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## CHAPTER 10 – CLAIMS SUBMISSION AND PAYMENT

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### ***General Information***

- CHNCT shall not be liable for payment to any provider/practitioner for services rendered to or for an individual determined not to be a member of CHNCT on the date(s) of service.
- Before a claim can be processed for payment, all necessary information on the CMS 1500 or UB04 forms must be completed correctly or the claim may be denied. For referred services, the appropriate prior authorizations must be obtained and appear on the claim form to qualify for payment. For non-referred services, only the services specified by contract are paid. Without all necessary information, claims processing may be delayed and claim payment denied.
- All clean claims will be processed and paid within forty-five days. A clean claim is defined as a bill for service(s) or goods, a line item of services or all services and/or goods for a recipient contained on one bill which can be processed without obtaining additional information from the provider of service(s) or a third party; a clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
- Any clean claim not paid within the 45-day time period will be paid interest at the rate of fifteen percent (15%) per annum commencing on the forty-sixth (46th) day after receipt.
- If CHNCT finds that claims are overstated based on medical or financial audits, an appropriate reduction in reimbursement will be made. Similarly, if CHNCT finds that an overpayment has been made, the provider will be notified that CHNCT is owed a refund, payable within 30 days after notification. If repayment is not made within the 30-day period, CHNCT reserves the right to reduce future claims payments by the overpayment amount.
- Below is a list of the documentation which is required when submitting claims with late charges :
- Copy of the late charges itemized statement
- Copy of original charges
- UB04 for late charges
- If medical records are necessary by CHNCT in order to adjudicate a claim, providers will receive a written request. CHNCT must receive the requested medical records within 90 days from the date of the written request.
- When CHNCT is the secondary payer, claims must be submitted with the primary payor's EOB within 120 days from the date of the primary payer's EOB.
- Claims submitted after the timely filing period, as defined in your Provider Agreement, when CHNCT is the primary payor will not be paid, absent extenuating circumstances as determined by CHNCT.
- Hospitals billing newborn inpatient claims should expect a slight delay in processing from CHNCT. At the time a newborn claim is received, CHNCT may not have received enrollment information on this member from HUSKY. If the newborn is not in our system, our Member Services department will contact HUSKY to verify the newborn should be enrolled with our plan and request that the necessary information is forwarded to CHNCT.
- When submitting claims for multidisciplinary exams, a provider must bill with the diagnosis code V62.5 (legal Circumstances) in order for CHNCT to process the claim appropriately.

### ***Members Held Harmless***

By entering into a provider agreement with us, you have agreed to accept payment directly from CHNCT. Payment from CHNCT constitutes payment in full for all covered services you render to CHNCT HUSKY A, HUSKY B and Charter Oak Health Plan members, except any permissible co-payment allowed by the HUSKY B and Charter Oak Health Plan program. Providers may

not balance bill CHNCT HUSKY A, HUSKY B and Charter Oak Health Plan members for the difference between your actual charge and the contracted amount. Federal law prohibits billing any Medicaid recipient for covered services. A Provider may only bill a HUSKY A member for goods and services, which are not covered by Medicaid, when the member knowingly elects to receive the goods or services and enters into an agreement in writing to pay for such goods or services prior to receiving them.

### ***Co-payment Limitations for HUSKY B***

Providers may not collect co-payments for HUSKY B Covered Services from members of federally recognized American Indian tribes and Native Alaskans who have been determined to qualify for this exemption. The notation “NO COPAY” on the HUSKY B identification card identifies such Members, and providers should ensure that such members do not pay a co-payment by looking at the identification card.

Other families participating in HUSKY B may be eligible for an annual aggregate co-payment limit, and are not obligated to pay any co-payment once that limit has been reached in a plan year. When an eligible family reaches the annual aggregate co-payment limit, CHNCT shall inform providers that the co-payment

limit has been met, that the providers and any subcontractors cannot charge further co-payments within the annual period, and the date when the annual period ends. CHNCT provides this same information to the member.

Providers are required to repay any erroneously collected co-payments (either because the member is a “NO COPAY” member, or has met the applicable co-payment limit) to the member within 3 months of detection of the erroneous collection.

### ***Coordination of Benefits***

Coordination of benefits (COB) is a process, regulated by State law that allows health plans to eliminate the opportunity for a person to profit from duplicate health plan coverage. Under detailed rules, generally one health plan is determined to be “primary” and that plan pays without regard to the other. The “secondary” health plan then makes only a supplemental payment, which results in a total payment of not more than

the amount payable for the covered service or more than the total billed. CHNCT coordinates benefits with Medicare and any other health plans that may be responsible for paying for a member’s health care. HUSKY A is always payer of the last resort.

CHNCT is responsible for educating its members on how to access services when a third party insurer covers a member. If a third party insurer requires the member to pay any co-payment, coinsurance or deductible, CHNCT is responsible for making these payments on behalf of the member, even if the services are provided outside of CHNCT’s provider network.

If the member’s third party insurer pays for only some of the services or for only part of a particular service, CHNCT is liable up to the amount covered by CHNCT’s fee schedule for the full extent of services covered, even if the services are provided outside the CHNCT provider network. In no instance, shall members be liable for co-payments for the services. CHNCT is bound by any prior authorization decisions made by the third party insurer.

Workers’ compensation and no-fault automobile insurance carriers, if applicable, are always primary; HUSKY A is always last payer. If there is clinical care rendered as a result of a motor vehicle accident, CHNCT would not deny the claim. CHNCT has a contract with an entity to pursue CHNCT’s receipt of monies, which has been paid out in third party liability situations, such

as motor vehicle accident related care.

To reduce the time required to process a possible COB claim, providers are encouraged to question members as to whether duplicate coverage exists or may exist. If it does, we ask that the provider indicate on the claim form whether a member is covered by another health plan. When CHNCT is the secondary carrier, the provider must bill the primary carrier first. When payment or a denial is received from the primary carrier, a copy of the primary carrier's EOB should be included with claim sent to CHNCT. The primary carrier's EOB must be a complete EOB with total payments and explanation of denial codes in order for CHNCT to coordinate.

Providers are required to inform CHNCT of any potential third-party coverage available to the member or if a provider becomes aware that a member has lost eligibility for third-party coverage previously available.

There is no COB with HUSKY B or Charter Oak If a HUSKY B or Charter Oak member has other insurance coverage, he or she would be ineligible for HUSKY B, HUSKY Plus and Charter Oak. These programs are for uninsured children and adults.

If any amount is due and payable by the provider/practitioner to CHNCT under contractual agreement or any other agreement between the parties, and the amount remains unpaid for a period of time as defined in your Provider Agreement after written notice, CHNCT shall have the right to set-off this amount and apply it against any and all amounts due CHNCT.

### ***Claim Requirements***

CHNCT requires certain information to be included on a claim in order for it to be considered and processed. The criteria listed below do not define a "clean claim" or determine if a claim will be paid; it only establishes the minimum requirements for CHNCT to consider the form a claim.

The following information should be submitted on a CMS 1500 Form, or in an electronic format acceptable to CHNCT, in order for the information to be considered a claim:

<b><u>Item Number</u></b>	<b><u>Item Description</u></b>
1a	Insured's ID Number
2	Patient's Name
3	Patient's Birth Date and Sex
4	Insured's Name
10a	Patient's Condition- Employment
1 0b	Patient's Condition- Auto Accident
1 0c	Patient's Condition- Other Accident
11	Insured's Policy Group Number (if provided on ID card)
11d	is there another health benefit plan?
21	Diagnosis Code(s)
24A	Dates of Service
24B	Place of Service
24D	Procedures, Services or Supplies
24E	Diagnosis Code(s)
24F	Charges

24G	Days or Units
24J	Rendering Provider NPI
25	Federal Tax ID Number
28	Total Charge
31	Signature of Provider or Supplier with Date
32	Name & Address of Facility where Services were Rendered
33	Provider's or Supplier's Billing Name, Address, Zip Code, Phone Number, and Medicaid Number
33A	Vendor NPI

**The following information should be submitted on a UB04 Form, or in an electronic format acceptable to CHNCT, in order for the form to be considered a claim:**

<b><u>Item Number</u></b>	<b><u>Item Description</u></b>
1	Provider Name and Address
3	Patient Control Number
4	Type of Bill
5	Federal Tax ID Number
6	Statement Covers Period
8	Patient Name
10	Patient's Birth Date
11	Patient's Sex
12	Admission Date
13	Admission Hour
14	Type of Admission
16	Discharge Hour
17	Discharge Status
1-28	Condition Codes
1-34	Occurance/Date
1-36	Ocurrance/Span
39-41	Value Amount/Codes
42	Revenue Codes
43	Revenue Description
44	HCPCs/ CPT4 Codes
45	Service Date
46	Service Units
47	Total Charges by Revenue Codes
50	Payer ID
51	Provider's Medicaid Number

56	Vendor NPI Number
58	Insured's Name
60	Patient's ID Number
62	Insurance Group Number (if on ID Card)
66A and B	Diagnosis
69	Admitting Diagnosis
72	E-Code
74-74E	Principal Procedure
76	Attending NPI Number
78 and 79	Other Physician

\*\*There may be additional requirements for providers who submit claims electronically to CHNCT. For more information on electronic claims submission, please contact CHNCT's Management Information Systems department at 1-203-949-4000.

### ***Corrected Claim***

When submitting a corrected CMS 1500claim due to a billing error (i.e. 5th digit diagnosis denial, invalid CPT-Codes, etc.) please have the corrected claim stamped to clearly identify that this is a "Corrected Claim." This will prevent the claim from being denied as a duplicate claim. Corrected claim submissions are subject to the timely filing limitation of 120 days from the date of service.

UB04 providers: Please submit corrected claims with bill Type ending with the number 7.

If you are appealing a policy denial, (i.e., no authorization, timely filing, etc.) this should be submitted as an appeal. Please refer to the Provider Appeal Section in this manual.

### ***Notification of TIN Changes***

Notify the Provider Relations Department immediately of any changes in your Tax Payer Identification Number (TIN) and your billing or office address. Failure to do so may result in delays or incorrect reimbursement. The Internal Revenue Service requires that we obtain your accurate TIN. If the TIN you provide is incorrect, we may withhold all payments until the error is corrected. Included within the Appendices section is a Provider Change of Information Form that you can complete and fax to the Provider Relations Department to notify our office of any changes.

### ***Claims Mailing Address:***

**Medical/Surgical:** Community Health Network of Connecticut, Inc.  
 Claims Department  
 11 Fairfield Blvd., Suite 1  
 Wallingford, CT 06492

### ***Ancillary Provider Billing***

#### **Instructions: Home Health Services:**

All home health services require prior authorization. These include home nursing visits, home therapies and home health aide visits.

Home health services for behavioral health diagnoses should be authorized through the Connecticut Behavioral Health Partnership (CTBHP) and the claims should be billed directly to EDS.

For paper claims please complete the UB-04 with all required fields including NPI, service dates including beginning and end dates of service, procedure codes, billing provider, place of service, patient name, patient ID number, home health type of claim, charges, referring provider, ICD 9 diagnosis, procedure code, etc.

### ***Electronic Claims Submission:***

**Electronic Claims:** Community Health Network of CT fully supports HIPAA standard transactions and is capable of processing these transactions electronically. We do not accept claims electronically in any other format. Claims submitted with codes or information that does not conform to HIPAA regulations will be rejected by our system.

Community Health Network of Connecticut accepts claims electronically in two ways. You may use either method to forward your claims to us.

**Commercial Clearinghouse:** We use WebMD (NEIC/Envoy) as our commercial clearinghouse. The only transactions currently supported by this portal are the 837 Institutional and the 837 Professional. Costs to the provider for any transactions sent via the WebMD portal are the responsibility of the provider.

WebMD provides some reports back to providers for claims submitted via their network but we have no control over these reports and cannot add to them.

To send via the WebMD clearinghouse use our payor number: 62149

McKesson is another clearinghouse that allows transmission of both 837 formats. Additionally you can receive the 835 Electronic Remit via McKesson. Contact your McKesson representative for instructions.

Some other clearinghouses have agreements with WebMD and can forward claims to us via these agreements. If you use ProxyMed, NDC or another clearinghouse, contact your clearinghouse representative and they will assist you in forwarding claims to us.

**Direct Connection:** We have established two direct connection web portals that are available, free of charge, to our providers. For information regarding setup, go here: ([link to Direct Claims Page](#)) For issues concerning a specific claim(s) call our Claims Department at 800-440-5071

**ePower:** We also provide a web based claims and eligibility verification system. See the description under ePower.

**Companion Guides:** Companion Guides from WebMD/Envoy are available from Envoy. Companion Guides for our Direct Connection are listed below: 837P Professional Claims

### **Submit your claims directly to Community Health Network Of Connecticut**

Community Health Network Of Connecticut has two direct connect portals you may use to submit your claims.

Here is how it works. Your software creates a claim file that you can drop off at one of our direct connect websites. This file gets forwarded to us and you will be notified, electronically, of the number of claims received, the number accepted and which claims were rejected. There are additional claims reports that you can run. You can even look up a submitted claim and see it presented on the screen in the same format you would see if it were a printed claim.

You may also see the 835 Electronic Remit or other files coming back to you.

What do you need? Your system must be capable of connecting to a direct connect portal on the Internet. This is accomplished using your Internet browser and connection. Check with

your software vendor to see if you can go direct or produce the necessary HIPAA compliant file formats to upload. Some systems are limited to using a specific clearinghouse so verify that you can connect and use a direct portal. Make sure your system can generate HIPAA compliant transactions.

How do you start? After you have verified that your software can direct connect and supports HIPAA transactions, visit either of our direct connect websites for instructions on how to register. If you need assistance in picking a site, contact your Provider Representative at Community Health Network Of Connecticut. The number is 800-440-5071. You will have to sign a business partner agreement with the operators of the site to start. After the paper work is complete, you will be given instructions on how to access the site. You will need to complete a testing process that includes sending test files or receiving return test files for the transactions you want to use.

## **The best part? It is free to you!!**

### ***Clinical Lab Services:***

Standard outpatient clinical lab services performed at a participating clinical lab do not require prior authorization.

Outpatient laboratory services billed with a behavioral health diagnosis should be billed directly to EDS. Please contact the Connecticut Behavioral Health Partnership (CTBHP) for any questions regarding HUSKY or Charter Oak behavioral health related lab charge questions. Contact Advanced Behavioral Health (ABH) for any questions regarding SAGA behavioral health related lab charge questions.

For all medical clinical lab paper claims please complete the CMS-1500 claim form with all required fields including member name, ID#, place of service, referring provider, bill type, charges, CPI, ICD 9 diagnosis, procedure code, etc.

For questions on electronic claims please see the Electronic claims section above.

### ***MEDS/DME:***

All DME or medical supplies over \$500 require prior authorization. All rentals require prior authorization. All requests for DME or supplies from non-par providers require prior authorization.

For DME or medical supplies please complete the CMS-1500 claim form with all required fields including

member name and member ID#, HCPCS code(s), date of service, billing and referring provider, NPI number, place of service, bill type, charges, ICD-9 diagnosis, etc.

### ***Skilled Nursing Facilities (SNFs):***

All skilled nursing facility stays require prior authorization.

For paper claims submission please submit the UB-04 claim form and complete all required fields including member name, ID#, admission and discharge dates, place of service, bill type, charges, ICD-9 diagnosis, NPI number, procedure codes, referring provider, admission type and source etc.

For electronic claims please reference the electronic claims information listed under home health services.