

PROVIDER ALERT

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES
General Assistance Behavioral Health Program (GABHP)

Provider Alert No. 3

Issued June 20, 2005

Transition of ASO Operations Frequently Asked Questions (FAQs)

After thorough review and evaluation of proposals received in response to an RFP, DMHAS awarded the right to negotiate the ASO contract to Advanced Behavioral Health, Inc. (ABH). This contract will begin July 1, 2005 and will enable DMHAS to further enhance access and outcomes for GA clients through integrated administrative and management services. As part of the active transition process, the following document provides responses to a comprehensive list of the most frequently asked transition questions:

CLAIMS SUBMISSIONS

1. Does the Provider Manual outline changes or clarify what's needed for filing?

The Provider Manual does include billing tips for Institutional (UB92) and Professional (CMS-1500) claims for agencies, and provides basic information about how to obtain access to the secure, web-based single claims entry system and/or submit batch files. The ABH Companion Guide, available on the GA resource page at www.abhct.com provides specific information about testing and certification needed for batch claims file submission.

2. Will paper claims still be accepted from small agencies?

Paper claims will continue to be accepted, but should be submitted to the following address for claims submitted on or after 7/1/05 : GA Behavioral Health Program, c/o Advanced Behavioral Health, Inc., P.O. Box 1325, Middletown, CT 06457.

3. Which days of the week are claims processed? Is there a cut-off day for submissions during the twice weekly claims processing?

Claims will be processed as they are received by ABH during regular business hours, Monday through Friday. There is not a cut-off day for claims submissions. The Internet-based single and batch claims entry can be used 24 hours/day, 7 days/week. Payments are processed and mailed to providers twice weekly, generally each Tuesday and Friday.

4. What is the turnaround time for paper vs. electronic submission?

Turnaround time for paper claims is slightly longer than that for electronic claims submissions. Claims submitted using the ABH Internet-based single claim data entry system would be adjudicated within 5-10 minutes following submission. Batch-file claims submissions will be adjudicated in the order that they are received, generally within 1 – 4 hours. Paper claims are entered and processed in the order that they are received, and turnaround time is more likely to be affected by slow mail delivery, and incomplete and/or illegible documentation. In general, all legible paper claims are entered and processed with 1-3 business days of receipt.

5. Will changes be made to the Explanation of Benefit (EOB) remittance format?

Changes have been made to the format used for EOB Remittance Advice forms mailed to providers after 7/1/05. The new format, which has been designed to be easier and more efficient to read, will list transactions by service location, then level of care, followed by client. If the provider has submitted an internal claim identification number with the claim submission, this number will be reflected on the remittance advice. EOB codes used on the remittance advice will not change, unless there is a need for a more specific description than available in the current EOB codes. Description of the EOB codes will be listed at the end of each remittance.

6. Will providers continue to submit claims to ValueOptions for dates of service prior to 7/1/05? How will claims unresolved prior to 7/1/05 be handled?

No. Any claims received on or after 7/1/05 will be processed by ABH, regardless of the date of service. ValueOptions will process claims received on or before June 30. Claims received by ValueOptions on or before 6/30/05 and pended for eligibility will be denied with a special code, and should be resubmitted to ABH on or after July 1.

7. May providers continue to submit electronic claims currently being submitted to other agencies in the same manner as previously submitted?

There are minimal changes for Providers who have been submitting batch-file claims submissions. The file format will remain the same as that used prior to 7/1/05. The changes to the batch-file claims submission process will be as follows:

- a. Starting 7/1/05, Providers will need to submit batch claims files to the ABH website. Providers will no longer submit files through the ValueOptions web site on and after 7/1/05.*
- b. Providers will need to request access to the Internet-based submission site, submit test files and obtain certification for batch-file submissions. Additional information about how to obtain access and certification is available in the 837 Companion Guide on the GA Resource page at www.abhct.com.*
- c. The VOI/EDI software currently used by providers to create batch file submissions will no longer be able effective 7/1/05. In its place, Providers will use the ABH web-based single claims data entry system, which will function in an almost identical fashion to the VOI/EDI software. Use of this system will require users to obtain a secure login/password.*

Providers must submit an Access Request Form requesting individual access. If you have additional questions, would like to learn more about the single claims data entry system, or would like to make arrangements for batch file testing and certification, please fax your completed Access Request form to Ken Aligata, Provider Relations Director, at (860) 704-6145. Please be sure to identify on the form the type(s) of access you are requesting.

8. Will there be changes to the use of VOI/EDI software, which allowed providers to data enter claims and submit them as batches? Will new software be needed?

The VOI/EDI software currently in use will be replaced by a secure, web-based single claims data entry system accessible through the ABH website on 7/1/05. This system will require Internet access, but will not require the EDI or any other additional software. Use of this web-based system will require a secure individual login and password. Providers interested in using the web-based single claims data entry system should complete and submit an ABH Internet Access Request form to ABH. A copy of the Access Request form is available on the GA resource page at www.abhct.com. Completed Access Request Forms can be faxed to: Ken Aligata, ABH Provider Relations Director, at (860) 704-6145. Batch claims submissions using the VOI/EDI software will not be accepted on or after 7/1/05. Providers will use the ABH web-based single claim data entry system.

9. Will old login/passwords still work for providers that already have them for the ABH website?

Providers with current, active access to the ABH Electronic Registration System (ERS) will be able to continue to use their existing login and password. If the individual with access to ERS also wishes to obtain access to the ABH Claims Entry System (ACES), a new ABH Internet Access Request form should be submitted, identifying your current login name as well as other required information. Individuals with access to both ERS and ACES will use a single login and password combination to access either system.

10. May provider staff use a single "master user" ID, or does each staff need his/her own login/password?

In order to be in compliance with current federal privacy and security regulations (HIPAA), ABH must retain control over distribution of access logins and passwords. This requires use of individually-assigned login/password accounts.

11. What is the process for getting started on 837 file testing?

Information explaining the process for obtaining access, testing and certification (approval) for submission of 837 claims files is available in the 837 Companion Guide, available on the GA Resource page at www.abhct.com.

12. Will ABH be accepting 837 Professional and 837 Institutional?

ABH will be using the HIPAA-compliant 837 Professional and 837 Institutional file formats for electronic batch-file claims submissions.

13. What is the ABH electronic payer ID# for Institutional and Professional claims? Does ABH have/use/need an NEIC number?

Currently, we will be using "ABH" as the payer ID, which will be found in the Payer loops for both 837I and 837P. Also, "ABH" will be used as the Interchange Receiver ID. The use of a payer ID is required for batch-file claims submissions only at this time. There is no requirement for ABH to obtain an NEIC number at this time.

14. What is the procedure for handling (claims) error reports? Will an Electronic 835 Response File be available online?

Claims error reports are generated when a batch claims file transmission cannot be completed due to formatting errors. Error reports will be available on the download page of the web-based ABH Claim Entry System (ACES). If the file submitted has no formatting errors, the process is complete and the claims included in the batch will be processed. If there are errors, the provider can download the file, make the necessary adjustments and resubmit the batch.

15. How can providers re-process claims?

Providers may resubmit their claims on paper for reprocessing together with a copy of the "Reconsideration/Appeal Request" form available on the GA Resource page at www.abhct.com. Providers are asked to complete the Reconsideration form, providing a description of the problem or discrepancy, and to fax the completed Reconsideration form and corrected claim via fax to the GABHP Claims Department at (860) 704-6145. The Reconsideration Form will alert the claims department that corrected or additional information is indicated on the attached claim form. Providers may also call GA Customer Service at 800-606-3677, Option 2, with any questions they may have regarding reprocessed claims.

16. How will third-party clearinghouse submissions be handled? Is a contract required for a third-party clearinghouse?

ABH will allow submission of claims via use of a third-party clearinghouse or vendor if certain conditions are met. Third-party clearinghouses/vendors must request access to the ABH Internet-based claims system, the website to be used for batch claims submissions. The third-party vendor must submit a separate ABH Internet Access Request form for each provider agency for which they anticipate submitting claims. The Access Request form is available on the GA Resource page at www.abhct.com. The completed Access Request Form must be submitted to ABH accompanied by a copy of the signed Business Associate or Trading Partner agreement between the provider and the clearinghouse and can be faxed to Ken Aligata, Provider Relations Director, at (860) 704-6145. Additional information is available in the ABH 837 Companion Guide available on the GA Resource page on the ABH website.

17. Are HCPCS codes required for outpatient services billed on a UB92? (e.g., if Rev Code 912 is billed, is HCPC required on that line item – H0015, 59480, etc?)

Yes, HCPCS codes will continue to be required for outpatient services billed on a UB92 (Institutional) form.

18. Will there be any change in the procedure codes currently in use?

NO, there will not be any change to current GA Behavioral Health Program procedure codes. The comprehensive list of procedure codes is available in the GA Provider Manual on the GA Resource Page at www.abhct.com.

19. Will Providers still be able to check claims status via the Internet?

YES. Starting 7/1/05, Providers will be able to check claims status via the ABH website using an individual login/password. The capacity to check claim status via the ABH website will be available on 7/1/05 and access is strongly recommended for all contracted GA BHP Providers. Access, which requires use of a secure login and password, can be granted to any contracted GA BHP Provider, regardless of the manner in which claims are submitted. The Access Request form is available on the GA Resource page at www.abhct.com. Providers without Internet access may contact the ABH Customer Service staff at (800) 606-3677, Option 2 to check claims status.

20. How should 1-week billing be handled for Methadone treatment when the from/to date is split between two weeks?

It is recommended that providers submit span billing claims for Methadone Maintenance (Procedure Code H0020) using a consistent start day in the week, with the exception of the first week in care. Using the example of a client admitted on May 18, 2005 and a weekly billing cycle that runs from Monday through Sunday, the provider would submit the first unit of service as 5/18/05 – 5/22/05 (Wednesday through Sunday), the second week as 5/23/05 – 5/29/05 and subsequent claims starting on Monday of each week.

21. What is the timely filing limit?

The timely filing limit for claims is 180 days from date of service. If eligibility for General Assistance has not been determined on the date of service, the timely filing limit for claims will be 180 days from the date that eligibility begins.

22. When eligibility for SAGA is retroactive, how should claims be handled?

Providers are strongly urged to verify eligibility before submitting a claim, and should not submit claims without an EMS ID number to avoid delays in claims processing. Claims submitted prior to eligibility determination will be pended for up to 90 days in order to determine retroactive eligibility.

23. Will ABH continue to accept retroactive take-backs (Medicaid recoupments)? How will existing negative balances be handled? Will ABH accept refunds?

ABH will continue the process of recouping claims for clients who have become retroactively eligible for Medicaid. When necessary, these recoupments may result in a negative balance. The process currently in place for Medicaid recoupments will remain the same. Any negative balances remaining on 6/30/05 will be transferred from ValueOptions to ABH. ABH will not be accepting refunds.

24. For providers w/ multiple sites, will checks be mailed to each separate location or to one address for the entire agency?

ABH will continue to mail checks to one contact address per provider organization.

25. Value Options has implemented vendor numbers for multi-site providers. Will those numbers remain the same? Will providers' CTGA number remain the same?

There will not be a change to the existing provider organization and vendor identification numbers currently in use for the GA Behavioral Health Program.

26. Are any further billing trainings required? Will ABH staff be available to provide on-site provider trainings?

Training is not required to use the new web-based single claims data entry system, but technical assistance sessions will be held during the month of June for providers who may have additional questions about electronic claims submission. Please contact the ABH Provider Relations Director, Ken Aligata, at (800) 606-3677, Ext 6440 to schedule attendance at any of the trainings. Trainings will be held on Thursday, June 23rd and Monday, June 27th from 9:30 to 11:00am. After 7/1/05, Providers may contact the ABH Customer Service staff at (800) 606-3677 with questions or to schedule an on-site technical assistance visit.

27. Our clinic is under a hospital tax ID. Do we submit claims on a UB92 or CMS-1500 (HCFA-1500) form?

Clinics operating under a hospital's tax ID number would submit claims using the UB92 form.

AUTHORIZATIONS/UTILIZATION MANAGEMENT

28. Please provide details about the hours of operation for pre-certs, reviews, and transition process for clinical authorization.

The table on the following page illustrates the change in hours of operation for telephonic pre-certification of services that will be effective 7/1/05.

	<i>Current</i>		<i>Post 7/1/05</i>	
	<i>Hours of Operation</i>	<i>Days/Wk</i>	<i>Hours of Operation</i>	<i>Days/Wk</i>
<i>Pre-certifications</i>	8:00am – 6:00pm	7	24 hours a day	7
<i>Continued Stay Reviews</i>	8:00am – 5:00pm	Monday - Friday	8:00am – 5:00pm	Monday - Friday

Providers with access to the ABH Electronic Registration System (ERS) may continue to obtain authorizations and enter discharge notifications 24 hours/day. Any authorizations issued prior to 7/1/05 for dates of service after 7/1/05 will remain in effect. The phone number for the GA Behavioral Health Program will remain 1-800-606-3677.

29. How will the authorization process work? How can providers obtain requests for continued authorization?

Beginning at 8:00 am on July 1, 2005, Providers may request authorizations for acute and residential levels of care 24 hours/day, 7 days/week, 365 days/year. Much of the authorization process will remain unchanged. Telephonic reviews will continue to be expected for acute inpatient mental health, inpatient detoxification, 23-Hour/Observation beds, Crisis Stabilization/Respite, Residential services, PHP and SA II.D/Ambulatory Detox with on-site monitoring. Providers will continue to seek authorizations for IOP, Outpatient, Ambulatory Opioid Dependence Detox/SA I.2 or SA I.D, and Methadone Maintenance through use of the ABH Electronic Registration System (ERS) or via fax submission of the OTR form. Requests for psychological testing will continue to be accepted through fax submission of the completed Psychological Evaluation Request (PER) Form. Copies of the OTR and PER form are available on the GA Resource page at www.abhct.com.

Continued stay authorizations will continue to be performed Monday through Friday, 8:00 am – 6:00 pm for levels of care reviewed telephonically. Providers with access to ERS may continue to request authorizations 24 hours/day, 7 days/week. OTRs may be faxed to ABH at any time. If you have any additional questions regarding the authorization process, please feel free to contact the ABH UM staff at (800)606-3677, Option 1.

30. Is it a HIPAA violation to submit an Outpatient Treatment Review Form (OTR) for clients not currently enrolled in/eligible for SAGA?

Providers should routinely be requesting that clients sign a release of information that allows contact and exchange of information with an insurance company for the purposes of payment. If the provider believes a client is potentially eligible for SAGA, the client should be asked to sign a release that allows disclosure to ABH or the GA Behavioral Health Program for purposes of treatment authorization and payment.

31. May providers charge a client who initially refuses to authorize the release of information preventing the provider from obtaining timely authorization?

NO. Clients who are active on General Assistance may NOT be billed, or balance billed, for behavioral health services that are provided. Providers may submit

appeal requests for authorizations administratively denied for late notification because the client refused to sign. The appeal request should include a copy of the release indicating that the client refused to sign, the date the attempts to obtain a signature were made and the signature of the staff member who witnessed the refusal to sign.

32. May providers request, and obtain, backdated authorizations for continued stay?

Requests for continued stay authorizations for any level of care must be made no later than the day the original authorization expires. For non-acute levels of care continued stay reviews submitted through use of the OTR form requests can be made one to two days PRIOR to the expiration of the original authorization.

33. Will requests for authorization for outpatient mental health services be granted if the client is already authorized for outpatient substance abuse services?

Requests for authorization of outpatient mental health services while a client is concurrently in outpatient substance abuse services will be reviewed on a case-by-case basis by the utilization management clinical staff to determine the medical necessity of the request. GA Behavioral Health Program policies do not allow authorization of services that are identified to be duplicate or similar in nature,

34. Will there be any changes to currently accepted psych (psychological testing request) forms? Where can the forms be found?

Requests for psychological or neuropsychological testing can continue to be submitted using the Psychological Evaluation Request (PER) form used currently. The completed PER form is then faxed to ABH at (860) 704-6145. A copy of the form is located in the Appendix of the GA BHP Provider Manual, and is also available on the GA Resource page at www.abhct.com. If you do not have Internet access, please contact ABH at (800) 606-3677, Ext. 6440 to request a copy of the form.

35. Will new authorizations be required for services previously authorized?

No, there will be no need for new authorizations to be issued for service dates previously authorized.

PROVIDER CREDENTIALING/CONTRACTING

36. Will reimbursement fees remain the same?

There are no imminent changes to the fee schedule.

37. How will pending new or revised provider contracts be handled?

Any provider contracts with pending contracts revisions that remain in process on 6/30/05 will be transferred from ValueOptions to ABH. ABH will work with DMHAS to resolve outstanding contract issues.

38. What are the anticipated processes and timelines for future credentialing and re-credentialing processes?

There are no planned changes to the credentialing/recredentialing process at this time. Providers will be notified regarding any future changes to these processes as they occur.

39. Do hospitals need to be re-credentialed by ABH? Will there be a requirement that all hospital physicians, PhDs, LCSWs, APRNs, etc. need to be re-credentialed or can the credentialing be delegated to the hospital?

All existing GA Provider contracts will remain in effect after 7/1/05, including hospitals. All providers, including hospitals, will continue to be recredentialed on a periodic basis. At this time, there is no plan to individually credential all hospital physicians, PhDs, LCSWs, APRNs, etc.

If you have any additional questions about the transition of the GA Behavioral Health Program on Friday, July 1, 2005, please email the ABH Provider Relations Director, Ken Aligata, at GATransition@abhct.com. Contact numbers for DMHAS and ABH are listed below.

**Advanced Behavioral Health, Inc. Contact Information
1-800-606-3677**

Debbie O'Coin, VP for GA Programs – Ext. 6129
Diane Michaelsen, Clinical Director – Ext. 6132
Jenny DeMars, Claims Director – Ext. 6254
Ken Aligata, Provider Relations Director – Ext. 6440
Bob Burke, Operations Director – Ext. 6441
Elizabeth Maldonado-Thomas, Customer Service Manager – Ext. 6166
John Sims, Community Liaison – (866) 213-4759
**Paul Zakarian, Asst. Program Manager, GA Intensive Recovery Supports
Program – Ext. 6128**
Beth Lawton, Manager, Basic Needs Program - Ext. 6970

DMHAS Contacts

Contract Issues – Mark McAndrew, Project Director (860) 418-6843
Basic Needs Program – Marlene Jacques, RN, (860) 418-6974

ABH will provide advanced notices of changes in utilization management procedures and/or clinical criteria by both email and postal mail service to GA BHP providers.

Additional resources materials, including the GA Behavioral Health Program Provider Manual, can be found on the GA Resource Page at www.abhct.com and on the DMHAS website at www.dmhas.state.ct.us/gaprogram.htm.