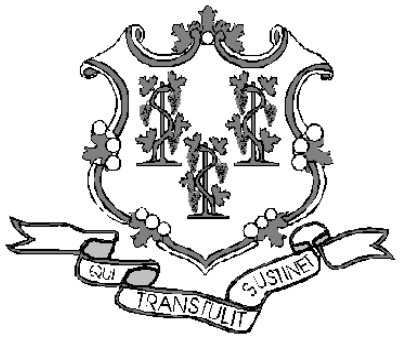
Connecticut Department of Social Services

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

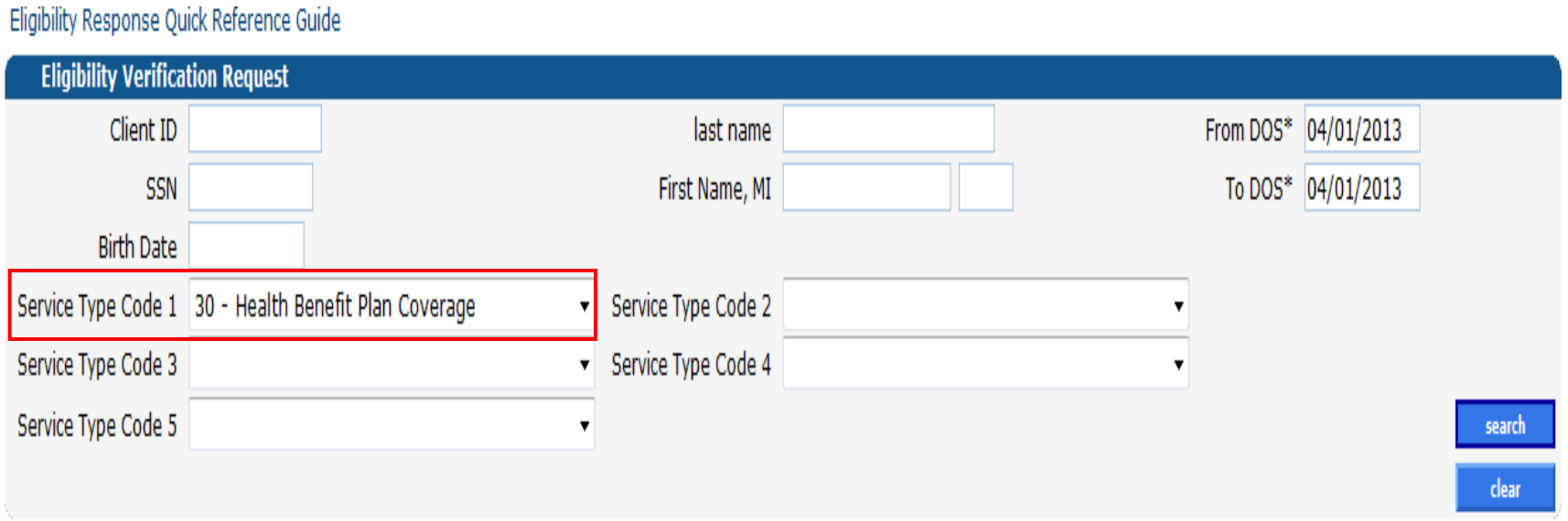
Search by Service Type Codes

- 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



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	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 ***

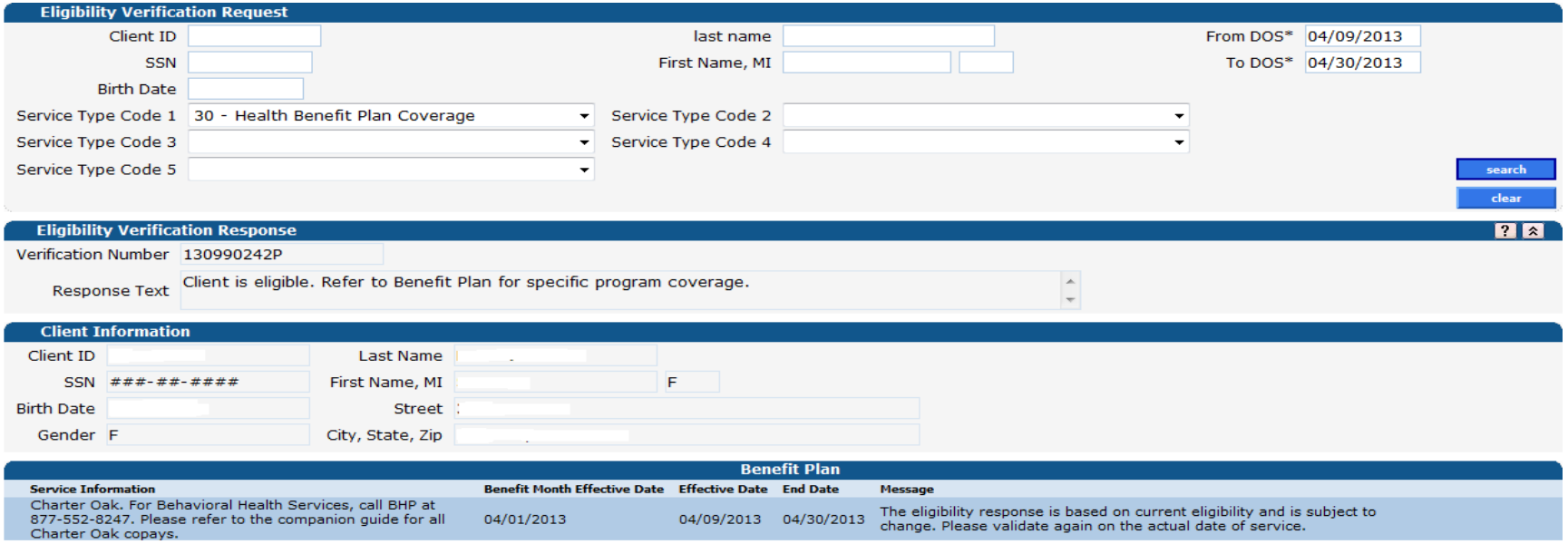
Service Type Codes - HP Services

Service Type Code	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.



Provider Re-Enrollment

- DSS requires the periodic re-enrollment of all providers.

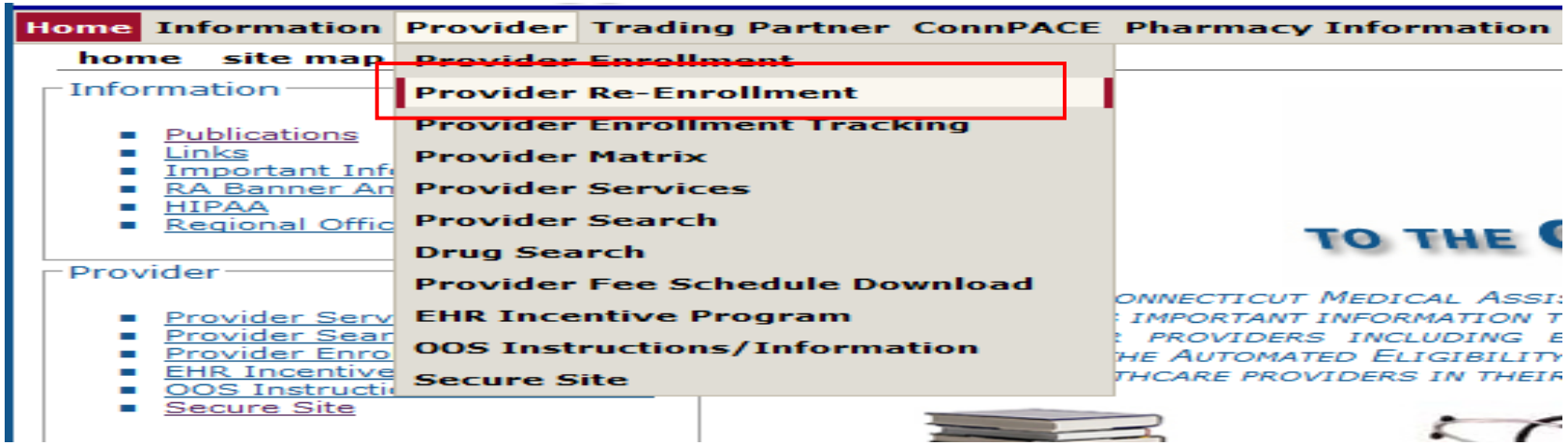
- Re-enrollment Period
  - Hospitals who complete their re-enrollment on or after January 1, 2012 will be required to re-enroll every five years.

- 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).

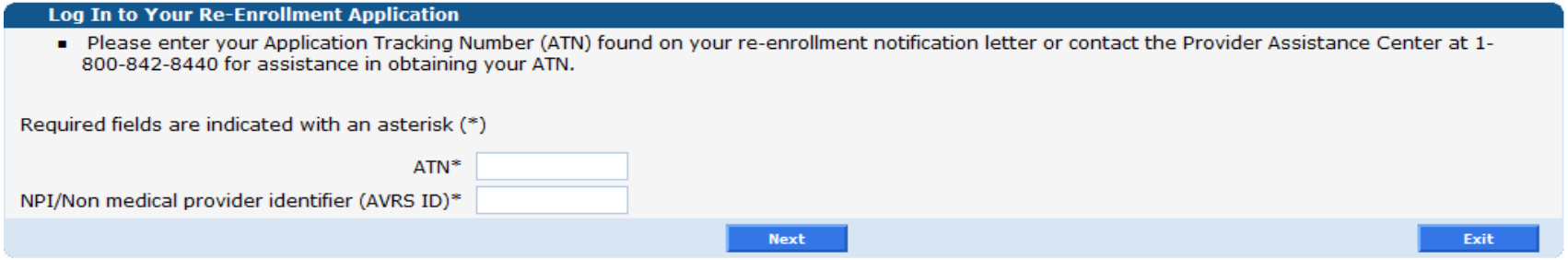
- This letter contains the Application Tracking Number (ATN). The ATN and NPI or AVRS ID are required to access re-enrollment application.

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



Account Demographics

Maintain Organization Members

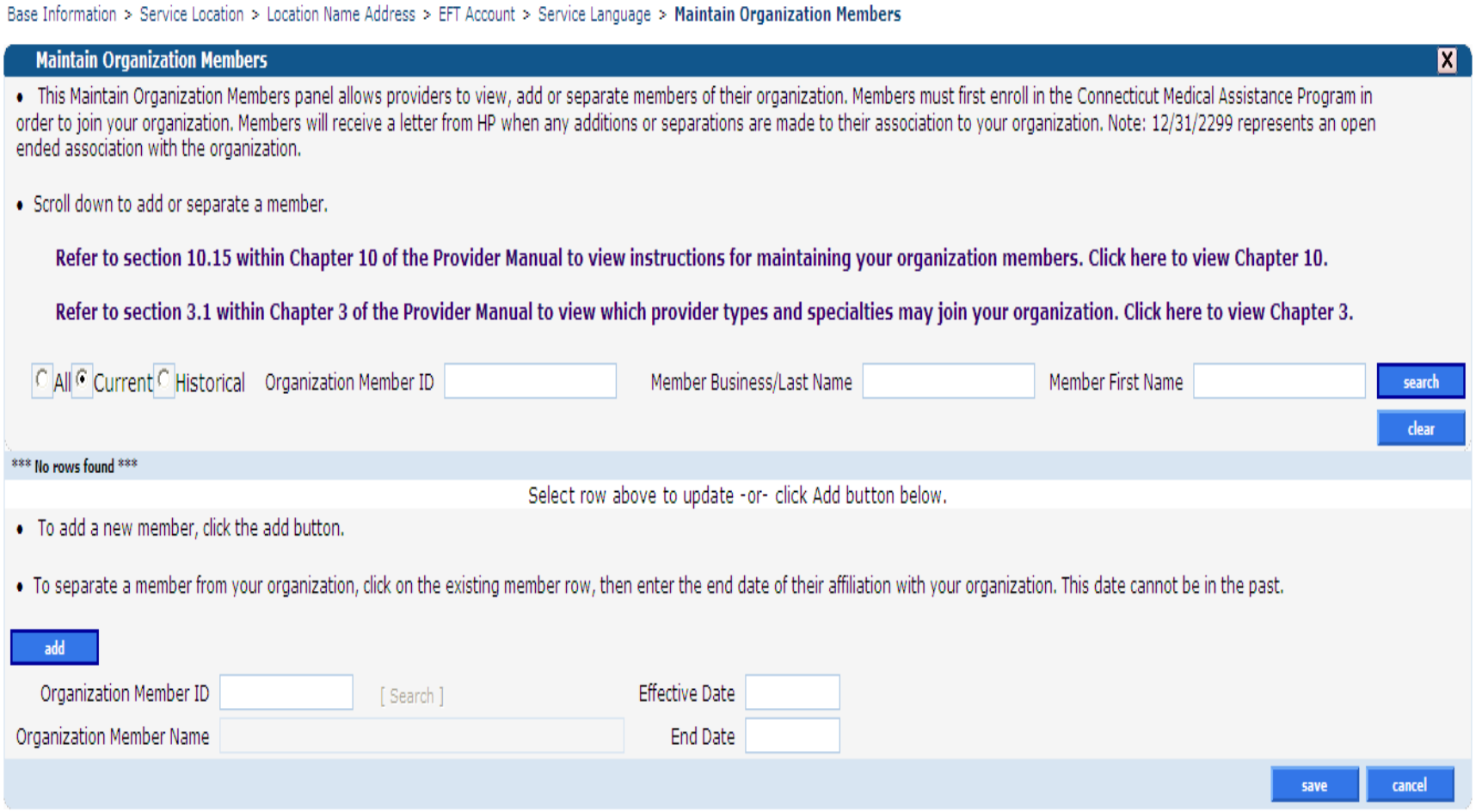
- Effective January 1, 2012 the Department of Social Services (DSS) will require most performing providers employed by or contracted with hospitals or clinics to enroll in the Connecticut Medical Assistance Program.

- 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



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 then 6 months it will need DSS approval.

- Enter end date as 12/31/2299 and hit save.

Web Claim Submission

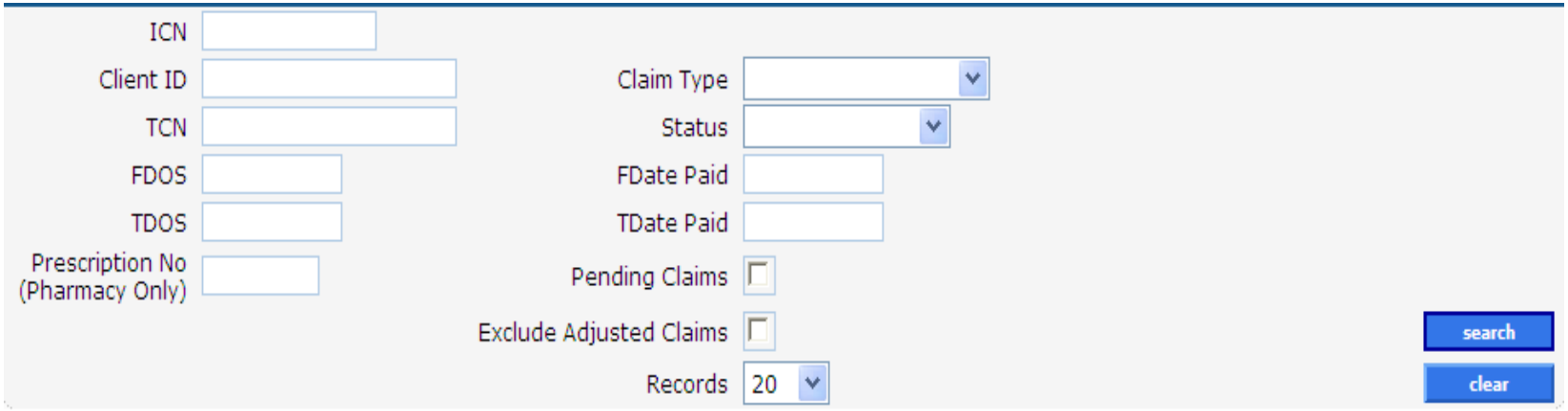
Top 5 reasons to use the Web claim submission tool:

- 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.



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

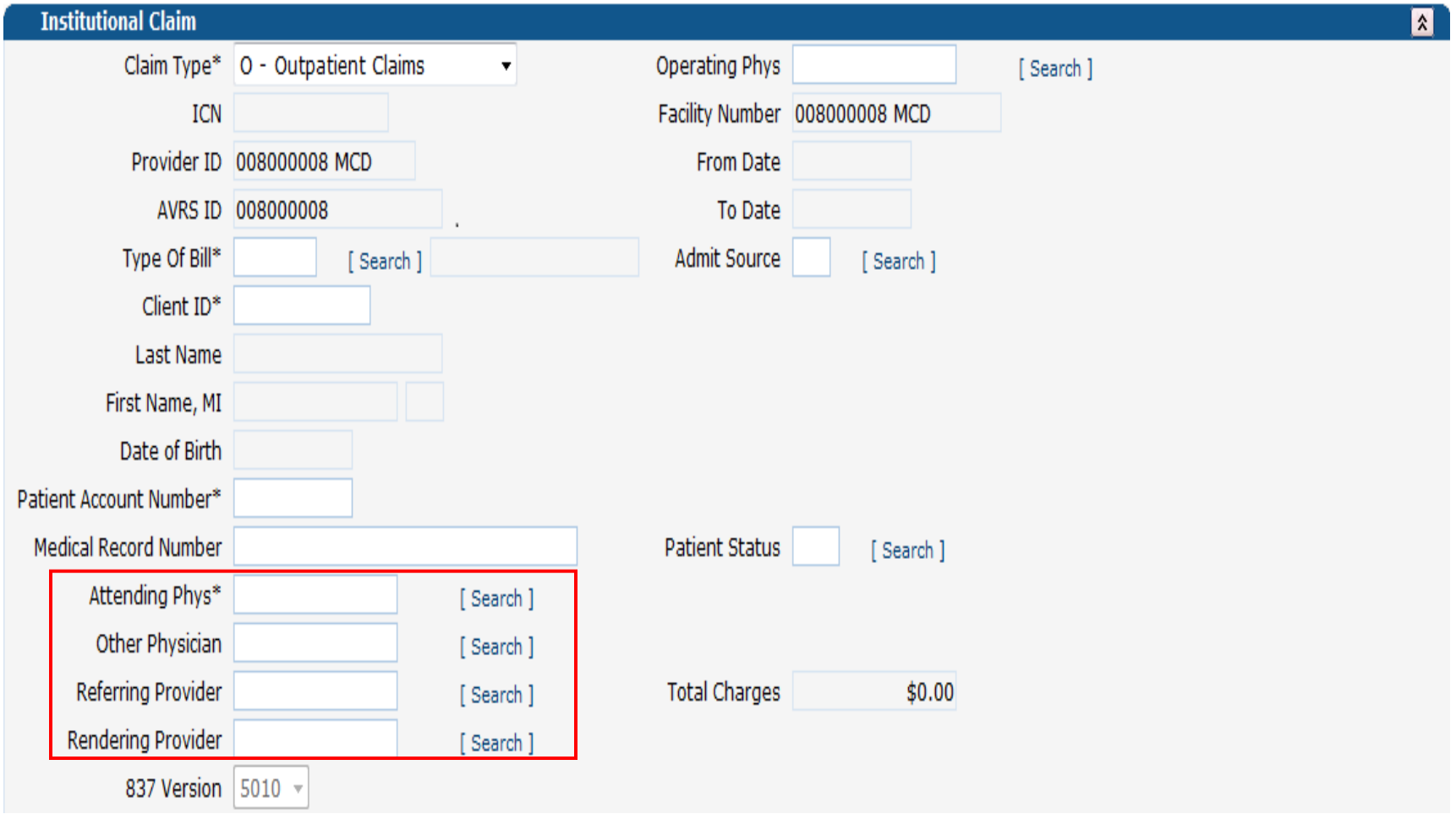
- Claims with an ICN that begins with either 12 or 13. These claims were specially handled by HP. The provider should contact HP before attempting to adjust these claims.

- 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.

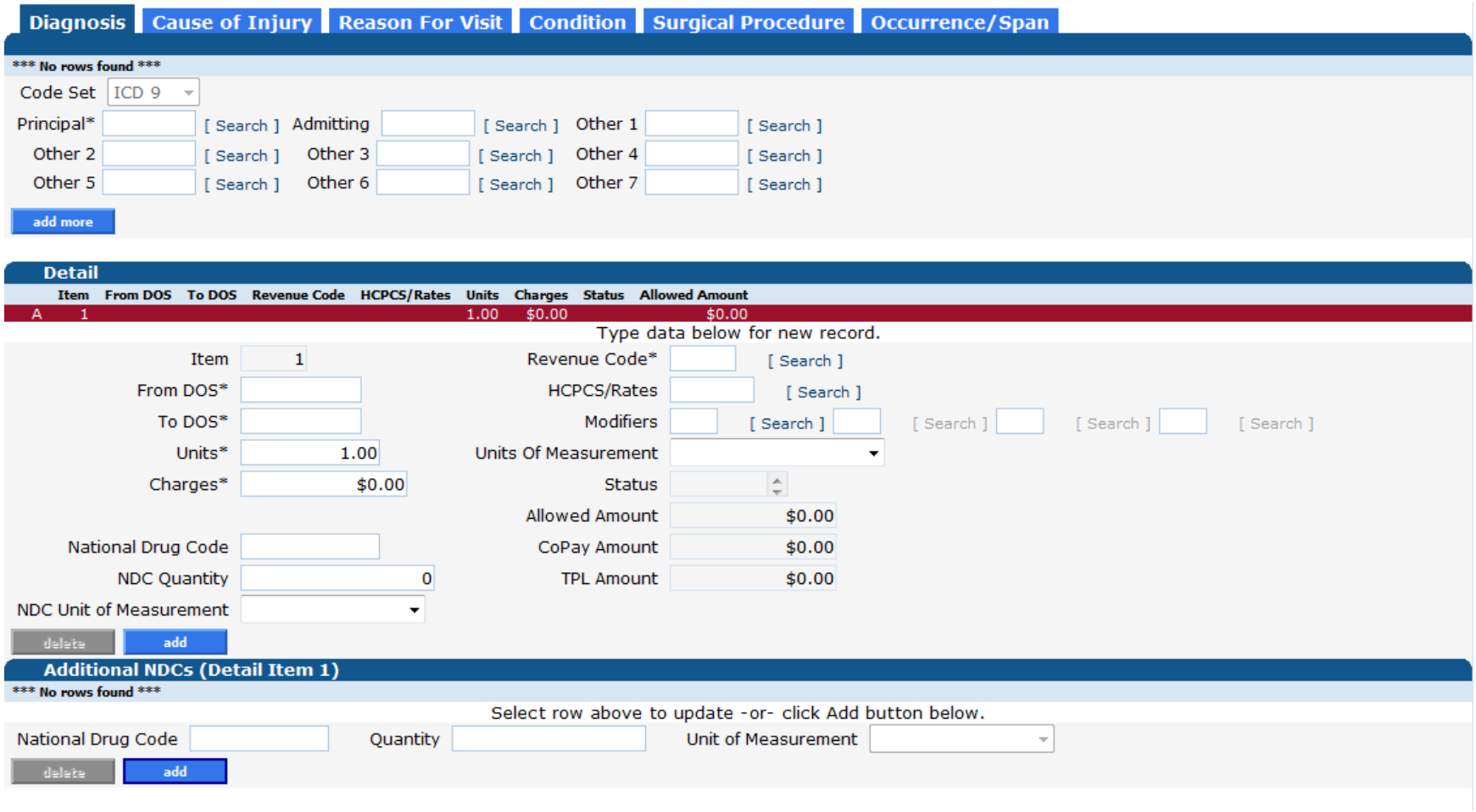
Web Claim Submission

Outpatient Clams Type



Web Claim Submission

Outpatient Claim Type



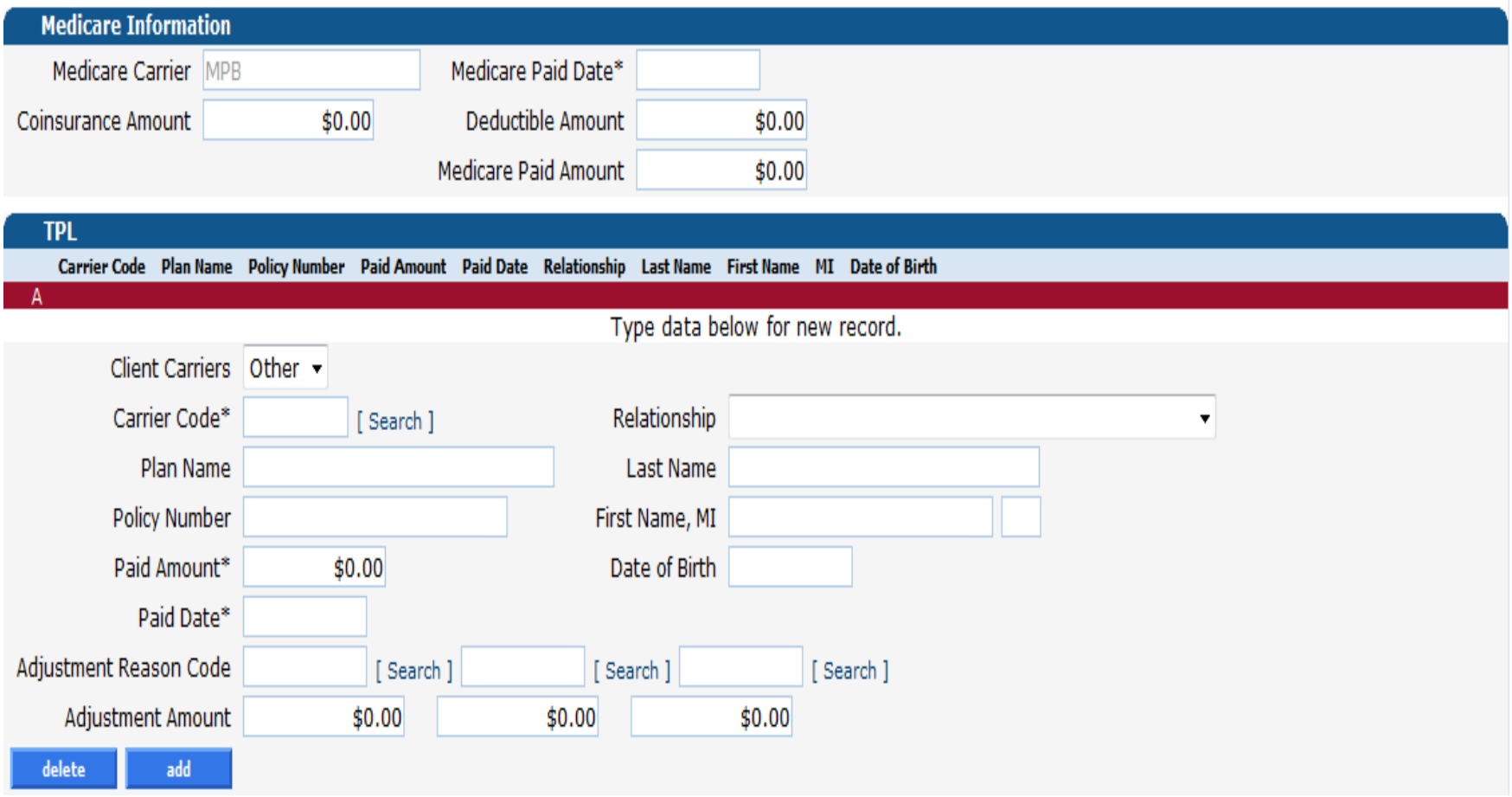
Web Claim Submission

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



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

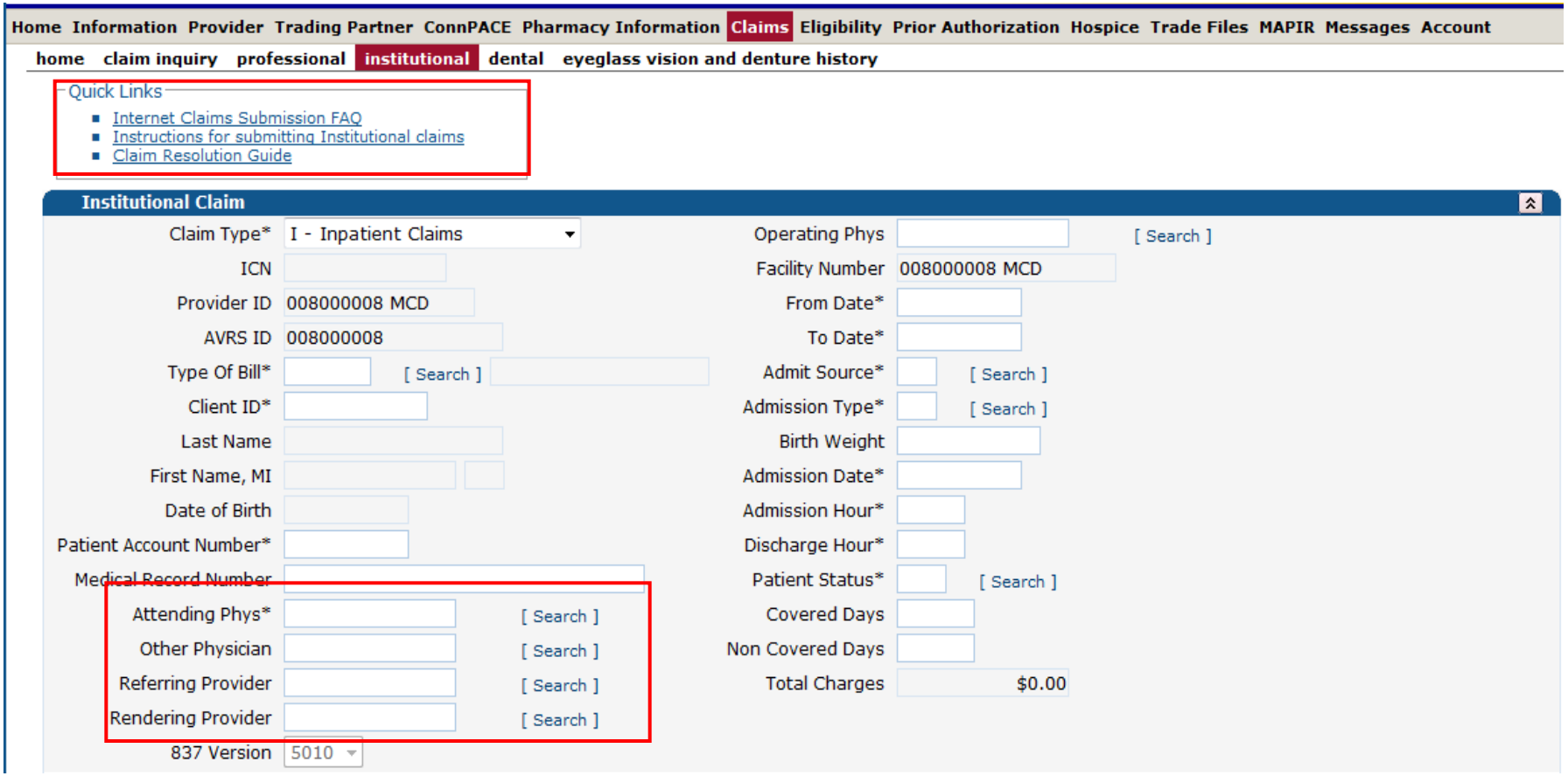
EOB Information

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 Clam Type



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

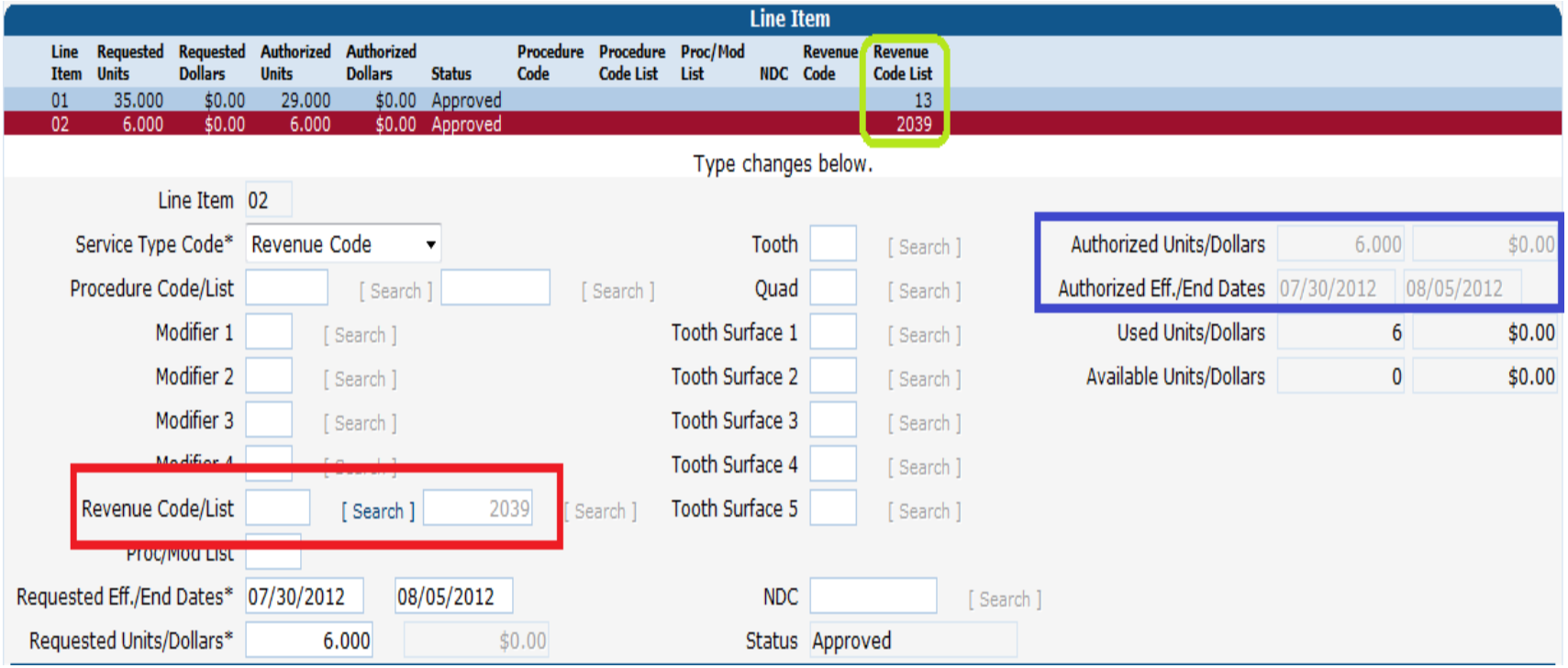
Provider bulletin 2012-32 Hospital Inpatient Services

- 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



- 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 Hospital ▾

Number Title inpatient

search

clear

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

RCC	*Description*	*CPT or HCPC*	*Comment*	*RCC*	*Description*	*CPT or HCPC*	*Comment*
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.

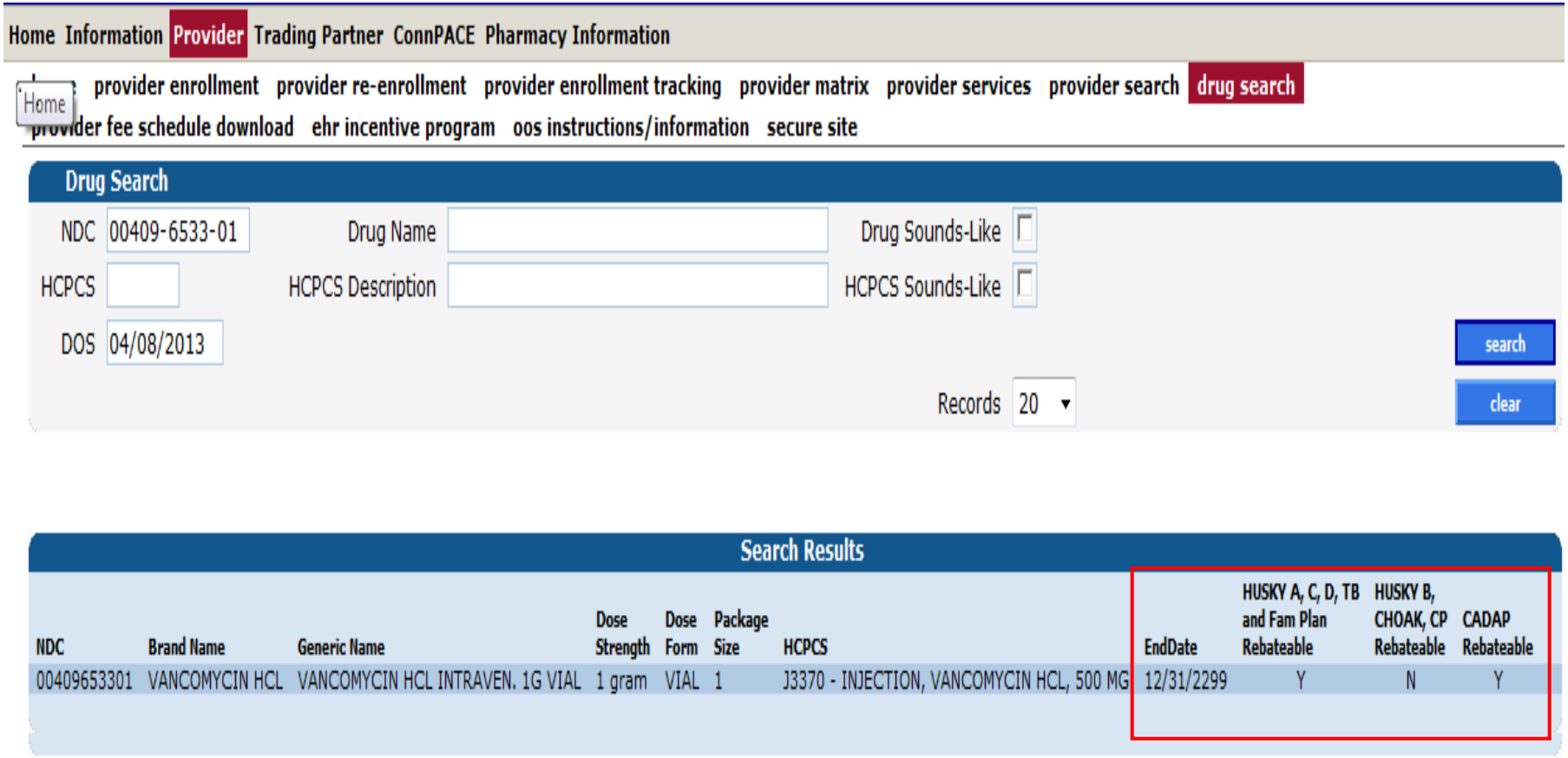
Hospital Billing

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



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 additional 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