 “Inpatient Claim Requires Authorization”

- Cause
  - The Inpatient claim requires prior authorization (PA) and there is no PA record on file in an approved status that has the same provider ID, client ID and approved dates of service that match the claim’s billing provider, client ID and admit date. The admit date must fall within the dates of service approved by CHNCT.
- Resolution
  - If the PA status is not approved and shows a status of “in-process” , the PA has either not been finalized by CHNCT or you may have to contact CHNCT to update the status of the authorization.

Claim Resolution Guide

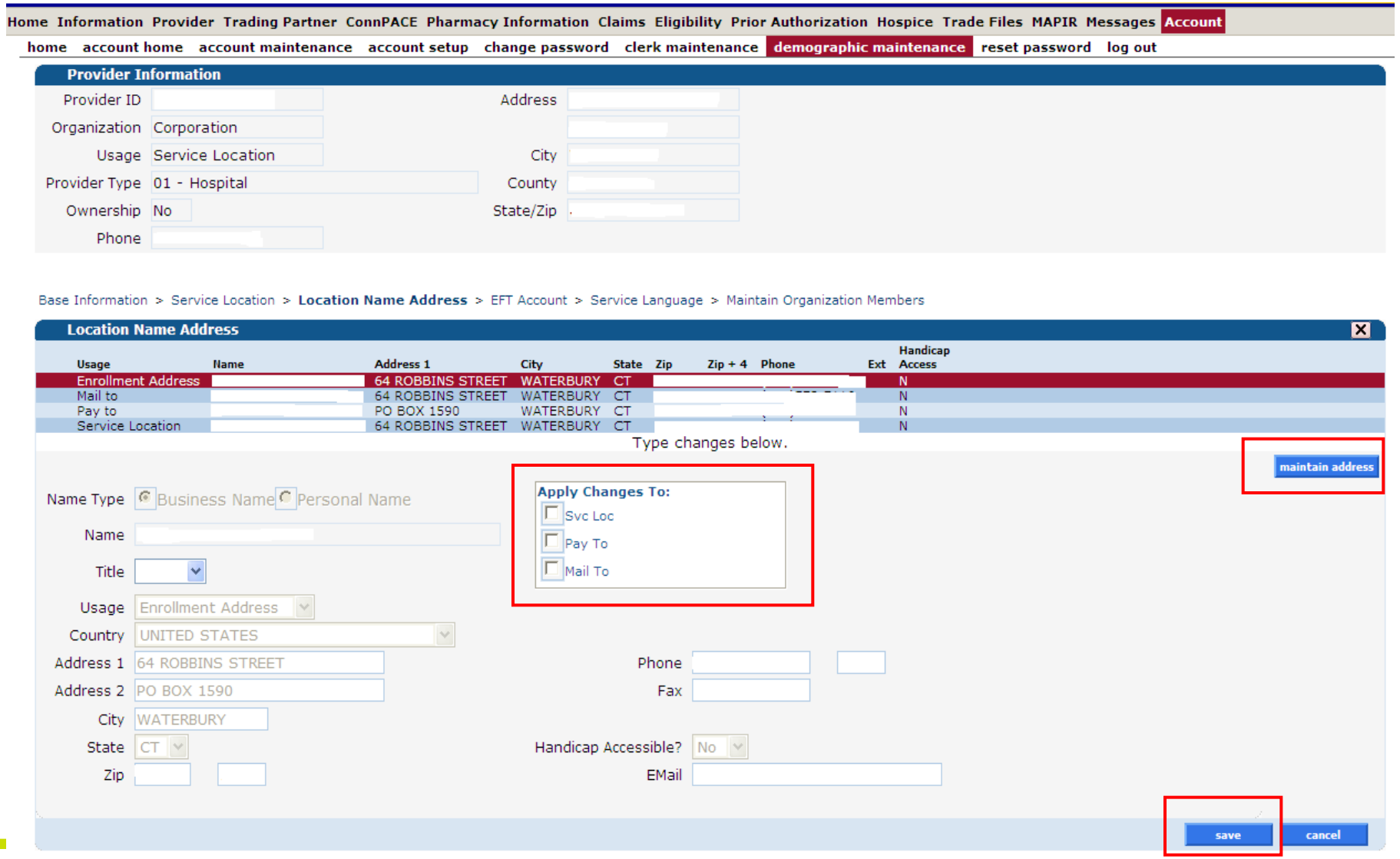
EOB 3004 “Inpatient Claim Requires Authorization”

- Cause
  - The inpatient claim does not require PA when the claim is due to a delivery, but the claim’s primary diagnosis code must indicate delivery.

- Resolution
  - If the claim is for a delivery, please verify the primary diagnosis. If the primary diagnosis indicates delivery please re-submit the claim. If the primary diagnosis does not state delivery then the inpatient claim will require a prior authorization.

New Enrollment Address on Web

- New Provider Enrollment Address



New Enrollment Address on Web

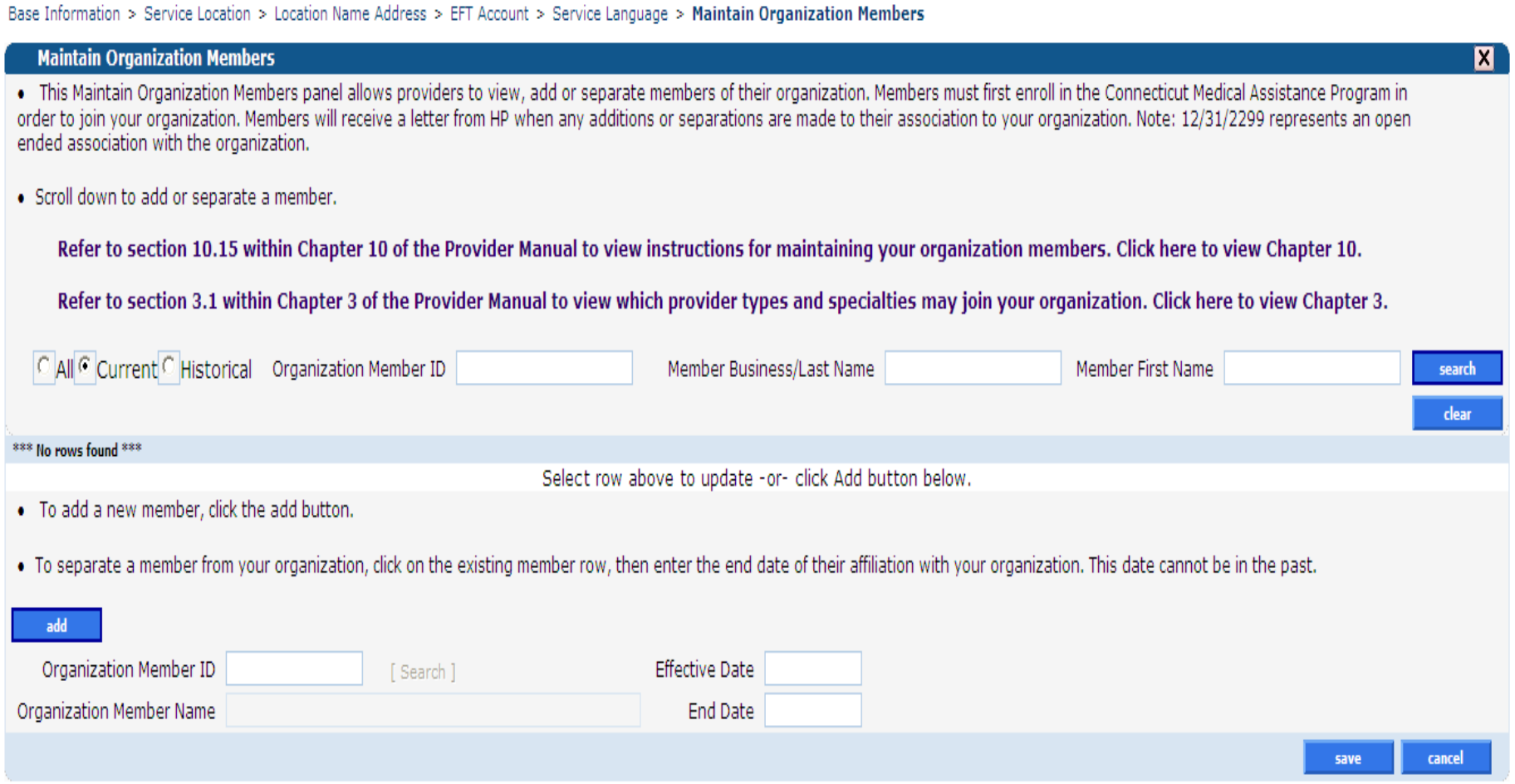
New provider enrollment address on secure Web site.

- To change the address:

  - Click on the enrollment address row then click on maintain address.
  - Change the enrollment address.
  - Click save in the bottom right corner of the panel.
  - "Save was Successful" message should appear confirming the address change.

Provider Enrollment Enhancements

Maintain Organization Members



Provider Enrollment Enhancements

Maintain Organization Members

- Maintain Organization Members panel allows provider to add, view, or separate members of their hospital. Members must first be enrolled in the Connecticut Medical Assistance Program in order to join your organization.

- Members will receive a letter from HP when any additions or separation are made to their association to your organization.

Provider Enrollment Enhancements

Maintain Organization Members

- To add a new member, click the add button.
- Search for the provider
  - Enter provider's NPI or AVRS ID and hit search.
- Enter effective date (date of hire or start date at the hospital).
- Enter end date as 12/31/2299.
- Hit Save

Training Session Wrap Up

- Where to go for more information www.ctdssmap.com
  - Important Messages
    - Hospital interChange IM updated monthly
  - Provider Bulletins
- HP Provider Assistance Center (PAC): Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays:
  - 1-800-842-8440
  - 1-800-688-0503 (EDI Help Desk)

Time for Questions

- Questions & Answers