

CHNCT HAS NEW CLAIMS PROCESSING ADDRESS



Effective immediately, all completed paper medical/surgical claims are sent to our new claim processing center at:

Community Health Network of Connecticut, Inc.
Claim Processing Center
PO Box 830704
Birmingham, AL 35283-0704

These claims include:

- Completed single CMS1500 and UB04 claim forms
- Completed CMS 1500 and UB04 claim forms with attachments to support the claims
- Completed CMS 1500 and UB04 claim forms with other insurance EOB attached for coordination of benefit
- All corrected medical/surgical claims

All other correspondences should be sent to the following address:

Community Health Network of Connecticut, Inc.
11 Fairfield Blvd., Suite 1
Wallingford, CT 06492

We will continue to forward all paper claims received at 11 Fairfield Blvd., Suite 1, Wallingford, CT 06492 to our new claim processing center on your behalf during this transition period.

Providers submitting paper claims must use original red CMS-1500 and UB-04 claim form, as these claims will be electronically scanned.

Providers interested in submitting claims electronically to CHNCT should contact CHNCT's Management Information Systems (MIS) department at 1.203.949.4000 for more information.

ATTENTION: CHARTER OAK AUTHORIZATIONS

Certain services provided to Charter Oak members require prior authorization in order for the claims to be paid. Beginning on September 15, 2010, CHNCT will strictly enforce this policy. Please visit the provider page on our website at www.chnct.org for the most up-to-date information. Click on "Benefits and Prior Authorization Grid."

Community Health Network of Connecticut, Inc.
"The One with the Sun"



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FRAUD OR ABUSE,
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CHNCT'S
Fraud Reporting
Hotline
1.866.700.6109

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Network News

Community Health Network of Connecticut, Inc.

A Newsletter for CHNCT Providers

September 2010

CHNCT NAMES QUEST DIAGNOSTICS ITS PREFERRED LABORATORY

CHNCT Urges Members to Use Quest Diagnostics for Labs

CHNCT has named Quest Diagnostics its preferred laboratory effective September 1, 2010. Quest Diagnostics is the world's leading provider of diagnostic testing, information and services, offering physicians a range of products and services including:

- Industry-leading standards of quality, integrity and clinical excellence, providing the greatest level of consistency and security for your practice.
- Access to more than 3,000 clinical, esoteric and anatomic pathology tests performed at one of Quest Diagnostics' 32 testing facilities nationwide.
- Convenient patient access to testing services with more than 90 Patient Service Centers (PSCs) in Connecticut, as well as online PSC Locator and Appointment Scheduling to minimize wait times.
- Consultation services with more than 800 MD and PhD specialists for rare or difficult test results.

- 24/7 access to electronic lab orders, results and other office solutions through Care360® Physician Portal with more than 150,000 physicians enrolled.
- Electronic prescription capability to order and renew prescriptions to save you and your staff time.
- Patient-friendly reports help you more easily explain test results and improve patient compliance.

CHNCT asks that you now refer your CHNCT patients to Quest Diagnostics for laboratory services. No prior authorizations will be required for laboratory services performed by Quest Diagnostics. CHNCT will deny claims from all non-participating laboratories.



CMS Implementation of Process to Provide States with Information on Providers and Suppliers that have been Terminated from the Medicare or CHIP Programs

Section 6401(b)(2) of the Patient Protection and Affordable Care Act of 2010 (PPACA), P.L. 111-148, requires CMS to establish a process to make available to State Medicaid and Children's Health Insurance Plan (CHIP) agencies certain information on Medicare providers and suppliers that are terminated from participation in the Medicare program or CHIP. In addition, PPACA section 6501 amends section 1902(a)(39) of the Social Security Act (the Act) to require that States terminate any Medicaid provider that has been terminated from participation by Medicare or another State Medicaid program.

The Center for Program Integrity (CPI) and the Center for Medicaid, CHIP and Survey and Certification (CMCS) have issued Informational Bulletin CPI-B-10-1 regarding this process. According to the bulletin, CMS is working towards the development of a system that will enable information on terminated providers and suppliers to be shared across programs in an automated manner. In the interim, CMS will be disseminating this information to States on a recurring basis through email and by posting the information to a secure website that is sponsored by the Medicaid Integrity Institute (MII).

Beginning January 1, 2011, States will be required to terminate from participation in Medicaid any provider that

has been terminated from the Medicare program or from another State's Medicaid program. Although States aren't required to take any action against these providers at this time, CMS is strongly encouraging States to review the list to identify any providers that are currently participating in their State's Medicaid or CHIP program. If there are providers currently participating in the Medicaid or CHIP program that have been previously terminated from Medicare, CMS is encouraging States to evaluate the provider to determine if it is appropriate to initiate termination action at this time, or if additional oversight and scrutiny of the provider is warranted.

CMS is also establishing a process to provide terminated CHIP provider information to States at a national level so that this information can be shared with Medicaid consistent with section 6401(b)(2). Some CHIP programs operate under the State Medicaid Agency and in these instances, CHIP terminated provider information is often already shared with Medicaid.

There are 16 reasons outlined in 42 CFR 489.53 in which CMS can terminate an agreement with a provider. CHNCT would encourage its provider network to review these regulations and the informational bulletin referenced in this article.

ATTENTION: NOTICE OF CONTRACTUAL AMENDMENT



Effective November 1, 2010, there will be a change in the provisions of CHNCT's Provider Agreement. This change will impact all claims received on or after that date.

This amendment changes the terms of Section 5.5 such that interest payments for clean claims will only be payable when the time between receipt of such claims by CHNCT and release of payment due for those claims is in excess of sixty (60) days. The current provision calls for payment of interest after forty-five (45) days.

HUSKY B COPAYMENT CHANGES

Due to recently enacted legislation, several copayments in the HUSKY B program changed as of July 1, 2010. In most instances, what was previously assigned a \$5 copayment will now be \$10.

Copayments for the following services increased as of July 1, 2010. The new copayment amounts are as follows:

- Non-preventive office visits—\$10
- Routine vision exam and refraction—\$15
- Routine hearing screen—\$15

There will not be a copayment for the following services:

- Newborn exam in the hospital

- WIC evaluations
- Prenatal care for women under age 19
- Regular newborn screening exam—in the hospital or the office
- Regular physical exams or well-child visits, and lab tests related to those exams
- Immunizations and the office visit for the immunization
- Emergency department visits
- Allergy injections

If you have any questions on these changes, please contact CHNCT's Provider Call Center at 1.800.440.5071, Option 7.

CHNCT BROADENS ITS METHOD OF MEMBER OUTREACH



CHNCT now utilizes an Interactive Voice Response system to provide welcome and reminder calls, health risk assessments and educational wellness for its members. This new system is being used as a way to increase access to CHNCT's members.

This new system allows outreach to be quickly extended to all members and their caregivers during a longer time period. Calls are now being made from 9 a.m. to 7 p.m. on weekdays and from 10 a.m. to 5 p.m. on weekends. This intervention affords CHNCT

the combination of technology and human touch as alerts generated from these calls are directed to outreach staff, who will then call the member to assist with any needs expressed.

If you have any questions or would like more information on CHNCT's new Interactive Voice Response system, please contact your Provider Relations Representative.

CHNCT NOW OFFER KRAMES ONLINE, A COLLECTION OF HEALTH EDUCATION MATERIALS



CHNCT's Provider Network now has the opportunity to access Krames Online, a comprehensive collection of health education materials, which can be used to engage and support patients and their families in participation in health self management. CHNCT has

partnered with Krames Online so to provide the highest quality of educational resources for its providers and members.

Krames Online can be accessed by visiting www.chnct.org. Click the Krames Online logo. This resource includes a library of more than 3,100 illustrated educational materials, which provides another option for learning about procedures, diagnoses, treatments, wellness and prevention topics.

CHNCT UPDATES PROVIDER RECONSIDERATION PROCESS

CHNCT updated its Provider Reconsideration Process, effective August 2, 2010. This process gives providers an avenue to address claims denied for administrative reasons, which were denied by CHNCT in error and reported within 60 days of the date of the remit. (This process is not for claims that were denied due to medical necessity.)

If you feel that CHNCT denied a claim in error and it is within 60 days of the remit, please contact the Provider Call Center at 1.800.440.5071.

The call center representative will decide whether the claim was denied in error. If it is determined that the



claim denied in error, they will facilitate reprocessing your claim(s).

If a claim is denied for COB and you believe that CHNCT is the primary payer, you must:

- Fax CHNCT a term letter from the primary payer; OR
- Fax CHNCT information from the (former) primary payer's website that shows an end date for the Member's coverage; OR
- Fax CHNCT an EOB from the (former) primary payer showing the member was not eligible with that plan on the date of service. This will allow CHNCT to process the claim for the specific Date of Service; OR
- Provide the name and social security number of the policyholder. With this information CHNCT can investigate whether another policy is primary.

Please note: This process is not a replacement to a provider's appeals rights.

If you feel that CHNCT denied a claim in error and it is more than 60 days of the remit, please contact your Senior Provider Relations Representative.

If you have any questions regarding this communication, please contact the Provider Call Center at 1.800.440.5071.

PLEASE REGISTER FOR ePower



One of the services CHNCT offers its participating providers is the ePower tool. This free, web-based tool allows providers to verify claim status, member eligibility and authorizations.

Upon registration, you will receive an ePower User Manual along with an Administration Manual that will help you navigate through the ePower software.

To obtain access, complete the ePower Amendment found on our website at www.chnct.org. Please print out two copies of the Amendment and mail both original copies to:

CHNCT Provider Relations
11 Fairfield Blvd., Suite 1
Wallingford, CT 06492

Once CHNCT receives a list of the users at your practice, they will be set up with a user name and password. It is quick and easy.

If there are any issues or if your password needs to be reset, simply call our Provider Call Center at 1.800.440.5071.

ATTENTION:

CHNCT recently discovered that we are unable to retrieve faxes received on June 28, 2010 and June 29, 2010 due to a system error. If you faxed any correspondence to 203.265.3590 on either of these dates, please re-fax them so we can process your requests. We apologize for any inconvenience this may cause. We appreciate your patience while we resolve this issue. Thank you.