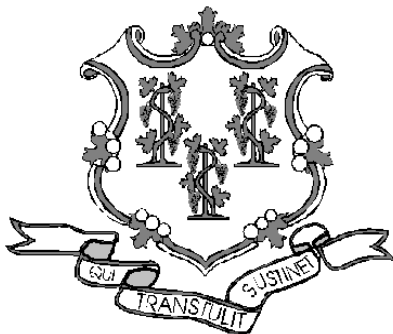




Connecticut Department of Social Services

Caring for Connecticut



Hospital Refresher Workshop

Presented by

The Department of Social Services
& HP Enterprise Services



Training Topics

- **Web Eligibility Screen Enhancements**
- **Provider Re-enrollment**
- **Account Demographics**
- **Web Claim Submission**
- **Prior Authorization**
- **Hospital Inpatient Services**
- **Provider Bulletins**
- **Hospital Billing**
- **Questions**

Web Eligibility Screen Enhancements

- On the secure Web site www.ctdssmap.com the eligibility verification request screen has been enhanced to include two key functionalities.
 - Search by Service Type Codes.
 - Charter Oak Deductible, Coinsurance and Out of Pocket Information and Charter Oak and HUSKY B copay amounts.

Web Eligibility Screen Enhancements

Search by Service Type Codes

- Providers will now be able to search by up to five (5) different service type codes. The service type codes allow providers to verify the client's eligibility benefit coverage for specific services. The service type codes are drop down fields that the provider can select when verifying a client's eligibility.
- The first service type code field defaults to 30 – Health Benefit Plan Coverage. If the provider searches by that default selection, it will return with all the service type codes that are covered for the client's benefit plan.

Web Eligibility Screen Enhancements

Search by Service Type Codes

Eligibility Response Quick Reference Guide

Eligibility Verification Request

| | | | | | |
|---------------------|-------------------------------------|---------------------|---|-----------|---|
| Client ID | <input type="text"/> | last name | <input type="text"/> | From DOS* | <input type="text" value="04/01/2013"/> |
| SSN | <input type="text"/> | First Name, MI | <input type="text"/> <input type="text"/> | To DOS* | <input type="text" value="04/01/2013"/> |
| Birth Date | <input type="text"/> | | | | |
| Service Type Code 1 | 30 - Health Benefit Plan Coverage ▼ | Service Type Code 2 | <input type="text" value=""/> | | |
| Service Type Code 3 | <input type="text" value=""/> | Service Type Code 4 | <input type="text" value=""/> | | |
| Service Type Code 5 | <input type="text" value=""/> | | | | |

search

clear

The following are some of the service types providers can search for:

| | |
|--|-------------------------------------|
| 1 – Medical Care | 50 – Hospital Outpatient |
| 30 – Health Benefit Plan Coverage | A7 – Psychiatric - Inpatient |
| 47 – Hospital | MH – Mental Health |
| 48 – Hospital Inpatient | PT – Physical Therapy |

Web Eligibility Screen Enhancements

Search by Service Type Codes

- When searching by specific service types, hospitals should use specific hospital service type codes based on the services you are providing.
 - 48 Hospital - Inpatient
 - 50 Hospital - Outpatient
 - 51 Hospital – Emergency Accident / Emergency Medical should only be searched for Emergency Room claims only.
- For complete Charter Oak and HUSKY B benefits, hospitals can refer to the Web site www.huskyhealth.com clicking on “For Providers”, then “Benefits and Authorizations”, then selecting the applicable grid that matches the services the provider is providing.

Web Eligibility Screen Enhancements

The Service type code field will also provide coinsurance percentages for Charter Oak clients and copay amounts for both Charter Oak and HUSKY B clients.

Benefit Plan

| Service Information | Benefit Month Effective Date | Effective Date | End Date | Message |
|--|------------------------------|----------------|------------|---------|
| Charter Oak. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Charter Oak copays. | 04/01/2013 | 04/02/2013 | 04/02/2013 | |

Deductible Information

| Service Information | Effective Date | End Date | Base Deductible Amount | Remaining Amount |
|---------------------|----------------|------------|------------------------|------------------|
| Charter Oak | 04/01/2013 | 03/31/2014 | \$200.00 | \$200.00 |

Out of Pocket Information - Includes Deductible and Coinsurance

| Service Information | Begin Date | End Date | Out of Pocket Amount | Remaining Amount |
|---------------------|------------|------------|----------------------|------------------|
| Charter Oak | 04/01/2013 | 03/31/2014 | \$400.00 | \$400.00 |

Service Type Codes - HP Services

| Service Type Code ^A | Service Type Information | Copay | Coinsurance |
|--------------------------------|--------------------------|---------|-------------|
| 48 | Hospital - Inpatient | \$0.00 | 10% |
| 50 | Hospital - Outpatient | \$0.00 | 20% |
| 86 | Emergency Services | \$0.00 | 0% |
| MH | Mental Health | | |
| PT | Physical Therapy | \$35.00 | 0% |

Web Eligibility Screen Enhancements

- Web eligibility search for a Charter Oak Client will return two new information panels:

- Deductible Information:

- This provides the client's deductible amount for the benefit plan year within which the date of service falls. This will also provide the remaining deductible for a current period when searching a current date. If the provider is searching for a date of service in history, the remaining deductible amount will not be returned.

Web Eligibility Screen Enhancements

- Out of Pocket Information – Includes Deductible and Coinsurance:
 - This provides the client's out of pocket amount which includes deductible and coinsurance for the benefit plan year. If the provider is searching for an eligibility date in history, a remaining out of pocket amount will not be returned.
- Deductible and Out of Pocket are based on claims processed at the time eligibility is verified.

Web Eligibility Screen Enhancements

Charter Oak Deductible, Coinsurance and Out of Pocket Information and Charter Oak copay amount.

Example 1: Charter Oak client using the current date of service (DOS)

| Benefit Plan | | | | |
|--|------------------------------|----------------|------------|---------|
| Service Information | Benefit Month Effective Date | Effective Date | End Date | Message |
| Charter Oak. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Charter Oak copays. | 04/01/2013 | 04/02/2013 | 04/02/2013 | |

| Deductible Information | | | | |
|------------------------|----------------|------------|------------------------|------------------|
| Service Information | Effective Date | End Date | Base Deductible Amount | Remaining Amount |
| Charter Oak | 04/01/2013 | 03/31/2014 | \$200.00 | \$200.00 |

| Out of Pocket Information - Includes Deductible and Coinsurance | | | | |
|---|------------|------------|----------------------|------------------|
| Service Information | Begin Date | End Date | Out of Pocket Amount | Remaining Amount |
| Charter Oak | 04/01/2013 | 03/31/2014 | \$400.00 | \$400.00 |

| Service Type Codes - HP Services | | | |
|----------------------------------|--------------------------|---------|-------------|
| Service Type Code | Service Type Information | Copay | Coinsurance |
| 48 | Hospital - Inpatient | \$0.00 | 10% |
| 50 | Hospital - Outpatient | \$0.00 | 20% |
| 86 | Emergency Services | \$0.00 | 0% |
| MH | Mental Health | | |
| PT | Physical Therapy | \$35.00 | 0% |

Web Eligibility Screen Enhancements

Charter Oak Deductible, Coinsurance and Out of Pocket Information and Charter Oak copay amounts.

Example 2: Charter Oak client using DOS in history (3/1/13).

| Benefit Plan | | | | |
|--|------------------------------|----------------|------------|---------|
| Service Information | Benefit Month Effective Date | Effective Date | End Date | Message |
| Charter Oak. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Charter Oak copays. | 03/01/2013 | 03/01/2013 | 03/01/2013 | |

| Deductible Information | | | | |
|------------------------|----------------|------------|------------------------|--|
| Service Information | Effective Date | End Date | Base Deductible Amount | Remaining Amount |
| Charter Oak | 04/01/2012 | 03/31/2013 | \$150.00 | Remaining Amount is only available for current requests. |

| Out of Pocket Information - Includes Deductible and Coinsurance | | | | |
|---|------------|------------|----------------------|--|
| Service Information | Begin Date | End Date | Out of Pocket Amount | Remaining Amount |
| Charter Oak | 04/01/2012 | 03/31/2013 | \$300.00 | Remaining Amount is only available for current requests. |

| Service Type Codes - HP Services | | | |
|----------------------------------|--------------------------|---------|-------------|
| Service Type Code | Service Type Information | Copay | Coinsurance |
| 48 | Hospital - Inpatient | \$0.00 | 10% |
| 50 | Hospital - Outpatient | \$0.00 | 20% |
| 86 | Emergency Services | \$0.00 | 0% |
| MH | Mental Health | | |
| PT | Physical Therapy | \$35.00 | 0% |

Web Eligibility Screen Enhancements

HUSKY B copay amounts

Example 3: HUSKY B client using current date of service

| Benefit Plan | | | | |
|--|------------------------------|----------------|------------|---------|
| Service Information | Benefit Month Effective Date | Effective Date | End Date | Message |
| HUSKY B. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Husky B copays. | 04/01/2013 | 04/01/2013 | 04/01/2013 | |

| Deductible Information | | | | |
|------------------------|----------------|----------|------------------------|------------------|
| Service Information | Effective Date | End Date | Base Deductible Amount | Remaining Amount |
| Husky B | | | \$0.00 | |

| Out of Pocket Information - Includes Deductible and Coinsurance | | | | |
|---|--|--|--|--|
| *** No rows found *** | | | | |

| Service Type Codes - HP Services | | | |
|----------------------------------|----------------------------|---------|-------------|
| Service Type Code ^Δ | Service Type Information | Copay | Coinsurance |
| 35 | Dental Care | | |
| 42 | Home Health Care | \$0.00 | 0% |
| 47 | Hospital | \$0.00 | 0% |
| 50 | Hospital - Outpatient | \$0.00 | 0% |
| 98 | Prof (Phys) Visit - Office | \$10.00 | 0% |

Web Eligibility Screen Enhancements

- The eligibility verification request screen has been enhanced to verify eligibility to the end of the current month.
- The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

| Eligibility Verification Request | | | | |
|----------------------------------|-----------------------------------|---------------------|----------------------|---|
| Client ID | <input type="text"/> | last name | <input type="text"/> | From DOS* <input type="text" value="04/09/2013"/> |
| SSN | <input type="text"/> | First Name, MI | <input type="text"/> | To DOS* <input type="text" value="04/30/2013"/> |
| Birth Date | <input type="text"/> | | | |
| Service Type Code 1 | 30 - Health Benefit Plan Coverage | Service Type Code 2 | <input type="text"/> | |
| Service Type Code 3 | <input type="text"/> | Service Type Code 4 | <input type="text"/> | |
| Service Type Code 5 | <input type="text"/> | | | |
| | | | | <input type="button" value="search"/> |
| | | | | <input type="button" value="clear"/> |

| Eligibility Verification Response | |
|-----------------------------------|--|
| Verification Number | 130990242P |
| Response Text | Client is eligible. Refer to Benefit Plan for specific program coverage. |

| Client Information | |
|--------------------|------------------|
| Client ID | Last Name |
| SSN | First Name, MI |
| Birth Date | Gender |
| Street | City, State, Zip |

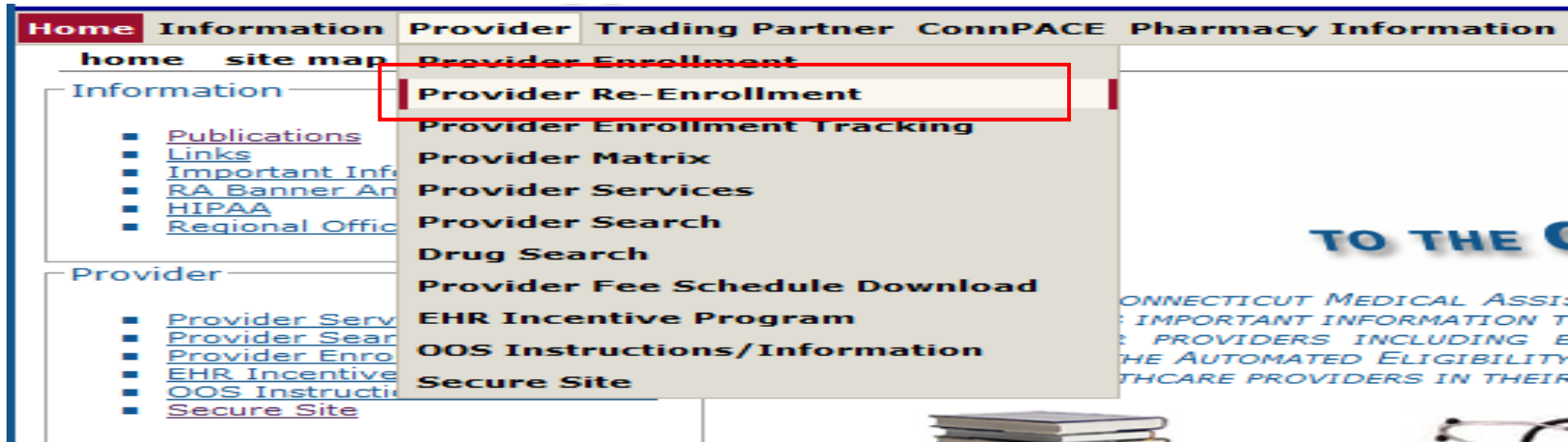
| Benefit Plan | | | | |
|--|------------------------------|----------------|------------|---|
| Service Information | Benefit Month Effective Date | Effective Date | End Date | Message |
| Charter Oak. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Charter Oak copays. | 04/01/2013 | 04/09/2013 | 04/30/2013 | The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service. |

Provider Re-Enrollment

- DSS requires the periodic re-enrollment of all providers.
- Re-enrollment Period
 - Hospitals who complete their re-enrollment on or after January 1, 2012 will be required to re-enroll every five years.
- Hospitals will receive a reminder letter when the provider is due for re-enrollment (30 days prior to the end of their previous enrollment contract).
- This letter contains the Application Tracking Number (ATN). The ATN and NPI or AVRS ID are required to access re-enrollment application.

Provider Re-Enrollment

- Select Provider Re-Enrollment from the Provider drop-down menu



- To log-in to your Re-Enrollment Application, enter the ATN and NPI or AVRS ID

Log In to Your Re-Enrollment Application

- Please enter your Application Tracking Number (ATN) found on your re-enrollment notification letter or contact the Provider Assistance Center at 1-800-842-8440 for assistance in obtaining your ATN.

Required fields are indicated with an asterisk (*)

ATN*

NPI/Non medical provider identifier (AVRS ID)*

Account Demographics

Maintain Organization Members

- Effective January 1, 2012 the Department of Social Services (DSS) will require most performing providers employed by or contracted with hospitals or clinics to enroll in the Connecticut Medical Assistance Program.
- Maintain Organization Members panel allows providers 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 separations are made to their association by your organization.

Account Demographics

Maintain Organization Members

Base Information > Service Location > Location Name Address > EFT Account > Service Language > **Maintain Organization Members**

Maintain Organization Members X

- This Maintain Organization Members panel allows providers to view, add or separate members of their organization. Members must first enroll in the Connecticut Medical Assistance Program in order to join your organization. Members will receive a letter from HP when any additions or separations are made to their association to your organization. Note: 12/31/2299 represents an open ended association with the organization.
- Scroll down to add or separate a member.

Refer to section 10.15 within Chapter 10 of the Provider Manual to view instructions for maintaining your organization members. [Click here to view Chapter 10.](#)

Refer to section 3.1 within Chapter 3 of the Provider Manual to view which provider types and specialties may join your organization. [Click here to view Chapter 3.](#)

☐ All ☒ Current ☐ Historical Organization Member ID Member Business/Last Name Member First Name

*** No rows found ***

Select row above to update -or- click Add button below.

- To add a new member, click the add button.
- To separate a member from your organization, click on the existing member row, then enter the end date of their affiliation with your organization. This date cannot be in the past.

Organization Member ID [Search] Effective Date

Organization Member Name End Date

Account Demographics

Maintain Organization Members

- To add a new member (provider must be already enrolled in Medicaid), 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). This can be backdated up to 6 months from today's date. If it needs to be backdated longer than 6 months it will need DSS approval.
- Enter end date as 12/31/2299 and hit save.

Web Claim Submission

Top 5 reasons to use the Web claim submission tool:

- Easily resubmit previously denied claims.
- Submit secondary claims from Other Insurance or Medicare.
- Adjust claims on the Web and eliminate paper Paid Claim Adjustment Requests (PCAR).
- Claim results are immediate.
- Eliminate paper claims.

Web Claim Submission

Claim Inquiry - 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" value="v"/> |
| Client ID | <input type="text"/> | Status | <input type="text" value="v"/> |
| 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" value="v"/> |
| | | | <input type="button" value="search"/> |
| | | | <input type="button" value="clear"/> |

Web Claim Submission

Claim types that can be submitted through the secure Web site www.ctdssmap.com

- Third Party Liability (TPL) and Medicare paid or denied claims.
- Outpatient claims with National Drug Coding (NDCs).
- Re-submission and adjustments if they are within timely filing.
 - Please refer to provider manual chapter 5 for timely filing guidelines.

Web Claim Submission

Claim types that cannot be submitted through the secure Web site www.ctdssmap.com

- Claims with an ICN that begins with either 12 or 13. These claims were specially handled by HP. The provider should contact HP before attempting to adjust these claims.
- Paid Medicare crossover claims. They must be voided, then resubmitted.
- Adjusting claims that are past timely filing. If the hospital tries to adjust these claims, they will end up denied for timely filing and the monies that were originally paid will be re-couped.



Web Claim Submission

Outpatient Clams Type

| Institutional Claim | | | |
|-------------------------|-----------------------|-----------------|---------------|
| Claim Type* | O - Outpatient Claims | Operating Phys | [Search] |
| ICN | | Facility Number | 008000008 MCD |
| Provider ID | 008000008 MCD | From Date | |
| AVRS ID | 008000008 | To Date | |
| Type Of Bill* | [Search] | Admit Source | [Search] |
| Client ID* | | | |
| Last Name | | | |
| First Name, MI | | | |
| Date of Birth | | | |
| Patient Account Number* | | | |
| Medical Record Number | | Patient Status | [Search] |
| Attending Phys* | [Search] | | |
| Other Physician | [Search] | | |
| Referring Provider | [Search] | Total Charges | \$0.00 |
| Rendering Provider | [Search] | | |
| 837 Version | 5010 | | |

Web Claim Submission

Outpatient Claim Type

Diagnosis **Cause of Injury** **Reason For Visit** **Condition** **Surgical Procedure** **Occurrence/Span**

*** No rows found ***

Code Set

Principal* [Search] Admitting [Search] Other 1 [Search]

Other 2 [Search] Other 3 [Search] Other 4 [Search]

Other 5 [Search] Other 6 [Search] Other 7 [Search]

add more

Detail

| Item | From DOS | To DOS | Revenue Code | HCPCS/Rates | Units | Charges | Status | Allowed Amount |
|------|----------|--------|--------------|-------------|-------|---------|--------|----------------|
| A | 1 | | | | 1.00 | \$0.00 | | \$0.00 |

Type data below for new record.

Item

Revenue Code* [Search]

From DOS*

HCPCS/Rates [Search]

To DOS*

Modifiers [Search] [Search] [Search] [Search]

Units*

Units Of Measurement

Charges*

Status

Allowed Amount

National Drug Code

CoPay Amount

NDC Quantity

TPL Amount

NDC Unit of Measurement

delete add

Additional NDCs (Detail Item 1)

*** No rows found ***

Select row above to update -or- click Add button below.

National Drug Code

Quantity

Unit of Measurement

delete add

Web Claim Submission

Third Party and Medicare secondary claims can be submitted to HP through the Web.

- Billing Instructions are located under Chapter 11 “Other Insurance and Medicare Billing Guides” on the Web site www.ctdssmap.com under Publication scroll to Provider manuals then Chapter 11 and select in the drop down “Institutional Other Insurance/Medicare Billing Guide” and hit View Chapter 11.

Web Claim Submission

Medicare Information and TPL Panels

| Medicare Information | | | | | | | | | |
|----------------------|-------------------------------------|----------------------|-------------------------------------|--|--|--|--|--|--|
| Medicare Carrier | <input type="text" value="MPB"/> | Medicare Paid Date* | <input type="text"/> | | | | | | |
| Coinsurance Amount | <input type="text" value="\$0.00"/> | Deductible Amount | <input type="text" value="\$0.00"/> | | | | | | |
| | | Medicare Paid Amount | <input type="text" value="\$0.00"/> | | | | | | |

| TPL | | | | | | | | | |
|---------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|----------------------|----------------------|----------------------|------------|----|---------------|
| Carrier Code | Plan Name | Policy Number | Paid Amount | Paid Date | Relationship | Last Name | First Name | MI | Date of Birth |
| A | | | | | | | | | |
| Type data below for new record. | | | | | | | | | |
| Client Carriers | <input type="text" value="Other"/> | | | | | | | | |
| Carrier Code* | <input type="text"/> | [Search] | Relationship | <input type="text"/> | | | | | |
| Plan Name | <input type="text"/> | | Last Name | <input type="text"/> | | | | | |
| Policy Number | <input type="text"/> | | First Name, MI | <input type="text"/> | | <input type="text"/> | | | |
| Paid Amount* | <input type="text" value="\$0.00"/> | | Date of Birth | <input type="text"/> | | | | | |
| Paid Date* | <input type="text"/> | | | | | | | | |
| Adjustment Reason Code | <input type="text"/> | [Search] | <input type="text"/> | [Search] | <input type="text"/> | [Search] | | | |
| Adjustment Amount | <input type="text" value="\$0.00"/> | <input type="text" value="\$0.00"/> | <input type="text" value="\$0.00"/> | | | | | | |
| <input type="button" value="delete"/> | | <input type="button" value="add"/> | | | | | | | |

Web Claim Submission

- Claim Status and EOB Information

Claim Status Information

Claim Status PAID

Claim ICN 2212228100008

Paid Date

Paid Amount \$750.00

Charter Oak Coinsurance \$0.00

Charter Oak Deductible \$0.00

EOB Information

| Detail Number | Code | Description |
|---------------|------|--|
| 0 | 2100 | CLIENT NOT FOUND ON ELIGIBILITY MANAGEMENT SYSTEM. |
| 0 | 9997 | REFER TO DETAIL EOB |
| 1 | 9977 | PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED |
| 2 | 9980 | ANCILLARY SERVICES INCLUDED IN PER DIEM RATE. |
| 3 | 9980 | ANCILLARY SERVICES INCLUDED IN PER DIEM RATE. |
| 4 | 9980 | ANCILLARY SERVICES INCLUDED IN PER DIEM RATE. |

cancel

adjust

void

copy claim

new claim

Web Claim Submission

Inpatient Claim Type

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

home claim inquiry professional **institutional** dental eyeglass vision and denture history

Quick Links

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

Institutional Claim

| | | | |
|-------------------------|---------------------------------|------------------|---------------------------------|
| Claim Type* | I - Inpatient Claims | Operating Phys | <input type="text"/> [Search] |
| ICN | <input type="text"/> | Facility Number | 008000008 MCD |
| Provider ID | 008000008 MCD | From Date* | <input type="text"/> |
| AVRS ID | 008000008 | To Date* | <input type="text"/> |
| Type Of Bill* | <input type="text"/> [Search] | Admit Source* | <input type="text"/> [Search] |
| Client ID* | <input type="text"/> | Admission Type* | <input type="text"/> [Search] |
| Last Name | <input type="text"/> | Birth Weight | <input type="text"/> |
| First Name, MI | <input type="text"/> | Admission Date* | <input type="text"/> |
| Date of Birth | <input type="text"/> | Admission Hour* | <input type="text"/> |
| Patient Account Number* | <input type="text"/> | Discharge Hour* | <input type="text"/> |
| Medical Record Number | <input type="text"/> | Patient Status* | <input type="text"/> [Search] |
| Attending Phys* | <input type="text"/> [Search] | Covered Days | <input type="text"/> |
| Other Physician | <input type="text"/> [Search] | Non Covered Days | <input type="text"/> |
| Referring Provider | <input type="text"/> [Search] | Total Charges | \$0.00 |
| Rendering Provider | <input type="text"/> [Search] | | |
| 837 Version | 5010 | | |

Prior Authorizations

Inpatient admissions that change from Medical to Psychiatric

- 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.

Prior Authorizations

Inpatient admissions that change from Psychiatric to Medical

- 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.
- If the hospital gets two authorizations for one admission their claim may be only partially paid or the claim may deny due to the two authorizations overlapping.
 - In this case the hospital would be required to have one of the authorization voided for the claim to process correctly.

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).
- 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

Outpatient Radiology Services

- 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.
- For retro-eligibility, hospitals should be contacting Care to Care for prior authorization for radiology services that require PA @ CHNCT provider line at 1-800-440-5071.
 - Hospitals must show proof that the member was not eligible at time of services.

Prior Authorizations

Outpatient Radiology Services

- Revenue center code (RCC) 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 valid CPT codes will not require a PA.
- For a complete list of imaging and radiology services that require PA, please refer to provider bulletin 12-18 "Important Changes to Radiology Services"
- Advanced imaging and nuclear cardiology procedures performed as part of an emergency or observation room visit will NOT require prior authorization. HP will pay without PA as long as they are billed on the same claim.

Prior Authorizations

Third Party Liability and/or Medicare

- For clients who have other insurance, hospitals are required to follow the same PA procedures for those clients who do not have other insurance.
- For clients that are dually eligible with Medicare or Medicare HMO (Commercial Medicare), a PA will not be required if Medicare approves the service as the primary payer.

Hospital Inpatient Services

Provider bulletin 2012-32 Hospital Inpatient Services

- Effective for dates of service on or after January 1, 2012, the behavioral health ASO will utilize a distinct service class and revenue center code when authorizing medically necessary discharge delay for HUSKY Health youth under the age of 19.
- There will be no change in the revenue center codes (RCC) for medically necessary acute days. The revenue center code for pediatric psychiatric medically necessary discharge delay is 224.

Hospital Inpatient Services

Provider bulletin 2012-32 Hospital Inpatient Services

- There will not be distinct authorizations for the acute care days and the discharge delay days. Effective immediately, all days of the stay will be included under a single authorization number, but distinguished by the dates covered as either acute care days or discharge delay days.
- Hospitals' current Value Options authorizations could contain revenue code/list 13 for acute care days and the new revenue code/list 2039 for the discharge delay days. In these cases the hospital should be billing the discharge delay days with RCC code 224.

Hospital Inpatient Services

Provider bulletin 2012-32 Hospital Inpatient Services

| Line Item | | | | | | | | | | |
|-----------|-----------------|-------------------|------------------|--------------------|----------|----------------|---------------------|---------------|--------------|-------------------|
| Line Item | Requested Units | Requested Dollars | Authorized Units | Authorized Dollars | Status | Procedure Code | Procedure Code List | Proc/Mod List | Revenue Code | Revenue Code List |
| 01 | 35.000 | \$0.00 | 29.000 | \$0.00 | Approved | | | | | 13 |
| 02 | 6.000 | \$0.00 | 6.000 | \$0.00 | Approved | | | | | 2039 |

Type changes below.

Line Item 02

Service Type Code* Revenue Code

Procedure Code/List [Search] [Search]

Modifier 1 [Search]

Modifier 2 [Search]

Modifier 3 [Search]

Modifier 4 [Search]

Revenue Code/List [Search] 2039 [Search]

Proc/Mod List

Requested Eff./End Dates* 07/30/2012 08/05/2012

Requested Units/Dollars* 6.000 \$0.00

NDC [Search]

Status Approved

Authorized Units/Dollars 6.000 \$0.00

Authorized Eff./End Dates 07/30/2012 08/05/2012

Used Units/Dollars 6 \$0.00

Available Units/Dollars 0 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

- In these cases the hospital should be billing the discharge delay days with RCC code 224.

Hospital Inpatient Services

Provider bulletin 2012-32 Hospital Inpatient Services

- When the hospital has a PA with both acute care days and discharge delay days, the hospital will need to submit two claims to HP.
 - One claim should be billed for the acute care days as a Type of Bill (TOB) "112" with a patient status "30".
 - The second claim for the discharge delay days (RCC 224) should be billed as a TOB "114" with patient status "01".

Provider Bulletins

Provider Bulletins

- Access the Publications page by selecting Publications from either the Information box on the left hand side of the home page or from the Information drop-down menu.
- Bulletin Search 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 provider title, you can search by any word as long as that word is in the title of the bulletin.

Provider Bulletins

Provider Bulletins

- Provider bulletin search by title using the word “inpatient”

Bulletin Search

Year

Provider Type

Number

Title

| Search Results | | |
|-------------------|---|----------------|
| Bulletin Number ▾ | Title | Published Date |
| PB12-61 | Certificate of Need Requirement for Inpatient Admissions for Individuals Under t... | 12/19/2012 |
| PB12-32 | Hospital Inpatient Services | 07/09/2012 |
| PB11-75 | Payment for Inpatient Hospital Care Provided to Inmates | 10/04/2011 |
| PB11-45 | Inmate Inpatient Hospital Coverage | 10/10/2011 |
| PB07-51 | Connecticut Behavioral Health Partnership Coverage of Professional Services for ... | 01/01/2007 |
| PB06-54 | Connecticut Behavioral Health Partnership (CTBHP) Implementation of Prior Author... | 01/01/2006 |
| PB06-102 | Clarification in the Processing of Behavioral Health Related Inpatient Claims fo... | 01/01/2006 |
| PB04-19 | Change to Inpatient Claim Submission Requirements with a Medicare Part B Payment | 01/01/2004 |
| PB03-76 | Change in the Processing of Behavioral Health Inpatient Claims For State Adminis... | 01/01/2003 |

Provider Bulletins

Provider Bulletin 2013-11 "RCC Crosswalk to New Psychiatric Procedure codes for 2013"

- The purpose of this bulletin is to provide guidance to outpatient hospitals concerning the new psychiatric procedure codes for 2013.
- Several hospitals have asked the department for guidance concerning how to crosswalk the new CPT codes to RCC used by the hospitals.
- The department is not changing how it defines or how providers should authorize the following RCCs:
 - 900-901, 905-907, 913-916 and 918-919

Provider Bulletins

Provider Bulletin 2013-11 Summary Chart

| <i>RCC</i> | <i>Description</i> | <i>CPT or HCPC</i> | <i>Comment</i> | <i>RCC</i> | <i>Description</i> | <i>CPT or HCPC</i> | <i>Comment</i> |
|------------|-------------------------|--------------------|--|------------|-----------------------|----------------------------------|---|
| 900 | Diagnostic evaluation | 90791, 90792 | Once upon completion of the evaluation | 914 | Individual Therapy | 90832-90838, 90845, 90865, 90880 | Not billable when a component of IOP, PHP or EDT. |
| 901 | Electroshock Treatment | 90870 | | 915 | Group Therapy | 90853 | Not billable when a component of IOP, PHP or EDT |
| 905 | IOP-Mental health | S9480 | Do not bill components | 916 | Family Therapy | 90846, 90847, 90849 | Not billable when a component of IOP, PHP or EDT |
| 906 | IOP-Chemical Dependence | H0015 | Do not bill components | 918 | Psychiatric Testing | 96101, 96110, 96111, 96118 | |
| 907 | Extended Day Treatment | H2012 | Do not bill components. DCF license required | 919 | Medication Management | 99201-99215, M0064 | Not billed the same day as PHP, IOP or other services performed by MD or APRN such as 90833, 90836 or 90838 |
| 913 | Partial Hospital | H2013 | Do not bill components | | | | |

- The department is not changing how it defines or how providers should authorize the following RCCs:
 - 900-901, 905-907, 913-916 and 918-919

Hospital Billing

Hospital Outpatient Surgery Claims

- If you need to bill multiple CPT codes, you will need to lump the total charges under the first surgery RCC code with the primary CPT code and then enter zero charge in the additional RCC line with the additional CPT codes.
- 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".

Hospital Billing

National Drug Codes (NDC)

- HUSKY A, C and D clients for RCCs 250-253, 258-259 and 634-637 require claims to be submitted with the NDC and HCPCS codes.
- Please refer to provider bulletin 2008-35 “National Drug Codes (NDC) Required for Outpatient Hospital Claims due to the Implementation of the Federal Deficit Reduction Act (DRA) of 2005” or provider bulletin 2008-42 “Most Frequently Asked Questions related to the billing requirements necessary to support and comply with the implementation of the Deficit Reduction Act (DRA) of 2005” for complete instructions on claim submission requirements for submitting National Drug Codes (NDC) required for outpatient hospital claims.

Hospital Billing

National Drug Codes (NDC)

- Charter Oak and 340B Hospitals you should not be submitting NDC and HCPCS codes.
 - If you are billing the following RCCs 250-253, 258-259 and 634-637 and billing for the same RCC multiple times, the additional RCC codes will deny as a duplicate with EOB 5000 "Possible Duplicate of a Paid Claim or a Claim Currently in Process".
 - When billing those RCC multiple times you should only bill the RCC one time and enter the total billed amount on that line.

Hospital Billing

National Drug Codes (NDC)

- If you need assistance determining the correct corresponding HCPCS codes that goes with the NDC you are billing, please refer to the Web site www.ctdssmap.com selecting "Provider" then "Drug Search".
 - You can enter the NDC code you are billing for and it will provide you with a corresponding HCPCS code.
 - Both the NDC and corresponding HCPCS code must be submitted for the claim to be processed. Failure to bill appropriately will either cause the services to be denied or re-couped due to the State not being able to collect rebate dollars.

Hospital Billing

Provider Drug Search

Home Information **Provider** Trading Partner ConnPACE Pharmacy Information

Home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search **drug search**

provider fee schedule download ehr incentive program oos instructions/information secure site

Drug Search

NDC Drug Name Drug Sounds-Like

HCPCS HCPCS Description HCPCS Sounds-Like

DOS

Records

| Search Results | | | | | | | | | |
|----------------|----------------|----------------------------------|---------------|-----------|--------------|---|------------|---|-------------------------------------|
| NDC | Brand Name | Generic Name | Dose Strength | Dose Form | Package Size | HCPCS | EndDate | HUSKY A, C, D, TB and Fam Plan Rebateable | HUSKY B, CHOAK, CP CADAP Rebateable |
| 00409653301 | VANCOMYCIN HCL | VANCOMYCIN HCL INTRAVEN. 1G VIAL | 1 gram | VIAL | 1 | J3370 - INJECTION, VANCOMYCIN HCL, 500 MG | 12/31/2299 | Y | N |

Hospital Billing

Revenue Center Code 724 and 729

- When billing inpatient hospital claims, hospitals can no longer bill with RCC 724 and 729 as ancillary codes. Hospitals are required to bill these services under RCC 720.
 - If the hospital bills inpatient claims with RCC 724 and/or RCC 729, the claims will deny with Explanation of Benefit (EOB) code 570 "Header Total Days Less Than Covered Days", 572 "Quantity Disagrees with Days Elapsed" and 876 "Header Quantity Disagrees with Days Elapsed"
 - Hospitals will need to correct the RCC code and re-submit the claim for processing.
- RCC 724 should not be used when billing outpatient claims.

Hospital Billing

Billing with CPT or HCPCS procedure codes

- The Department of Social Services (DSS) will be requiring hospitals to bill with a CPT or HCPCS procedure code on detail lines of an outpatient or outpatient crossover claim in addition to the RCC.
- Implementation is being delayed and will not occur on April 1, 2013 as originally announced. Prior to implementation the Department will notify providers of billing requirements and the effective date via a provider bulletin and/or IM.
- DSS anticipates there will be a short grace period during which time an edit will post to the claim, but the claim will still pay. The grace period will allow the Department and hospitals to identify and fix any issues prior to full implementation.

Hospital Billing

ICD-10 Changes

- On October 1, 2014 the ICD-9 code set used to report medical diagnosis and inpatient procedures will be replaced by ICD-10 code sets.
- The transition to ICD-10 is required for all providers, payers and vendors.
- Please note this change does not effect CPT coding for outpatient procedures and physician services.

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

