CONNECTICUT
Behavioral Health Partnership

Operations Subcommittee Meeting

Rapid Response Team Overview

June 18, 2010

Rapid Response Team

- A collaboration of the Department of Social Services, ValueOptions CT and HP Enterprise Systems to resolve intricate billing/authorization matters and identify possible systematic issues. Team efforts include:
  - Special Projects
  - Provider Inquiries
  - Provider Outreach & Education
  - Information Sharing
- Meeting Schedule
  - 1st and 3rd Friday of every month

Rapid Response Team Mission

- Provide fast responses to provider issues
- Identify possible systematic issues
- Educate providers on the authorization and claims payment process through telephonic outreach, provider visits and workshops

Rapid Response Team

- **ValueOptions CT / CT BHP Provider Relations:**
  - **Scott Greco** – (860) 263-2010
    - On site and off site provider trainings, PR liaison to clinical services and DSS, CT BHP Website, Provider Newsletter/Provider Manual Development, PR liaison to Regional Network Management
  - **Kyra Lorde** – (860) 263-2011
    - PR liaison to HP/DSS/DCF provider enrollment, CT BHP provider file update (PDV) and maintenance, PR liaison to National VO network operations
  - **Rob Urban** – (860) 263-2012
    - Provider Relations outreach, routine provider inquiries related to authorization troubleshooting, provider training support, PR liaison to CT BHP Customer Service, IT/Reporting, and Quality Management
  - **Yvonne Jones** – (860) 263-2020
    - Director, Customer Service and Provider Relations

Rapid Response Team

- **HP Provider Relations Representatives:**
  - Available based on specialty for escalated or high level issues. Responsible for provider training, provider newsletters, bulletins, liaisons to HP systems team
- **Paul Tom** – (860) 255-3845
  - Hospitals, Individual Practitioners
- **Susan Pausmer** – (860) 255-3970
  - Clinics, Long Term Care Facilities, State Institutions
- **Debbie Hockla-Kaba** – (860) 255-3847
  - Special Services Providers, Home Health Agencies, State Waiver Programs

Rapid Response Team

- **Department of Social Services (DSS):**
  - Answers provider inquiries regarding Medicaid policy and regulations, rates, and program administration

- **Teddi Leslie Creel –** (860)-424-5393
  - Medical Administration/Medical Policy – CT BHP
  - Medicaid FFS Policy Consultants
    - **Ondria Lucky** – (860)-424-5195
    - **Nina Holmes** – (860)-424-5486
    - **Ginny Mahoney** – (860)-424-5145

ValueOptions CT

- **ValueOptions CT Call Center** 1-877-552-8247
  - Provider Services
    - Telephonic Authorizations
    - Intensive Case Management
    - Clinical/Administrative Appeal Procedures
    - Complaints/Grievances
    - Technical Assistance
    - Provider Trainings
  - Member Services
    - Provider service referrals
    - Peer support services
    - Complaints/Grievances

CT BHP ValueOptions CT Website

www.ctbhp.com

Resources

Web Registration System

Provider Handbook

Covered Services

Authorization Schedule

Level of Care Guidelines

Provider Bulletins & Publications

Events and Trainings

ValueOptions CT Appeals

- **TYPES OF APPEALS**
  - **Administrative Appeal**
  - **Medical Necessity Appeal**
    - **Provider**
      - **Level I and Level II**
    - **Member**
      - **Level I and Level II**

ValueOptions CT Appeals

- **ADMINISTRATIVE APPEAL**
  - **Definition:** An appeal initiated by a practitioner or facility provider for which they have received a denial that was based on reasons other than medical necessity – such as: failure to follow required administrative procedures. There is only one level of appeals for administrative denials.
  - **Timeframe:** An appeal can be submitted verbally, writing or by fax up to 7 calendar days after receipt of notification of the denial. An acknowledgement letter will be mailed to the provider when the appeal is received and following determination of appeal decision.
  - **Turnaround Time:** The Administrative Appeals Committee will review the information submitted by the provider, make determination based on that information and send notice of the determination to the practitioner or facility provider within seven (7) business days following the receipt of the request for an appeal.

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL**
  - **Definition:** An appeal of a non-certification determination (denial) that was based on lack of medical necessity.
  - **Standard Appeal** – A request to review a denial determination decision concerning admission, continued stay or other behavioral healthcare service for a member who has received non-urgent services but has not been discharged from the level of care under consideration at the time the request for appeal is made.
  - **Expedited Appeal** – A request to review a denial determine decision concerning admission, continued stay, or other behavioral healthcare services for a member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize the life or health of the member.

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL: PROVIDER LEVEL I**
  - **Timeframe:** An appeal can be submitted verbally, writing or by fax up to 7 calendar days after receipt of notification of the denial. An acknowledgement letter will be mailed to the provider when the appeal is received and following determination of appeal decision.
  - **Additional Documentation:** As part of the appeals process, the provider, practitioner, or facility can submit written comments, documents, records, and other information relating to the case. ValueOptions takes all such submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.
  - **Turnaround Time:** For Standard Appeals – determination will be made within one (1) business day. For Expedited Appeals – determination will be made within hours.

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL: PROVIDER LEVEL II**
  - **Definition:** When the non-certification decision is upheld, in whole or in part, after a Level I Appeal review, the individual practitioner or facility provider has the right to request a Level II Appeal in writing.
  - **Timeframe:** A Level II Appeal can be requested up to fourteen (14) calendar days after a Level I Appeal determination.
  - **Turnaround Time:** Level II Appeal determinations are made and written notification of the decision is sent to the provider or facility provider within five (5) business days of the receipt of information deemed necessary and sufficient to render a determination.

ValueOptions CT Appeals

- A complete and detailed listing of the CT BHP Appeals process for Administrative, Level I & II Provider/Member Medical Necessity Appeals can be located in Section 7 of the CT BHP Provider Manual.
- All provider Appeal requests can be made verbally or in writing to:

The Connecticut Behavioral Health Partnership
Attention: Denials and Appeals Department
500 Enterprise Drive, Suite 4D
Rocky Hill, CT 06067
Local Fax (860) 263-2037 - Toll Free Fax (866) 434-7681
Phone: 1-877-552-8247

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL: MEMBER**
  - Member's Notice of Action (NOA) or Denial letter and appeal rights are sent to providers with the Provider Medical Necessity Denial Letter.
  - Provider may wish appeal on behalf of the member and can do so by completing "Appointment of Authorized Representative" which must be signed by the member.

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL: MEMBER**
  - Two levels
    - Level I is reviewed internally by the CT BHP
    - Level II is conducted externally based on the member's benefit package by either:
      - Administrative Hearing by DSS (HUSKY A)
      - Appeal review by DOI (HUSKY B)
      - Fair Hearing by DCF (DCF Limited Benefit Package)

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL: MEMBER LEVEL I**
  - **Timeframe:** An appeal can be submitted in writing by fax or by mail within 60 days of the receipt of notification of the denial on a form provided by the Departments.
    - HUSKY A Members will submit to Department of Social Services
    - HUSKY B/Limited Benefit (D05) Members will submit to CT BHP
  - **Turnaround Time:** For Standard Appeals – determination will be made no later than 30 days following the submission of the appeal. For Expedited Appeals – determination will be made within hours.

ValueOptions CT Appeals

- **MEDICAL NECESSITY APPEAL:**
  - **MEMBER LEVEL II**

- **Timeframe:**
  - HUSKY A Members: DSS will schedule Administrative Hearing for 30 days from the receipt of the Level I Appeal request
  - HUSKY B Members: Level II appeal to DOI within 30 days of the receipt of the Level I appeal determination. DOI will schedule Appeal Review and conduct Level II appeal.
    - DOI Level II Appeal Request Form
  - Limited Benefit (D05) Members: Level II appeal to DCF within 30 days of the receipt of the Level I appeal determination. DCF will schedule Fair Hearing and conduct Level II appeal.
    - DCF Level II Appeal Fair Hearing Request form

ValueOptions CT Appeals

- All HUSKY A member Appeal requests can be in writing to:

State of Connecticut – Department of Social Services (“DSS”)

Office of Legal Counsel & Administrative Hearings HUSKY A Appeals

25 Sigourney Street, 12th Floor

Hartford, CT 06106-5033

Local Fax (860) 424-5729

ValueOptions CT Appeals

- All HUSKY B/Limited Benefit member Appeal requests can be in writing to:

The Connecticut Behavioral Health Partnership
Attention: Denials and Appeals Department
500 Enterprise Drive, Suite 4D
Rocky Hill, CT 06067
Local Fax (860) 263-2037 - Toll Free Fax (866) 434-7681
Phone: 1-877-552-8247

ValueOptions CT

- **Retrospective Reviews**
  - **Definition:** Review of the medical necessity and appropriateness of health care services provided to a member performed for the first time subsequent to the completion of such health care services.
  - Appropriate only under one of the following circumstances:
    - Provider was unable to establish that the patient was a CT BHP member
    - Member's eligibility was approved retrospectively following the admission

HP Enterprise Services

Where to go when help is needed:

- **The HP Provider Assistance Center (PAC)**

  1-860- 269-2028 (local to Farmington)
  1-800- 842-8440 (Toll free)

  - Can assist with topics related to provider enrollment, claims, EDI and billing
  - If a provider feels they need to escalate a Provider Assistance Center call they may ask to speak with a Supervisor. They will be called back by a member of the Leadership team

HP Enterprise Services Website

www.ctdssmap.com

Resources

Web Claim Submission

Client Eligibility

Billing & Electronic Billing Instructions

Online Claim Inquiry

Prior Authorization Inquiry

Provider Enrollment

Provider Bulletins

Provider Manual

Provider Newsletters

Provider Training Workshops

Pharmacy Information

HP Enterprise Services Claims Processing

- CT BHP & Charter Oak claims may be submitted
  - Web site: www.ctdssmap.com
  - 837 Electronic Batch files
  - Paper Claims Submission

HP Enterprise Services
PO Box 2941 (CMS 1500 forms)
PO Box 2961 (UB-04 forms)
Hartford, CT 06104

HP Enterprise Services Claims Processing

- **Top 5 reasons to use the Web claim submission tool:**
  - Easily resubmit previously denied claims
  - Submit secondary claims containing payments or denials 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

HP Enterprise Services Claims Processing

- Timely Filing of Claims
  - CTBHP/Charter Oak
    - 120 days from the last submission unless the denial was for timely filing

(Please note, that Medicaid FFS timely filing is 1 year from the last submission unless the denial was for timely filing.)

HP Enterprise Services Claims Processing

Exceptions to timely filing:

- Remittance Advice – System will override automatically
  - Dated within 120 days from the date of resubmission for CTBHP clients, provided the denial was not for timely filing
- Retroactive Eligibility – System will override automatically
  - Claim must be submitted 120 days from the date the client's eligibility was added to the Connecticut Medical Assistance Program eligibility file
- Other Insurance Explanation Of Benefit - must be sent on paper if commercial insurance
  - Claims with a valid attachment must be received by HP within 120 days for CTBHP clients from the issuance date on the other insurance Explanation Of Benefit

HP Enterprise Services Claims Processing

- **HP Written Correspondence:**
  - The HP Written Correspondence Unit is an additional resource for claim research & requests for timely filing overrides
  - ***PLEASE NOTE: All written correspondence must have a cover letter and requests to override timely filing must have a Remittance Advice (RA) attached showing a progression of claim submission, provided the denial was not for timely filing or the override request must be related to client eligibility***

HP Enterprise Services
PO Box 2991
Hartford, CT 06104

Rapid Response Team
Special Project Requests

- A request for the Rapid Response Team to review a special CT BHP Timely Filing or Authorization related claim project must be approved by members of the Rapid Response Team.
- Providers should contact a Rapid Response Team Member to make a formal request.
  - http://www.ctbhp.com/RAPID_RESPONSE_TEAM_CONTACTS.pdf
- Provider should *not* send claims or backup documentation to HP or VO until the Rapid Response Team determines that there are potential valid reasons for retro-authorization or timely filing edits.
- Once a project is approved, the Rapid Response Team will collaborate with providers throughout the project to provide status updates, education and/or training tools.

Rapid Response Team

Q & A

Thank You