



COMMUNITY HEALTH NETWORK OF CONNECTICUT, INC.'S
PROVIDER NEWSLETTER

VOLUME 5, ISSUE 4, THIRD QUARTER ■ 2005

The Network News

Specialist Referrals: HUSKY A & B

Effective with dates of service July 1, 2005 forward, Community Health Network of Connecticut will no longer require referrals for participating network specialist office visits for our HUSKY A and HUSKY B membership.

Our other authorization requirements have not changed and a summary of these follows...

Services which continue to require authorization from the plan prior to delivery of care for HUSKY A & B: (summary information only - please refer to your Provider Manual for additional detail)

- Non-participating practitioner or facility services (exceptions being: Anesthesia, Emergency Department Care, OB/GYN, Family Planning, Lab and Radiology)
- Certain outpatient procedures (bunionectomy, carpal tunnel release, stripping and ligation of varicose veins and TMJ related procedures/treatment)
- All hospital inpatient admissions
- Admissions to skilled nursing or rehab facilities
- Audiology
- Cardiac Rehabilitation
- Nutrition, PT, OT, ST (Reminder: for members over 21 – optional services are not covered when performed by independent practitioners)
- Infertility related services
- Dialysis
- Durable Medical Equipment Rentals and DME purchases over \$500
- Home Healthcare
- Infusion Therapy and Infusion Drugs
- Non-formulary drugs and brand medications when generics are available
- Pain Management
- Pulmonary Rehab and Respiratory Therapy
- Synagis
- Reminder: **Ophthalmology Services: Block Vision is our vendor for all routine vision services for our HUSKY A and HUSKY B membership. Routine vision care services must be provided by a Block Vision provider. If a participating ophthalmologist sees a HUSKY A or HUSKY B member for a specific medical diagnosis (outside the 367.0 – 367.9 range) and provides a routine vision service required during the treatment of another medical condition, a referral will not be necessary. However, please note that routine vision services alone performed by a non-Block Vision provider will **not** be covered.
- ***Correction to the announcement mailed in June, 2005---- Nutrition will still require a referral and authorization.

This policy change does not impact referral requirements under the SAGA ASO agreement for which the Department of Social Services determines administrative practices.

If you have any questions regarding the above, please contact our Network Development Department at (800) 440-5071.

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TO REPORT SUSPECTED
FRAUD OR ABUSE,
PLEASE CALL CHNCT'S

**Fraud Reporting
Hotline**

1-866-700-6109

PCP Scheduling Standards: What You Need to Know



The National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a single provider identifier assigned by the Federal Government to healthcare providers. This identifier will be used to replace all the different provider identifiers currently being used for each health plan with which you do business. The purpose of the NPI is to improve the efficiency of the healthcare system and help to reduce fraud and abuse.

The Centers for Medicare & Medicaid Services (CMS) has issued a letter dated May 6, 2005, informing all healthcare professionals that they may apply for a new identifier starting May 23, 2005. Healthcare providers must use their NPI in HIPAA transactions by May 23, 2007 (small health plans have until May 23, 2008).

The CMS website has many useful articles related to the NPI. We strongly urge you to visit www.cms.hhs.gov to review the valuable information and to get instructions on how to apply for the NPI. If you are not sure if you or your facility should have an identifier, there are articles on the website to help you determine if you need to obtain one.

When your NPI has been assigned, you may begin submitting it in your HIPAA transactions. If you are unsure of where in your file to include this information, please refer to the appropriate Implementation Guide. Guides for all transactions are available at Washington Publishing Company's website, <http://www.wpc-edi.com>.

CHNCT requires that all participating providers maintain emergency coverage 24 hours a day, 7 days a week. Specifically, on-call coverage is a contractual obligation for any participating PCP. CHNCT should be informed of coverage arrangements.

Providers shall ensure that members have access to a live individual to handle medical problems in an emergency.

Additionally, PCP scheduling practices must ensure that:

- Emergency cases are seen immediately or referred to an emergency facility
- Urgent cases are seen within 48 hours of PCP notification
- Routine cases are seen within 10 days of member's request
- Well-care visits are scheduled within six weeks of PCP notification
- New member appointments are provided within two weeks of notification
- Maximum waiting times are within:
 - 30 minutes for scheduled appointments, and
 - within 60 minutes for unscheduled appointments, and
 - 30 minutes for a provider to respond to pages for urgent care needs and within 45 minutes for semi-urgent needs.
- Must have 24-hour on-call system
- All providers must be available through the contracted practice a minimum of 20-hours each week

CHNCT evaluates and monitors provider compliance with scheduling requirements. These scheduling requirements are designed to enhance access to health services and to provide assurance of service availability based on the urgency of need.

Please Note:

Community Health Network of Connecticut, Inc. (CHNCT) is changing Behavioral Health Vendors.

Effective September 1, 2005, ValueOptions will begin managing the behavioral health benefit for CHNCT. CHNCT has provided a comprehensive summary of frequently asked questions and answers which can be accessed by logging on to CHNCT's website at <http://www.chnct.org/About/news.htm>.

Electronic Claim Submissions

CHNCT HAS NOTICED AN INCREASE IN PAPER CLAIM SUBMISSIONS. PLEASE CONSIDER THE FOLLOWING:

1. Paper claims take longer to process, therefore slowing down your reimbursement
2. Sending paper versions of claims that you have submitted electronically will slow down the processing and result in duplicate claim rejections

We accept claims electronically via our clearinghouse or by direct connection. Our WebMD payer number is 62149. If you have questions, contact us at (800) 440-5071.

Reminder...

We are now located in Wallingford. Please send paper claims, referral forms, and correspondence to:

Community Health Network of Connecticut, Inc.
11 Fairfield Boulevard
Wallingford, CT 06492

Provider Appeal Process for Administrative Denials

The Appeal Process for Administrative Denials should be followed if a provider wishes to appeal a claim or a Care Management denial decision (authorization) which is based upon the provider's failure to comply with applicable CHNCT administrative policies and procedures (i.e. claim submission requirements or timeframes). Providers may appeal any such CHNCT denial decision within sixty (60) days after notice of the denial. Resubmitting a claim(s) is not considered an appeal and will be processed and denied as a "duplicate claim." A letter stating the intent to appeal must accompany the denied claim.

Please understand that the Appeals Coordinator will not accept a letter of appeal with a claim attached if the provider's office has not received a written denial from CHNCT. If there is no denial on file, the claim with the letter will be forwarded to the Claims Department for processing. All requests for appeals must be made in writing within sixty (60) days of the Remittance Advice to the Appeals Coordinator.

EDI Tips for HIPAA Submitters

ATTENTION PROVIDER BILLERS!

You will avoid payment delays when your file is formatted correctly. Here are a few tips that will help CHNCT process your claims more efficiently:

Rendering Provider

- ◇ If you are submitting the provider's middle initial, do not include it in the Name First field (loop 2310B, segment NM104).
- ◇ Please use the Name Middle field if applicable (loop 2310B, segment NM105).
- ◇ When populating the Name Last field, do not include the provider's title (loop 2310B, segment NM103). CHNCT does not require this information for claim adjudication.

Entity Type Qualifier

- ◇ If the rendering provider is a person, and you have submitted a provider's first and last name, the entity type qualifier must be "1" (loop 2310B, segment NM102).
- ◇ If the rendering provider is a non-person entity, and you have populated the last name field only, the entity type qualifier must be "2" (loop 2310B, segment NM102).

UB-92 BILLING REMINDER: SAGA Claims

SAGA Billing Reminder: All Emergency Room claims and Ancillary charges without a clinic attached should be billed to DSS.

UB-92 Corrected Claims can be billed electronically using Bill Type 137 outpatient or 117 for inpatient.



GOOD NEWS!

CHNCT has recently finalized a HUSKY and a SAGA contract with Lawrence and Memorial Hospital in New London and a HUSKY contract with MidState Medical Center in Meriden. They are now part of CHNCT's extensive hospital network.

IMPORTANT PHONE NUMBERS...

DEPARTMENT	PHONE	FAX
Main Switchboard	(203) 949-4000	(203) 265-2970
Provider Relations	(800) 440-5071	(203) 265-3609
Care Management	(800) 440-5071	(203) 265-3994
Claims	(800) 440-5071	(203) 265-3590
Member Services	(800) 859-9889	(203) 265-3197
SAGA Member Services	(866) 361-7242 (SAGA)	
Fraud Reporting	(866) 700-6109	



ePower Reminder!

ePower is a free on-line service that CHNCT offers to its participating providers. Through ePower, providers can look up eligibility history, claim status and specialists can look up authorizations for services. Provider office staff no longer needs to spend valuable time making telephone inquiries. Providers can obtain information on ePower by visiting our website at www.chnct.org and clicking on the ePower provider link, or by calling your Provider Relations Representative line at **(800) 440-5071**.

The Network News Provider Newsletter is a publication of Community Health Network of Connecticut, Inc. (CHNCT). It offers new policies and tips on following procedures for CHNCT, for administering both the HUSKY A and B and SAGA programs.

We pledge each member will be serviced with the highest level of respect, dignity, and professional integrity. In partnership with our provider network, we will continually seek to improve the healthcare status and well being of our members and their families that have entrusted us with their care.

Community Health Network of Connecticut, Inc.
11 Fairfield Boulevard, Wallingford, CT 06492
Phone: (203) 949-4000 Fax: (203) 265-2970
www.chnct.org

ePower Testimonials

We would like to here what our Provider Offices think about ePower? Call us at (800) 440-5071 or fax us your testimonial at (203) 265-3609.



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