Connecticut interChange MMIS

Provider Manual

Chapter 12 – Claim Resolution Guide

January 18, 2022

Connecticut Department of Social Services (DSS)
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Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	01/13/2011	Initial Release	All	All
1.1	08/15/2011	Revised to include new HIPAA 5010 edits.	12.2	13-15, 25-26
1.2	05/22/2012	Revised as a result of HIPAA 5010.	All	All
1.3	08/13/2012	Revised as a result of Web mandate for demographic maintenance.	12.2	15-17
1.4	10/15/2012	New EOBs added as a result of National Correct Coding Initiative, revised instructions for accessing the Companion Guide, removed reference to local call number.	12.1 12.2	2 14, 54-55
1.5	11/26/2012	Revised address for the submission of out-of-state claims.	12.2	47
1.6	07/12/2013	New EOBs added as a result of the Connecticut Home Care Program for Elders implementation and the Affordable Care Act requirements.	12.2	20, 34-35, 51, 53-56, 61
1.7	10/07/2013	New EOBs added as well as existing EOB revised as result of the Affordable Care Act Requirements.	12.2	4-5, 7, 56
1.8	12/30/2013	Updated to reflect shutdown of ConnPACE and Charter Oak Health Plan Programs, effective January 1, 2014. Also updated to reflect that Home Health Advance Beneficiary Notice (HHABN) will no longer be valid for dates of service December 9, 2013 forward.	12.2	29, 52, 57. 66
1.9	02/23/2014	Edit 1038 added and other OPR edits updated to include a reference to the new OPR listing.	12.2	34-36
2.0	12/04/2014	New EOBs added as well as existing EOBs revised.	12.2	All
2.1	01/01/2015	New EOBs added and existing EOBs revised as a result of DRG project.	12.2	All
2.2	04/14/2015	Added APR DRG EOBs.	12.2	All
2.3	09/22/2015	Added EOBs as a result of ICD-10 implementation, as well as updated existing	12.2	All

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		EOBs.		
2.4	11/01/2015	Updated to replace HP references/logo with Hewlett Packard Enterprise references/logo.	All	All
2.5	05/06/2016	Added Hospice Service Intensity Add-On (SIA) EOBs.	12.2	All
2.6	06/06/2016	APC EOBs added as a result of Outpatient Hospital Modernization	12.2	All
2.7	10/17/2016	Updated as a result of the elimination of paper claims. Added EOB 5025.	12.1 12.2	2 6, 50, 72, 91
2.8	04/21/2017	Updated logo and references from Hewlett Packard Enterprise to DXC Technology as well as zip code for PO Box 5007. Updated EOB 0512 and added EOBs 0337, 0316, 0365, 0630 and 5927. Removed some references to ICD-9.	12.1 12.2	All All
2.9	02/20/2018	Added EOBs 0326, 0878, 6250, 6528, 7501 and 7502	12.2	16, 59, 99-101
3.0	04/25/2018	Added EOBs 0047, 3327, 3328, 3329, 8236, 8237 and 8238	12.2	All
3.1	11/01/2018	Updated as a result of the change in CADAP program administration.	12.2	55, 88, 89
3.2	09/09/2019	Added EOBs 0013, 0014, 0562-0564, 0926 and 6230, and updated EOBs 2003, 4021, 4140 and 4227.	12.2	All
3.3	09/17/2019	Update to EOB 0563 to remove residents	12.2	31
3.4	06/04/2020	Update to EOBs 314 and 5078; added EOB 5077.	12.2	14, 102
3.5	11/1/2020	Update to EOBs 311, added 5460. Updated logo and references from DXC Technology to Gainwell Technologies.	All	All
3.6	03/02/2021	Added EOB 4742, 5454 and 5455	12.2	93, 104
3.7	03/15/2021	Added EOB 5456	12.2	106
3.8	10/05/2021	Added EOBs 2513, 2515, 2517, 2531, 2532, 2533, 2534, 2535, and 2536.	12.2	80, 81, 83-85
3.9	01/18/2022	Added EOBs 0626 and 6720.	12.2	41, 118

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12.1 Overview

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Claims processed by Gainwell Technologies on behalf of the Department of Social Services (DSS) are reported to the provider via a semi-monthly Remittance Advice (RA). Explanation of Benefit (EOB) codes are posted to claims to provide a brief explanation of the reason why claims were either suspended or denied. The EOB codes are also used to explain any discrepancies between amounts billed and amounts paid on paid claims.

Due to the complex nature of the Connecticut Medical Assistance Program and the many benefit plans it supports, providers have sought further clarification to the most commonly posted EOB messages. This chapter provides a detailed description of the cause of the EOB and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition. It is important to note that not all EOB descriptions will offer a resolution that will result in claim payment. Many EOBs are posted when a claim fails to meet DSS' policy guidelines and would, therefore, be deemed not payable.

Please note that the resolution instructions included in this chapter must be used in conjunction with existing claim submission instructions found in either Chapter 8 of the Provider Manual, the Web Claim Submission Guide, the Provider Electronic Solutions Software Billing Instructions or the Companion Guide when a specific data element(s) needs to be corrected. This guide has not been designed to duplicate information located in these publications. For example, if the resolution instructions indicate that the Referring Provider is missing from the claim, the location of this field on either a paper or electronic claim must be determined by accessing the appropriate claim submission instructions found in these publications. Please note that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers.

New EOBs will continue to be added to this chapter as new programs and policies are implemented. Gainwell Technologies' Provider Assistance Center is also available to answer questions related to claims processing and they can be reached toll free at 1-800-842-8440, Monday through Friday, excluding holidays, from 8:00 a.m. to 5:00 p.m.

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12.2 Explanation of Benefit Codes

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EOB Description

0013 Composite APC Applied

Cause
Procedure codes with status indicator “Q3” when payable separately from the Ambulatory Procedure Code (APC) payable procedure code on an outpatient claim will normally pay at the APC code list on the CMAP Addendum B. If those procedures are billed with other procedures with status indicator “Q3”, it could be paid through a composite APC code 08004 - 08008 which is not listed on CMAP Addendum B. The APC payment would be based on the composite APC weight, not the APC listed on the CMAP Addendum B.

Resolution
Composite APC weights are posted on the Centers for Medicare & Medicaid Services (CMS) Web site under Addendum A.

EOB Description

0014 Comprehensive APC Applied

Cause
Procedure codes with Status Indicator “J1” could pay the Ambulatory Procedure Code (APC) code on the CMAP Addendum B but, if it is billed with other services, it can be paid through a comprehensive APC code which might be listed on CMAP Addendum B for another code.

Resolution
Comprehensive APC weights are posted on the Centers for Medicare & Medicaid Services (CMS) Web site under Addendum A.

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EOB Description

0047 Confirmed Visit Units are Exceeded

Cause
This EOB code will post to a claim containing an EVV mandated service where there is a confirmed visit found in the Santrax system that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units on the confirmed visit are less than the units billed on the claim. This claim will pay, but it will cut back and pay the number of units on the confirmed visit.

Resolution
The visit's confirmed units must be increased in the Santrax system prior to claim resubmittal. If the client is active on their appropriate waiver and has an approved prior authorization for the service being provided, the claim can be resubmitted for payment.

Cause
This EOB code will also set if there are two visits for the same client and service on the same day and only one visit is confirmed in the Santrax system. The second visit must be confirmed in order for the claim to pay the total number of units billed for the day.

Resolution
When the second visit performed on the same day is in a confirmed status in Santrax, the claim can be adjusted and resubmitted for payment.

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EOB	Description

0204 Prescribing provider not authorized to prescribe

Cause
A pharmacy claim was submitted that contains a prescribing provider National Provider Identifier (NPI) that is sanctioned.

Resolution
The pharmacy claim is not payable while the prescribing provider is sanctioned. The client should be referred to an enrolled prescribing provider for a new script.

Cause
A pharmacy claim was submitted that contains a prescribing provider National Provider Identifier (NPI) that is not a provider type that is authorized to prescribe; such as: extended care facility, chiropractor, therapist, optician, pharmacy, DME, transportation, laboratory, radiology, hospice agency, behavioral health clinician, or naturopath.

Resolution
The pharmacy claim is not payable if the prescribing provider is not authorized to prescribe. The client should be referred to an enrolled prescribing provider who is authorized to prescribe, for a new script.

EOB	Description

0206 Submitted prescriber's ID is invalid

Cause
A pharmacy claim was submitted that contains a prescribing provider National Provider Identifier (NPI) that is not ten numeric digits (NPI format) or fails the NPI validation algorithm.

Resolution
Correct the NPI and resubmit the pharmacy claim.

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EOB Description

0207 Prescribing provider not enrolled

Cause
A pharmacy claim was submitted that contains a prescribing provider National Provider Identifier (NPI) that is not on file; or the NPI is on file, but does not have an “Active” or “Performing Provider Only” contract or is not in the process of enrolling with the Connecticut Medical Assistance Program (CMAP) on the dispense date of the claim.

Resolution
The pharmacy claim is not payable until the prescribing provider is either in the process of enrolling in CMAP or is enrolled with either an “Active” or “Performing Provider Only contract”.

For a onetime Prescribing Provider Exception (PPE) override, pharmacies may enter all 7’s in the Prior Authorization Number Submitted field, NCPDP 462-EV, in order to dispense a one-time, 14 day supply of the medication.

In the event that the patient is unable to obtain a new prescription from a CMAP enrolled provider prior to utilizing the 14-day supply of medication, pharmacies will be able to obtain a onetime Prescribing Provider Exception emergency override by entering all 4’s in the Prior Authorization Number Submitted field in order to dispense an additional 30-day supply of the prescribed medication.

If another, CMAP enrolled, prescribing provider authorizes verbal consent to cover the medication- documentation should be retained on the original prescription. The Prescribing Provider NPI must not be changed on the denied claim, and resubmitted. The pharmacy should create a new prescription identifying the new prescriber of the medication.

EOB Description

0209 Prescriber ID of group; Resubmit individual’s NPI

Cause
A pharmacy claim was submitted that contains a prescribing provider National Provider Identifier (NPI) that is associated with a group and not an individual.

Resolution
Change the NPI to the prescribing provider’s individual NPI and resubmit the pharmacy claim.

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EOB	Description

0224 Detail diagnosis code pointer invalid on paper claim

Cause
A professional paper claim was submitted that contains a diagnosis code pointer in field 24 E other than blank or 0 – 4.

Resolution
Correct the diagnosis code pointer and resubmit the claim. (Please note that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. Otherwise, claims should be submitted electronically or through the www.ctdssmap.com Web site.)

Cause
A professional paper claim was submitted that contains a diagnosis code pointer of 1 – 4 in field 24 E and no header diagnosis code was entered in field 21.

Resolution
Add the appropriate diagnosis code in field 21 and resubmit the claim. (Please note that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. Otherwise, claims should be submitted electronically or through the www.ctdssmap.com Web site.)

EOB	Description

0226 Referring Provider Name/Number is missing

Cause
The referring provider is missing on the professional claim. The referring provider is required when:

- The billing provider is a provider type 28 (laboratory) or 29 (radiology).
- The service billed is a consultation.
- The service billed is an eye examination performed at a nursing facility or skilled nursing facility.

Resolution
Enter the referring provider on the claim and resubmit the claim.

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EOB Description

0303 APC - Inappropriate specification of bilateral procedure

Cause

An outpatient claim is submitted for the same bilateral procedure code for multiple times, based on occurrences or units of service, on the same date of service without modifier 76 (Repeat procedure by same MD).

Resolution

Verify the procedures on claim to ensure that when two or more of the same bilateral procedures are billed on the same date of service modifier 76 is added. Correct and re-submit claim.

EOB Description

0304 APC - Service considered an inpatient procedure

Cause

An outpatient claim was submitted with an inpatient procedure code that returned a status indicator C "Inpatient Procedure".

Resolution

Verify the procedure code submitted on the claim. If it is incorrect, correct the claim and resubmit. Verify the patient status on the claim. If patient status was entered incorrectly, correct and re-submit claim. If the patient expired prior to admission, please verify if the claim was submitted with modifier CA “Procedure Payable Inpatient”. If the procedure is correct and the client is not expired, it is not a payable service when submitted as an outpatient claim.

Cause

An outpatient claim was submitted with an incorrect patient status when billing for an inpatient procedure and the client is expired.

Resolution

Verify the patient status on the claim. If patient status was entered incorrectly, correct and re-submit claim.

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EOB	Description

0305 APC - Medical visit on same day as type T or S procedure w/o modifier 25 - significant separate E&M service

Cause
A clinic or emergency department visit (status indicator V-clinic or emergency department visit paid under OPPS) has been billed without modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the same date of service as a significant procedure (status indicator S or T Significant Procedure payable under OPPS).

Resolution
Correct the claim by adding modifier 25. Re-submit the claim.

EOB	Description

0306 APC - Medical visit on same day as type T or S procedure

Cause
An outpatient medical visit is provided on same day as procedure with a status indicator of T or S.

Resolution
Verify the services billed on the claim to ensure that only one service with a status indicator T or S is billed on the same day of a medical visit. Re-submit the claim.

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EOB	Description

0307 APC - Invalid age

Cause
An outpatient service is provided on a client with an invalid age on file. The age is non-numeric or outside the range of 0-124 years.

Resolution
Verify the client's correct age. If incorrect, contact DSS eligibility office to correct the client's age. Contact information can be found at www.ctdssmap.com under Information refer to Chapter 1 Client Eligibility Issues.

EOB	Description

0308 APC - Invalid gender

Cause
An outpatient service is provided on a client with an incorrect gender on file.

Resolution
Verify the client's gender. If incorrect, contact DSS eligibility office to correct the client's gender. Contact information can be found at www.ctdssmap.com under Information refer to Chapter 1 Client Eligibility Issues.

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EOB Description
0309 APC - Only incidental services reported **Cause** The outpatient claim was submitted with only incidental services being billed. **Resolution** Please verify the procedures submitted on the claim. An outpatient claim without an APC payable service and just packaged services will be denied.

EOB Description
0311 APC - Implanted device without implantation procedure or administered substance without associated procedure **Cause** An outpatient claim was submitted with an APC status indicator of H “pass through device category” or U “Brachytherapy Sources” or APC 987-997 is present, but no procedure codes with status indicator of S, T “significant procedure payable under OPPS”, J1 “Hospital Part B services paid through a comprehensive APC” or non-implant type X procedure are present on the claim. **Resolution** Please verify the claim to see if procedure codes with status indicator S, T, J1 or non-implant status indicator X are present on the claim. If missing, add procedure and re-submit the claim.

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EOB	Description

0312 Multiple medical visits with the same RCC and same day require condition code G0

Cause
Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue center code family, without condition code G0 present to indicate that the visits were distinct and independent of each other.

Resolution
Condition code G0 “Distinct Medical Visit” should be added to the current claim, if applicable. Re-submit claim if condition code is added.

EOB	Description

0313 APC - Transfusion or blood product exchange without specification of blood product

Cause
An outpatient claim is submitted with a blood product transfusion or exchange procedure, but no blood product is billed. The transfusion or blood product exchange and the blood product do not have to be on the same date of service.

Resolution
Correct the claim by adding the blood product procedure and re-submit the claim.

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EOB Description

0314 APC - Observation revenue code on line item with non-observation HCPCS code

Cause
An outpatient claim was submitted with RCC 762 (observation) with a HCPCS other than HCPC code G0378 “Hospital observation per hr”.

Resolution
Please verify the procedure code submitted on the claim in connection with RCC 762. If it is incorrect, correct the claim and re-submit.

EOB Description

0315 APC - Inpatient separate procedures not paid when accompanied by another type T procedure

Cause
An outpatient claim is submitted on the same day as in Inpatient procedure and there is at least one HCPC code with a status indicator of T “significant procedure payable under OPPS.

Resolution
Verify the coding on the claim and re-submit the claim.

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EOB	Description

0316 APC - Incidental procedure not separately reimbursed

Cause
The outpatient claim consists entirely of a combination of lines that have been denied or rejected and have a status indicator N “Items and Services Packaged into APC Rates”.

Resolution
Please verify the procedure codes submitted on the claim. If incorrect, correct the claim and resubmit. Please review the other denial EOBs. If you correct those EOB codes, EOB 0316 might not apply to the claim when re-submitted.

EOB	Description

0317 APC - Service provided same day as an inpatient procedure

Cause
An outpatient service is provided on the same day as in inpatient procedure performed at the same hospital. This occurs on all other details that are billed on the same day as a procedure with a status indicator “C” inpatient procedure. This is recognized as an inpatient claim and will not pay any other lines as outpatient.

Resolution
Verify the procedure code that denied with EOB code 0304 “APC – “Service considered an inpatient procedure” is the same claim as the details that are denying EOB code 0317”service provided same day as an inpatient procedure”. Resubmit the claim if procedure is updated.

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EOB Description
0318 APC - Composite E/M condition not met for observation and line item date for code G0378 is 1/1 **Cause** An outpatient service is submitted with no specified E/M or critical care visit the day of or the day preceding the observation. **Resolution** Verify that there is no specified E/M or critical care visit the day of or the day preceding the observation. Claim will deny without this criteria. Correct the coding and re-submit the claim.

EOB Description
0319 APC - G0379 only allowed with G0378 **Cause** An outpatient service was submitted with Code G0379 “Direct refer hospital observation” without code G0378 “Hospital observation per hour” for the same line item date. G0379 is only allowed with G0378. G0379 indicates to Medicare that the patient arrived as a direct admit, but it does not count as the first hour. G0378 tells Medicare how long the patient stayed in observation. **Resolution** Hospitals are required to follow Medicare billing requirements related to observations. To correct, add a new detail line with G0378 and bill with correct units to demonstrate the number of hours spent in observation. Re-submit the claim.

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EOB Description

0322 APC - Service provided prior to FDA approval

Cause
An outpatient service was billed on a claim with a line detail for a date of service prior to Food and Drug Administration (FDA) approval.

Resolution
Please verify the procedure codes and or dates of service submitted on the claim. If incorrect, correct the claim and re-submit.

EOB Description

0323 APC - Service provided prior to date of National Coverage Determination (NCD) Approval

Cause
An outpatient service was billed on a claim with a line detail for a date of service prior to the approval date of National Coverage Determination (NCD).

Resolution
Please verify the procedure code and date of service submitted on the claim. If incorrect, correct the claim and re-submit.

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EOB	Description

0324 APC - The service was provided outside the period approved by CMS

Cause
An outpatient service is provided on a date that is outside the period approved by CMS.

Resolution
Please verify the procedure code and date of service submitted on the claim. If incorrect, correct the claim and re-submit.

EOB	Description

0325 APC - CA Modifier requires patient status code 20 (expired)

Cause
An outpatient claim was submitted for a patient status code 20 “expired” without modifier CA “Procedure Payable Inpatient”.

Resolution
Verify the patient was a status code 20 and add CA modifier. Re-submit the claim.

EOB	Description

0326 APC – Service Submitted for Denial

Cause
An outpatient claim was submitted with a condition code 21 “Billing for Denial Notice”.

Resolution
Please verify if claim should have been submitted with condition code 21. If not, remove condition code 21 and re-submit the claim.

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EOB Description
0327 APC - Incorrect billing of blood and blood products **Cause** An outpatient claim was submitted without two blood product claim lines. The outpatient claim that was submitted lacks two identical lines of HCPCS code, units and modifier BL “Special Acquisition of Blood and Blood Products”. **Resolution** Correct the coding of the blood and/or blood products using correct RCC, units and modifier BL. Re-submit the claim.

EOB Description
0328 APC - Units of service greater than 1 inappropriate for bilateral procedure reported with modifier 50 **Cause** An outpatient claim was submitted for a bilateral procedure with modifier 50 and units of service are greater than 1 on the same line. **Resolution** Providers are required to follow Medicare billing requirements related to units of service. Change the number of allowed units to 1. Re-submit the claim.

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EOB Description
0329 APC - Trauma response critical care code without revenue code 068x and CPT 99291 **Cause** An outpatient service was provided with a critical care code present without RCC 68X (trauma response) and 99291 (critical care first hour) on the claim. **Resolution** Verify the RCC or procedure code on the claim and re-submit the claim.

EOB Description
0332 APC - Incorrect billing of revenue code with HCPCS code **Cause** Revenue center code (RCC) 381 was billed with a HCPCS other than packed red cells (P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9057, P9058), or RCC 382 with HCPCS other than whole blood (P9010, P9051, P9054, P9056). **Resolution** Please verify the RCC or HCPCS submitted on the claim. If incorrect, correct the claim and re-submit. If the RCC or HCPCS is correct, it is not a payable service when submitted with those HCPCS codes.

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EOB	Description

0335 APC - Reduced/discontinued procedures are not payable

Cause
An outpatient claim was billed with code with modifier 52 “Reduced Service”, modifier 73 “Procedure Discontinued Prior to Anesthesia” or modifier 74 “Procedure Discontinued after Anesthesia”. These modifiers indicate the procedure was discontinued.

Resolution
Verify the modifier used on the outpatient claim. If it is incorrect, correct and re-submit the claim. If the procedure was reduced/discontinued, it is not a payable service.

EOB	Description

0337 APC Total amount allowed on APC claim is zero

Cause
An outpatient claim was billed with an APC payable procedure code that was denied with a different EOB code causing there to be no APC payable allowed amount on the claim.

Resolution
Review the other EOB code setting on the APC payable procedure code and, once you resolve that EOB, it should resolve EOB 0337 at the same time.

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EOB	Description

0338 APC - Service must be billed with procedure code

Cause
An outpatient claim was billed with a service that must have a procedure code.

Resolution
Verify whether the service requires a procedure code. If so, add the procedure code and re-submit the claim.

EOB	Description

0365 Principal procedure date is invalid or missing or Principal Procedure Code is Missing

Cause

An inpatient claim was submitted with an invalid or missing principal procedure date.

Resolution

The inpatient claim was submitted with a principal procedure with an invalid or missing date. The provider needs to verify principal procedure date and correct the date and re-submit the claim.

Cause

An outpatient claim was submitted with an operating provider, but no surgery procedure on the claim.

Resolution

Please verify the procedure codes submitted on your outpatient claim. If incorrect or missing, correct the claim and re-submit.

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EOB Description

0485 Diagnosis codes must be all same code set

Cause
A claim was submitted with diagnosis codes from both the ICD-9 and ICD-10 code sets.

Resolution
Diagnosis codes from only one code set can be submitted on a claim. Submit the diagnosis codes from the appropriate code set (ICD-9 or ICD-10) based on the date(s) of service on the claim.

- ICD-9 codes are valid for dates of service through 9/30/2015
- ICD-10 codes are valid for dates of service 10/1/2015 forward

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

EOB Description

0486 ICD surgical procedure code must be same code set (inpatient claims only)

Cause
An inpatient claim was submitted with surgical procedure codes from both the ICD-9 and ICD-10 code sets.

Resolution
Surgical procedure codes from only one code set can be submitted on a claim. Submit the surgical procedure codes from the appropriate code set (ICD-9 or ICD-10) based on date(s) of service on the claim.

- ICD-9 codes are valid for dates of service through 9/30/2015
- ICD-10 codes are valid for dates of service 10/1/2015 forward

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

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EOB Description

0487 ICD DX and surgical procedure must be same code set (inpatient claims only)

Cause
An inpatient claim was submitted with diagnosis codes and surgical procedure codes from both the ICD-9 and ICD-10 code sets.

Resolution
Diagnosis codes and surgical procedure codes from only one code set can be submitted on a claim. Submit the diagnosis codes and surgical procedure codes from the appropriate code set (ICD-9 or ICD-10) based on the date(s) of service on the claim.

- ICD-9 codes are valid for dates of service through 9/30/2015
- ICD-10 codes are valid for dates of service 10/1/2015 forward

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

EOB Description

0488 ICD surgical procedure not allowed on outpatient claim

Cause
An outpatient claim was submitted with one or more ICD surgical procedure codes.

Resolution
ICD surgical procedure codes are allowed only on inpatient claims. Remove the ICD surgical procedure code(s) from the outpatient claim and resubmit the claim.

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EOB	Description

0491 ICD9 surgical code qualifier after effective date (inpatient claims only)

Cause

An inpatient claim was submitted with one of the following ICD-9 surgical code qualifiers for a date of service after the ICD-10 implementation date of 10/1/2015.

- BR – Principal Procedure Code
- BQ – Other Procedure Code

Resolution

Change the surgical code qualifier to one of the following ICD-10 qualifiers and resubmit the claim.

- BBR – Principal Procedure Code
- BBQ – Other Procedure Code

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

EOB	Description

0492 ICD9 diagnosis code qualifiers after ICD10 implementation date

Cause

A claim was submitted with one of the following ICD-9 diagnosis code qualifiers for a date of service after the ICD-10 implementation date of 10/1/2015.

- BK – Primary Diagnosis
- BJ – Admit Diagnosis (Institutional)
- BN – Ecode Diagnosis (Institutional)
- BF – Other Diagnosis
- PR – Visit Diagnosis (Institutional)

Resolution

Change the diagnosis code qualifier to one of the following ICD-10 diagnosis code qualifiers and resubmit the claim.

- ABK – Primary Diagnosis
- ABJ – Admit Diagnosis (Institutional)
- ABN – Ecode Diagnosis (Institutional)
- ABF – Other Diagnosis
- APR – Visit Diagnosis (Institutional)

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

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EOB	Description

0512 Claim exceeds timely filing limit

Cause

The Department of Social Services timely filing limit for non-Behavioral Health Partnership services is one year. This EOB code will appear on the claim if any of the following conditions exist:

- The date the claim was received by Gainwell Technologies was greater than 366 days from the claim date of service OR,
- The date the claim was received by Gainwell Technologies was greater than 366 days from the Other Insurance Explanation of Benefit or Medicare Explanation of Medicare Benefit date OR,
- The Explanation of Medicare Benefit denial date is greater than 549 days from the date of service OR,
- The date the claim was received by Gainwell Technologies was greater than 366 days from the date the claim previously appeared on a Remittance Advice.
- The claim previously denied for timely filing.
- When there are multiple TPL Carriers and Medicare Carriers on the claim, if any one of the date checks do not meet these criteria, the EOB will set.

Tip: The claim receipt date can be identified within the Internal Control Number (ICN). For example, ICN 20**10031**200100 indicates the claim was received January 31, 2010. The year is located in the third and fourth positions and the day of the year (Julian date) is located in the fifth through seventh positions.

Resolution

If the claim meets any of the noted criteria above, the claim exceeds the timely filing limit and cannot be paid.

If the claim denied with this error condition but does not meet the noted criteria above, resubmit the claim with the appropriate supporting documentation (i.e. copy of Remittance Advice, Other Insurance Explanation of Benefit or Medicare Explanation of Medicare Benefit) and send the claim to the normal claim submission address located in Chapter 1 of the Provider Manual. Go to www.ctdssmap.com -> Information -> Publications -> Provider Manuals.

If the claim previously appeared on a Remittance Advice within the past 366 days, the claim must be resubmitted with the same provider ID, client ID, date of service, procedure/modifier and billed amount, otherwise, the claim will deny. If the previously processed claim denied for timely filing, the claim is not payable.

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EOB Description

0513 Client's name and number disagree

Cause

The name of the client submitted on the claim does not match the client's name on the Department of Social Services' client eligibility file associated to the Medicaid ID submitted.

Resolution

Perform a client eligibility verification transaction to identify the correct spelling of the client's name or to determine the client's correct Medicaid client ID and name on file. Correct the data in error and resubmit the claim.

Tip: The Web claim submission tool can easily resolve this error because the client's name on the Web claim reflects the name of the client on the Department of Social Services' eligibility file. Go to www.ctdssmap.com and login to your secure Web account. Using Claim Inquiry, enter the ICN of the denied claim and click the Search button. Verify the client ID entered is correct. Scroll to bottom of claim and click the Resubmit button.

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EOB Description

0518 Total accommodation days billed are not equal to the elapsed days

Cause

The number of days that span the claim header dates of service do not equal the sum of the covered and non-covered days billed at the detail.

Inpatient claims:

The header span dates are calculated by determining the elapsed days and subtracting one day ONLY if the patient status does not equal 30 (Still a Patient).

For example, if the statement covers period is January 1, 2010 through January 3, 2010 and the patient discharge status equals 30, the header span is 3 days. If the patient discharge status is any other value, the header span is 2 days.

The detail span dates are calculated by summing the days billed on all accommodation Revenue Center Codes (RCC) which are RCCs: 074, 077, 078, 079, 091, 099, and 100 through 219. The sum of the days billed for these accommodation RCCs must equal the header span days.

Note: This EOB will not post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Hospital modernization claims will instead post EOB 671 DRG covered/non-covered days disagree with the statement period.

Resolution

Review the header from and through dates of service, patient discharge status, detail dates of service and detail days billed to determine which field is in error, correct and resubmit the claim.

Cause

Nursing Home claims:

The header span dates are calculated by determining the elapsed days. If the patient status does not equal one of the following values, the system will automatically subtract one day:

20 Expired

30 Still a Patient

40 Expired at Home

41 Expired in a medical facility

42 Expired – place unknown

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For example, if the statement covers period is January 1, 2010 through January 31, 2010 and the patient discharge status equals 20, the header span is 31 days. If the patient discharge status is 01 (Discharged to home or self-care), the header span is 30 days.

The detail span dates are calculated by summing the days billed on all covered and non-covered days. The sum of the days billed must equal the header span.

Resolution
Review the header from and through dates of service, patient discharge status, detail dates of service and detail days billed to determine which field is in error, correct and resubmit the claim.

EOB	Description

0519 Admission date is after the from date of service

Cause
The admission date on an inpatient or long-term care claim is after the from date of service.

Note: This EOB will not post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Resolution
Correct either the admission date or the from date of service and resubmit the claim.

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EOB Description

0550 Electronic Adjustment Is Invalid

Cause
The client ID is missing or invalid.

Resolution
Enter the client ID that was submitted on the original claim that needs to be adjusted and resubmit the adjustment.

Cause
Billing provider ID is missing or invalid.

Resolution
Enter the provider ID that was submitted on the original claim that needs to be adjusted and resubmit the adjustment.

Cause
The Internal Control Number (ICN) is missing or invalid.

Resolution
Enter the ICN that was assigned to the original claim that needs to be adjusted and resubmit the adjustment.

Cause
The claim, based on the ICN submitted, is not in a paid status.

Resolution
Denied claims cannot be adjusted. The claim must be resubmitted as a new claim. If the claim is still in a paid status, the most current ICN must be submitted on the electronic adjustment. Perform a claim inquiry to determine the most current ICN assigned to the claim.

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Cause
Professional claim: The claim frequency code equals 1 and an ICN is submitted on the claim.

Resolution
If the electronic claim is an adjustment, change the claim frequency code to either a 7 to adjust the claim, or an 8 to recoup the original claim in full. If the claim is not an adjustment, remove the ICN from the claim.

Cause
Institutional claim: The third digit of the type of bill does not equal a 7 or 8 and an ICN is submitted on the claim.

Resolution
If the electronic claim is an adjustment, change the third digit of the type of bill to either a 7 to adjust the claim, or an 8 to recoup the original claim in full. If the claim is not an adjustment, remove the ICN from the claim.

EOB Description

0562 Referring provider type/specialty not valid for billing provider

Cause
This edit will post when the National Provider Identifier (NPI) of the referring provider in the header or detail of the claim is not valid for Durable Medical Equipment (DME) claims.

Resolution
Verify the referring provider on the claim, correct information and resubmit the claim. Examples of invalid providers include organizations such as hospitals or clinics, opticians, psychologists, etc.

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EOB	Description

0563 Ordering provider type/specialty not valid for billing provider

Cause
This edit will post when the NPI of the ordering provider on the claim detail is not valid for DME claims.

Resolution
Verify the ordering provider on the claim, correct information and resubmit the claim. Examples of invalid providers include organizations such as hospitals or clinics, opticians, psychologists, etc.

EOB	Description

0564 Rendering provider type/specialty not valid for billing provider

Cause
This edit will post when the NPI of the rendering provider is not a DME provider.

Resolution
DME providers should leave this field blank as it is not required on DME claims or should enter their billing NPI in the rendering field. Verify if the NPI entered is the NPI of the DME provider. If not, remove the NPI and re-submit the claim.

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EOB	Description

0570 Header total days less than covered days

Cause

For Inpatient claims with a patient status of 30 (Still Patient), the number of days in the header date span do not equal the sum of the detail units billed for the accommodation revenue center codes.

Accommodation revenue center code list:

074 - 074

077 - 079

091 - 091

100 - 219

224 – 224

724 – 724

729 - 729

Note: This EOB will not post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Hospital modernization claims will instead post EOB 672 DRG accommodation days inconsistent with the header date period.

Resolution

Correct either the header covered days, the patient status or the detail units billed for the accommodation revenue center codes and resubmit the claim.

Tip: The Department of Social Services will reimburse hospitals for the last day billed on an Inpatient claim only when the client remains in the hospital; therefore, this day must be included in the number of days billed at the detail.

Cause

For Inpatient claims with a patient status that **does not** equal 30 (Still Patient), the number of days in the header date span, minus one day, does not equal the sum of the detail units billed for the accommodation revenue center codes.

Accommodation revenue center code list:

074 - 074

077 - 079

091 - 091

100 - 219

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

224 – 224

724 – 724

729 - 729

Note: This EOB will not post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Hospital modernization claims will post EOB edit 672 Service days do not match total of accommodation units.

Resolution

Correct either the header covered days, the patient status or the detail units billed for the accommodation revenue center codes and resubmit the claim.

Tip: The Department of Social Services will not reimburse hospitals for the last day billed on an Inpatient claim when the client has either been discharged or has expired, therefore, this day must **not** be included in the number of days billed at the detail.

Cause

For Nursing Home claims with a patient status of 20 (Expired), 30 (Still Patient), 40 (Expired at Home), 41 (Expired in a Medical Facility) or 42 (Expired – Place Unknown), the number of days in the header date span do not equal the sum of the detail units billed for the accommodation revenue center codes.

Accommodation revenue center code list:

100

183

185

189

Resolution

Correct either the header covered days, the patient status or the detail units billed for the accommodation revenue center codes and resubmit the claim.

Tip: The Department of Social Services will reimburse nursing homes for the last day billed on a Nursing Home when the client remains in the nursing home or has expired, therefore, this day must be included in the number of days billed at the detail.

Cause

For Nursing Home claims with a patient status that **does not** equal 20 (Expired), 30 (Still Patient), 40 (Expired at Home), 41 (Expired in a Medical Facility) or 42 (Expired – Place Unknown), the number of days in the header date span, minus one day, does not equal the sum of the detail units billed for the accommodation revenue center codes.

Accommodation revenue center code list:

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100

183

185

189

Resolution

Correct either the header covered days, the patient status or the detail units billed for the accommodation revenue center codes and resubmit the claim.

Tip: The Department of Social Services will not reimburse nursing homes for the last day billed on a Nursing Home claim when the client was discharged, therefore, this day must not be included in the number of days billed at the detail.

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EOB	Description

0572 Quantity disagrees with days elapsed

Cause
For Inpatient claims, the sum of the detail units billed for the accommodation Revenue Center Codes (RCC) does not equal the header covered days or the revenue center code billed is incorrect.

Accommodation revenue center code list:

074 - 074

077 - 079

091 - 091

100 - 219

224 – 224

724 – 724

729 - 729

Note: This EOB will not post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Resolution
Correct either the header covered days, the detail units billed for the accommodation RCC, or the RCC and resubmit the claim.

Cause
For Nursing Home claims, the sum of the detail units billed for the accommodation revenue center codes does not equal the header covered days.

Accommodation revenue center code list:

100

183

185

189

Resolution
Correct either the header covered days or the detail units billed for the accommodation revenue center codes and resubmit the claim.

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EOB Description

0610 Tooth Number/Tooth Surface combination invalid

Cause
This edit will set when a procedure code is billed with a required tooth number and the tooth number/tooth surface combination is not valid.

Resolution
Verify the tooth number and tooth surface submitted on the claim. If it is incorrect, correct the claim and resubmit. If the tooth number and tooth surface is correct, it is not a payable service.

A list of tooth surface/tooth number combinations can be found in Provider Bulletin PB 14-62.

EOB Description

0617 Invalid claim version – submit in new HIPAA 5010 or NCPDP D.0

Cause
Non-pharmacy claim submitted in the HIPAA 4010 format.

Resolution
Submit claim in the HIPAA 5010 format. All electronic transactions and code sets are required to be submitted in the new 5010 version of the X12 HIPAA Transactions and Code Set Standards.

Companion Guides for HIPAA 5010 transactions are located on the www.ctdssmap.com Web site. From the Home page, navigate to *Trading Partner > EDI* and click on the *Companion Guide* link within the *EDI Documents* panel.

Cause
Pharmacy/Compound claim submitted in the NCPDP 5.1 format.

Resolution
Submit claim in the NCPDP D.0 format. All pharmacy and compound transactions are required to be submitted in the new NCPDP D.0 version.

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EOB Description

0618 Billing provider address cannot contain P.O. Box

Cause
If the claim is submitted via the secure Web portal, the provider's service location on the provider's file contains a P.O. Box as received via provider enrollment.

Resolution
The P.O. Box must be removed from the provider's service location on the provider's file. This can easily be completed by logging onto the main account user's secure Web account on www.ctdssmap.com and clicking on the Demographic Maintenance tab. Click on Location Name Address below the Provider Information panel, click on the Service Location row, click maintain address on the right, update the address and click save.

Once the address and all other errors have been corrected, resubmit the claim.

Tip: A P.O. Box may remain on all other address types; however, when submitting Web claims through the www.ctdssmap.com Web site, if the Service Location address does not contain a 9-digit zip code, an alternate address within your Provider profile (Mail to, Pay to, etc.) which does contain a 9-digit zip code is automatically substituted and submitted in order to avoid setting EOBs 0619 or 0620. In order to avoid having the alternate address used, which could cause the claim to deny, the zip code must be updated on the Service Location address. This can easily be completed by logging onto the main account user's secure Web account on www.ctdssmap.com and clicking on the Demographic Maintenance tab. Click on Location Name Address below the Provider Information panel, click on the Service Location address row, click Maintain Address on the right, update the zip code and click save.

Cause
The electronic claim was submitted with a P.O. Box in the billing provider's address.

Resolution
Replace the P.O. Box with the street address, correct all other errors and resubmit the claim.

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EOB	Description

0619 Zip code is not a valid 9 digit zip code

Cause
If the claim is submitted via the secure Web portal, the provider's zip code submitted via the provider enrollment application was not a full 9 digits, or the first 5 digits or last 4 digits of the zip code were all zeros.

Resolution
The zip code must be updated on the provider's file. This can easily be completed by logging onto the main account user's secure Web account on www.ctdssmap.com and clicking on the Demographic Maintenance tab. Click on Location Name Address below the Provider Information panel, click on the applicable address row, click maintain address on the right, update the zip code and click save.

Once the zip code and all other errors have been corrected, resubmit the claim.

Please note: Failure to supply a full 9 digit zip code for your Service Location address may result in EOB 0618 when submitting claims via the Web.

Cause
The claim was not submitted with a valid 9 digit zip code.

Resolution
Replace the invalid zip code with a valid 9 digit zip code, correct all other errors and resubmit the claim.

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EOB	Description

0620 Service facility zip code is invalid

Cause
The service facility's zip code submitted on the electronic claim was not a valid 9 digit zip code or the first 5 digits or last 4 digits of the zip code were all zeros. (The service facility is the location where the service was performed when other than the provider's office.)

Please note: Failure to supply a full 9 digit zip code for your Service Location address may result in EOB 0618 when submitting claims via the Web.

Resolution
Replace the invalid zip code with a valid 9 digit zip code, correct all other errors and resubmit the claim.

EOB	Description

0621 Billing provider entity type qualifier to provider type/specialty mismatch

Cause
The submitted billing provider entity type qualifier indicates an individual (1) and the determined provider type and specialty on file for the provider indicates a group (2).

Resolution
Correct the billing provider entity type qualifier and resubmit the claim.

Cause
The submitted billing provider entity type qualifier indicates a group (2) and the determined provider type and specialty on file for the provider indicates an individual (1).

Resolution
Correct the billing provider entity type qualifier and resubmit the claim.

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EOB Description

0622 Rendering provider type/specialty conflict with entity type qualifier

Cause
HIPAA 5010 standards require that the rendering provider be an individual and not an organization. The type and specialty associated with the rendering provider ID submitted on the claim indicates a group.

Resolution
Verify that the rendering provider ID submitted on the claim is for an individual and that the rendering provider entity type qualifier on the claim indicates an individual (1).

EOB Description

0626 ABC Dental Certification missing or not active on claim dates of service

Cause
ABC dental certification missing or not active on claim dates of service.

Resolution
Providers should verify their certification to participate in the ABC program from Connecticut Dental Health Partnership (CTDHP) is valid on their date of service.

In order for Connecticut Medical Assistance Program (CMAP) medical providers to participate in the ABC Program and be reimbursed for services, each provider must: (1) be eligible to bill off of the physician office and outpatient fee schedule; (2) complete the CTDHP training; (3) retain documentation of completion of the training and the continuing education units (CEU) certificate and provide a copy to the CTDHP for record keeping.

For questions regarding ABC Training or to sign up for a Training session, please contact the ABC Program Coordinator, 1-855-CT-DENTAL (855-283-3682).

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EOB Description

0630 Claims must be submitted via the EVV system

Cause

DSS requires that effective for dates of service on or after January 1, 2017 for non-medical service providers and April 3, 2017 for Home Health service providers, providers must utilize Electronic Visit Verification (EVV) when providing EVV mandated services to ABI, CHC and PCA Waiver clients. Claims matching the service authorizations for the client must be submitted via the EVV system. Claims for EVV mandated services not submitted via the EVV system will deny and post the EOB code.

Resolution

Verify that the services provided are EVV mandated services and submit claims for EVV mandated services through the EVV system.

EOB Description

0671 DRG covered/non-covered days disagree with the statement period

Cause

The covered days (value code 80) plus non-covered days (value code 81) does not equal the number of elapsed days based on the admission date and header through date of service. Add 1 to the service days if the patient status is 30 (still a patient). This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

For example, if the admission date is January 1, 2015, the header through date is January 30, 2015 and the patient discharge status equals 30, the sum of the covered and non-covered days must equal 30 days. If the patient discharge status is any other value, the sum of the covered and non-covered days must equal 29 days.

Resolution

Review the admission date, header through date of service, covered and non-covered days, and patient discharge status to determine which field is in error, correct and resubmit the claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0672 DRG accommodation days inconsistent with the header date period

Cause

The sum of the detail accommodation days billed does not equal the number of elapsed days based on the admission date and header through date of service. Add 1 to the service days if the patient status is 30 (still a patient). This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

For example, if the admission date is January 1, 2015, the header through date is January 30, 2015 and the patient discharge status equals 30, the sum of the detail accommodation days must equal 30 days. If the patient discharge status is any other value, the sum of the detail accommodation days must equal 29 days.

Accommodation revenue center code list:

074 - 074

077 - 079

091 - 091

100 - 219

224 – 224

724 – 724*

729 – 729*

Resolution

Review the admission date, header through date of service, detail accommodation days, and patient discharge status to determine which field is in error, correct and resubmit the claim.

- Inpatient hospitals that bill for Revenue Center Code (RCC) 724 or 729 as ancillary codes for inpatient claims will be required to bill these services under RCC 720.

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EOB	Description

0674 DRG interim claims not allowed

Cause
The inpatient claim was submitted with a patient status is 30 (still a patient) and the claim length of stay (LOS) is less than 29 days. The LOS is the through date minus admit date plus one day. This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Resolution
If the actual length of an inpatient admission is less than 29 days, the hospital must bill for the entire admission on one claim. If an inpatient claim is submitted with a patient discharge status of 30, indicating the patient is still in the hospital, it will be denied if the number of days submitted is less than 29 days.

Only one interim claim will be allowed when the actual length of stay reaches 29 days. In lieu of a second interim claim, the first interim claim must be adjusted, or recouped and resubmitted, if the hospital wishes to submit for payment any additional days of the stay.

EOB	Description

0682 Invalid discharge status

Cause
The patient discharge status submitted on the inpatient claim is either missing or invalid when the patient discharge status is needed to identify the DRG.

Resolution
Enter a valid patient discharge status and resubmit the corrected claim.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

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EOB Description

0683 DRG is ungroupable due to diagnosis and client's gender mismatch

Cause

The client's gender is missing or invalid on the DSS client eligibility file and the patient gender is needed to identify the DRG.

Resolution

Perform a client eligibility verification transaction to determine the client's gender. If the client's gender is incorrect, submit a request to correct the client's gender along with the denied claim's Internal Control Number (ICN) to ctxixhosppay@gainwelltechnologies.com. Gainwell Technologies will submit a request to DSS to update the client's eligibility file with a valid gender.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

0685 Ungroupable due to unacceptable principal diagnosis (V Code)

Cause
The principal diagnosis code submitted on the inpatient claim is a V-code that cannot be used as the principle diagnosis on the claim.

V-codes describe a circumstance which influences an individual's health status but is not a current illness or injury such as family history of ischemic heart disease. The V-code submitted on the claim may only be used as a contributing (secondary) diagnosis.

Resolution
Change the principal diagnosis code to a code that represents the current illness or injury and resubmit the claim.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

EOB	Description

0686 Edit ungroupable due to secondary diagnosis required

Cause
The principal diagnosis code submitted on the inpatient claim is a V-code that cannot be used as the principle diagnosis without a required secondary diagnosis.

V-codes describe a circumstance which influences an individual's health status but is not a current illness or injury (e.g. Family history of ischemic heart disease) and cannot be listed as the principle diagnosis on an inpatient claim without a secondary diagnosis.

Resolution
Either change the principal diagnosis code to a code that represents the current illness or injury, or add a secondary diagnosis and resubmit the claim.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

0688 Ungroupable due to sex conflict with principal diagnosis

Cause
The principal diagnosis code submitted on the inpatient claim is in conflict with the client's gender stored on the DSS client eligibility file.

Resolution
Verify the client's principal diagnosis code and if found to be incorrect, change the principal diagnosis to the correct diagnosis and resubmit the claim. If the diagnosis code is correct, perform a client eligibility verification transaction to determine the client's gender. If the client's gender is incorrect, submit a request to correct the client's gender along with the denied claim's Internal Control Number (ICN) to ctxixhosppay@gainwelltechnologies.com. Gainwell Technologies will submit a request to DSS to update the client's eligibility file with a valid gender. If the principal diagnosis code and gender are correct, the claim is not payable.

EOB	Description

0689 Diagnosis code cannot be used as principal diagnosis (E Codes)

Cause
The principal diagnosis code submitted on the inpatient claim is an E-code that cannot be used as the principle diagnosis on the claim. E-codes describe the cause of an injury, not the nature of the injury itself.

Resolution
Change the principal diagnosis code to a code that represents the current illness or injury and resubmit the claim.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

0690 Principal diagnosis invalid as discharge

Cause
The Inpatient claim contains an invalid principal diagnosis code. The International Classification of Diseases, Clinical Modification identifies diagnosis codes that require a more specific diagnosis code be submitted on the claim.

An ICD-10 example of this is E11 (Diabetes Mellitus).

Resolution
Change the principal diagnosis code on the claim to a more specific ICD-10 diagnosis code and resubmit the claim.

EOB	Description

0692 Edit invalid birth weight or age/birth weight conflict

Cause
The diagnosis and client birth weight submitted on the inpatient claim are in conflict with the client's age in days.

Resolution
Correct either the diagnosis code or client birth weight and resubmit the corrected claim.

Tip: The client birth weight must be between 150 and 9000 grams if the client's age in days is less than or equal to 14 days.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

0693 Invalid principal diagnosis

Cause
The principal diagnosis code submitted on the inpatient claim is either missing or invalid. The International Classification of Diseases, 10th Revision (ICD-10) requires additional characters.

An example of an ICD-10-CM code that is unacceptable to report on an inpatient claim is E11 (Diabetes Mellitus).

Resolution
Change the principle diagnosis code to a more specific diagnosis code and resubmit the corrected claim.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

EOB	Description

0702 Hospice room and board not covered without nursing home authorization

Cause
The hospice claim was submitted with Revenue Center Code (RCC) 658 (Hospice Room and Board-Nursing Facility) for a client who has not received authorization by the Department of Social Services to be in the nursing home.

Resolution
Once the nursing home authorization has been added to the client's eligibility file, the claim can be resubmitted.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0704 Revenue center code not allowed for hospice client

Cause
A long term care claim with revenue center code 100 was submitted for a client with an active hospice lock-in on the date(s) of service in question.

Resolution
Room and board claims for hospice clients must be submitted by the hospice agency with which the client is currently locked-in; they cannot be submitted by the nursing facility. This claim will not pay unless submitted by the hospice provider.

EOB Description

0706 Service not covered for Hospice client

Cause
The claim was submitted for a client who has been enrolled in the Hospice program. Services billed by any provider other than the Hospice provider may only be reimbursed if the service is unrelated to the hospice condition.

Resolution
If the service is not related to the hospice condition, a GW modifier must be submitted on the claim in order to receive reimbursement. If the client is also a Connecticut Home Care Program client, the care plan must also include the GW modifier in order to receive reimbursement.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description
0710 Revenue not covered for client enrolled in Medicare hospice **Cause** The hospice claim was submitted for a client who has been authorized for Medicare hospice services and the claim contains a Revenue Center Code (RCC) other than 658. **Resolution** Only RCC 658 is valid when billing a hospice claim for a client with a Medicare hospice lock-in. Correct the RCC and resubmit the claim, otherwise, the claim is not payable.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0711 Claim denied. Client does not have hospice lock-in

Cause

The hospice claim is submitted for a client who has not yet been authorized by the Department of Social Services to receive hospice services from the billing provider.

Tip: DSS should execute the client's election into the hospice program within 10 business days from date of receipt of the election form. If the lock-in is not in place within 10 days of the submission of the election form to DSS, the hospice provider should contact DSS. DSS will not back date election forms not received within 10 days of election.

Resolution

Perform a client eligibility verification transaction to determine if the client has been locked-in to the billing hospice agency.

If the lock-in is in place, resubmit the claim to Gainwell Technologies.

If lock-in is not authorized for the date of service:

- If services billed are Revenue Center Code (RCC) 658 (Hospice Room and Board-Nursing Facility), the Nursing Home must bill these charges as a routine room and board claim.
- If services billed are either RCC 651 (Hospice/RTN Home) or 652 (Hospice/CTNS Home), the Hospice must bill comparable Home Health services under their Home Health Agency Provider Number.
- If services billed are RCC 656 (Hospice/IP Non-Respite), either the Hospital or Nursing Home must bill charges as a routine Hospital or Nursing Home stay.
- If services billed are RCC 657 (Hospice/Physician), the professional provider must bill charges as a routine medical claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0722 Occurrence code 55 required

Cause
Claims that contain either the Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment.

Resolution
Resubmit the claim with occurrence code 55.

EOB Description

0723 Occurrence code 55 missing date

Cause
Claims that contain either the Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. If the client does not have a date of death on the EMS file or the date of death on the claim is missing the detail will deny.

Resolution
Resubmit the claim with the date of death.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0724 Occurrence code 55 invalid date

Cause
Claims that contain either the Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. If the client does not have a date of death on the EMS file or the date of death on the claim is invalid, the detail will deny.

Resolution
Resubmit the claim with a valid date of death.

EOB Description

0725 Date of death not within 7 days

Cause
Claims that contain either the Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. If the client has a date of death on the EMS file, we will confirm that the SIA details occurred within seven days of the date of death. If the client does not have a date of death on the EMS file and the date of death on the claim is more than seven days from the date of service of the SIA, the detail will deny.

Resolution
If the SIA services did occur within the last seven days of life, resubmit the claim with correct dates of service.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

0744 Other Provider Qualifier missing or invalid

Cause
The qualifier associated with the provider was either; invalid, missing or not DK (Ordering), DQ (Supervising), or DN (Referring) in box 17 on the CMS 1500 form (02/12). This edit will only set on paper claims and is not applicable to electronic claims.

Resolution
Please note that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. If the claim meets one of those exception criteria, enter a valid qualifier and resubmit the claim. Otherwise, this claim must be resubmitted via the Web portal.

EOB	Description

0760 Condition code restriction for billed procedure

Cause
An inpatient, outpatient or professional claim for an abortion procedure code for a date of service 10/1/2015 forward is submitted without an appropriate abortion condition code.

Resolution
Include one of the below condition codes on the claim along with the abortion procedure code and resubmit the claim:
AA - Abortion Performed due to Rape
AB - Abortion Performed due to Incest
AC – Abortion Performed due to Genetic Defect, Deformity, or Abnormality
AD - Abortion Performed due to Life Endangering Physical Condition
AE – Abortion Performed due to Physical Health of Mother that is not Life Endangering
AF – Abortion Performed due to Emotional/Psychological Health of the Mother
AG – Abortion Performed due to Social or Economic Reasons
AH – Elective Abortion

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EOB Description

0770 MUE Units Exceeded

Cause

The Medically Unlikely Edit (MUE) edit occurs when a provider bills more than the maximum units of service for a HCPCS/CPT code than would be reported under most circumstances for a single client on a single date of service.

Resolution

Please verify the units billed on the outpatient claim.http:/// Correct the claim and re-submit.

Providers can refer to the CMS MUE tables by referring to the link below to obtain published quarterly additions, deletions, and revisions: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

0813 Claim denied after medical policy review

Cause
Gainwell Technologies does not have on file the required valid hysterectomy consent form (W-613) which is required when the claim contains a hysterectomy related service. The appropriate ICD-10 surgical procedure code must be used.

Resolution
Submit a valid hysterectomy consent form to the following address:

Gainwell Technologies
Attn: Medical Policy Unit
P.O. Box 2942
Hartford, CT 06104

Cause
The hysterectomy consent form was received by Gainwell Technologies but contains missing or invalid information. The consent form was returned to the sender outlining the errors contained on the form.

Resolution
Resubmit a valid hysterectomy consent form (W-613) which contains the following:

- Patient name
- Patient Medicaid ID
- Patient or Physician signature
- Date the patient or Physician signed the consent form

The denied claim may then be resubmitted.

If the consent form was not originally completed according to Federal guidelines, the claim cannot be paid.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0814 Claim denied for medical policy review

Cause
Gainwell Technologies does not have on file the required valid sterilization consent form (W-612) which is required when the claim contains a sterilization relate service. The appropriate ICD-10 surgical procedure code must be used.

Resolution
Submit a valid sterilization consent form to the following address:

Gainwell Technologies
Attn: Medical Policy Unit
P.O. Box 2942
Hartford, CT 06104

Cause
The sterilization consent form was received by Gainwell Technologies but contains missing or invalid information. The consent form was returned to the sender outlining the errors contained on the form.

Resolution
If a second valid consent form exists, submit this sterilization consent form (W-612) which must meet the following federal guidelines:

- The date of service on the claim must match the date of sterilization (field 20) on the consent form.
- The date the client was sterilized must be greater than 30 days and less than 180 days from the date of the client's signature.
- The date of the signature of the person obtaining consent must be the same as the date of the client's signature.
- The interpreter must enter the date the form was signed and it must be the same as the date of the client's signature.
- The client must be at least 21 years of age on the date the consent form was signed.

The denied claim may then be resubmitted.

If the consent form was not originally completed according to Federal guidelines, the claim cannot be paid.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

0818 Invalid processor control number

Cause
The claim was submitted for a CADAP client and the Processor Control Number (PCN) submitted on the claim does not equal CTPCNPTD. (Only for claims with dates of service prior to November 1, 2018)

Resolution
Change the PCN to CTPCNPTD and resubmit the claim.

Cause
The claim was submitted for a HUSKY A, HUSKY B, HUSKY C, or HUSKY D client and the PCN submitted on the claim equals CTPCNPTD.

Resolution
Change the PCN to the Medicaid specific PCN provided by your vendor/VAN and resubmit the claim.

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EOB Description

0840 HCPC required when drug revenue code is billed

Cause

The Outpatient claim was submitted with one of the following drug related Revenue Center Codes (RCC) without the corresponding Healthcare Common Procedure Code (HCPC).

RCC: 250 – 253, 258 – 259 or 634 - 637

Resolution

Enter the HCPC that corresponds to the RCC and National Drug Code (NDC) submitted on the claim.

Tip: To determine the correct HCPC code associated to the RCC and National Drug Code, go to www.ctdssmap.com → Provider → Drug Search, enter the NDC code then hit search. For information related to unlisted HCPC codes, refer to Provider Bulletins PB 08-35 and PB 08-42. Provider bulletins are located under Information, then Publications.

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EOB Description

0861 NDC is missing or invalid

Cause
The claim contains a drug related procedure code, but the National Drug Code (NDC) is either missing or invalid.

Resolution
Enter the correct NDC associated to the drug related procedure code and resubmit the claim.

Cause
NDC submitted on the claim meets one of the following criteria.

- The NDC is terminated on or after the claim date of service.
- The NDC is not rebateable on the claim's date of service.
- The NDC is on the Drug Efficacy Study Implementation (DESI) list on the claim's date of service.
- The NDC is an institutional product.
- The NDC is repackaged or an inner package.
- The NDC is not active on the Drug file.

Resolution
If the NDC was entered correctly, the drug product is not payable.

If the NDC was entered incorrectly, correct the NDC and resubmit the claim.

Tip: To determine the correct NDC associated to the drug related procedure code, go to www.ctdssmap.com → Provider → Drug Search, enter the procedure code then hit search.

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EOB	Description

0863 Detail date of service is not within header date of service

Cause

The detail From Date of Service (FDOS) or To Date of Service (TDOS) submitted on the claim is outside of the header dates of service.

For example, if the header dates of service cover the period of January 10, 2011 through January 20, 2011 and the detail FDOS is prior to January 10 or the detail TDOS is after January 20, the claim will deny with this EOB.

Resolution

Correct either the FDOS/TDOS on the detail of the claim, or the dates of service specified on the header, and resubmit the claim.

EOB	Description

0878 Allowed Amount is Zero Manual Priced Outpatient APC, Provider Fee Schedule, if Not Outpt Contact PAC.

Cause

Outpatient APC claim with details with Status Indicator (SI) equal to “Q1, Q2, Q3 or Q4” on a manually priced claim with a detail with SI “C”, payment rate “MP” and payment type “Surg”.

Resolution

Details with SI “Q1 - Q4” will be included in the manually priced amount and will not allow any additional reimbursement. Please verify detail with SI “C” for allowance.

Cause

The claim type is not an outpatient APC claim type and the service is on the provider’s fee schedule.

Resolution

Contact the Provider Assistance Center (PAC) at 1-800-842-8440.

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EOB	Description

0920 3M Grouper Error

Cause
The diagnosis code and client birth weight submitted on the inpatient claim for the newborn are in conflict.

Resolution
Correct either the diagnosis code or client birth weight and resubmit the corrected newborn's claim.

Example: If the birth weight submitted on the claim is 2400 grams, and the diagnosis description states "Preterm NEC 2500+ grams", the hospital would need to correct either the birth weight or diagnosis code.

Note: This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

EOB	Description

0926 APC Grouper Error

Cause
The grouper returns a non-zero return code value when the grouper considers the Type of Bill invalid.

Resolution
Correct the Type of Bill and resubmit the outpatient claim.

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EOB Description

1024 Provider is not authorized to bill for this client

Cause
For Nursing Home claims, the pay start has not been established for this client. DSS has not yet updated the Eligibility Management System (EMS) with authorization for this client to reside in the billing provider's facility.

Resolution
The claim is not payable until EMS is updated with the client's pay start/authorization to be in the billing provider's Nursing Home. Resubmit the claim when the pay start has been established.

Cause
For Assisted Living, Acquired Brain Injury, Connecticut Home Care, Personal Care Assistance and Hospice claims, DSS has not yet updated EMS with authorization for the client to be serviced by the billing provider.

Resolution
The claim is not payable until EMS is updated with the client's authorization for the client to be serviced by the billing provider.

To determine if EMS has been updated, perform a client eligibility verification transaction. Once EMS has been updated, resubmit the claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1033 Attending physician not enrolled on date of service

Cause

The attending provider ID submitted on the Institutional claim is either not on file with the Connecticut Medical Assistance Program (CMAP) or the provider's enrollment is not in effect on the claim's date of service. When the referring provider ID is not present on the claim, and the service is considered to be a referred service, the attending provider needs to be enrolled in the CMAP per the Affordable Care Act mandate.

Resolution

Request that the attending provider enroll in the CMAP in order to avoid future claim denials.

A provider enrollment Wizard is available via the www.ctdssmap.com Web site by clicking on Provider, then Provider Enrollment. Once on the Participation Type panel, select Ordering/ Prescribing/ Referring Provider Only, this presents an abbreviated version of the enrollment application.

A list of enrolled providers eligible to order/prescribe/refer services on behalf of HUSKY clients is available on the secure Web portal at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links. This list includes the provider's enrollment effective date and their re-enrollment due date. It also includes providers who are not yet enrolled, but who have submitted an enrollment application.

Once the attending provider is enrolled in CMAP, and their enrollment is in effect for the claim's date of service, the claim can be resubmitted.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1035 Referring provider not enrolled on date of service

Cause

The referring provider ID submitted on the Institutional, Professional, Dental or Crossover claim is either not on file with the Connecticut Medical Assistance Program (CMAP) or the provider's enrollment is not in effect on the claim's date of service. The referring provider needs to be enrolled in the CMAP per the Affordable Care Act mandate.

Resolution

Request that the referring physician enroll in the CMAP in order to avoid future claim denials.

A provider enrollment Wizard is available via the www.ctdssmap.com Web site by clicking on Provider, then Provider Enrollment. Once on the Participation Type panel, select Ordering/ Prescribing/ Referring Provider Only, this presents an abbreviated version of the enrollment application.

A list of enrolled providers eligible to order/prescribe/refer services on behalf of HUSKY clients is available on the secure Web portal at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links. This list includes the provider's enrollment effective date and their re-enrollment due date. It also includes providers who are not yet enrolled, but who have submitted an enrollment application.

Once the referring provider is enrolled in CMAP, and their enrollment is in effect for the claim's date of service, the claim can be resubmitted.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1036 Ordering provider not enrolled on date of service

Cause

The ordering provider ID submitted on the Professional or Professional Crossover claim is either not on file with the Connecticut Medical Assistance Program (CMAP) or the provider's enrollment is not in effect on the claim's date of service. The ordering provider needs to be enrolled in the CMAP per the Affordable Care Act mandate.

Resolution

Request that the ordering provider enroll in the CMAP in order to avoid future claim denials.

A provider enrollment Wizard is available via the www.ctdssmap.com Web site by clicking on Provider, then Provider Enrollment. Once on the Participation Type panel, select Ordering/ Prescribing/ Referring Provider Only, this presents an abbreviated version of the enrollment application.

A list of enrolled providers eligible to order/prescribe/refer services on behalf of HUSKY clients is available on the secure Web portal at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links. This list includes the provider's enrollment effective date and their re-enrollment due date. It also includes providers who are not yet enrolled, but who have submitted an enrollment application.

Once the ordering provider is enrolled in CMAP, and their enrollment is in effect for the claim's date of service, the claim can be resubmitted.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1038 Ordering/Referring provider missing when required

Cause
An ordering or referring provider ID was not submitted on the claim. Professional and Professional Crossover claims submitted by Rehabilitation Clinics, Free-standing Renal Dialysis Clinics, DME/Hearing Aid Dealers, DME/Medical & Surgical Supplies, DME/Medical Supply Dealers, DME/Durable Medical Goods, DME/Orthotic and Prosthetic Devices and Therapist Group providers must submit either an ordering or referring provider on all claims.

Resolution
Enter an ordering or referring provider ID and resubmit the claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1040 Ordering/Referring/Attending provider is not enrolled on date of service

Cause

This edit will set on an Institutional, Professional, Dental or Crossover claim when the ordering, attending, or referring provider is an unlicensed Student/Resident with an NPPES primary taxonomy of 390200000X (Student/Resident) who is not enrolled in CMAP or the provider's enrollment is not in effect on the claim's date of service. The ordering/referring/prescribing provider needs to be enrolled in the CMAP per the Affordable Care Act mandate.

Resolution

This edit was implemented in a post and pay status and will only post to claims with dates of service prior to 10/1/2014. The post and pay status means that the edit will post to a claim but it is not the cause of a denial. Providers should address the remaining errors that caused the claim to deny and resubmit the claim.

Note: Effective 10/1/14 and forward, claims that contain a non-enrolled resident as the attending, ordering or referring provider will deny with one of the following EOB's; 1033 Attending provider not enrolled on date of service, 1035 Referring provider not enrolled on date of service, 1036 Ordering provider not enrolled on date of service, 1042 Resident not allowed as attending provider.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1900 Billing provider's taxonomy is invalid

Cause
The billing provider's taxonomy submitted on the claim is not a valid taxonomy.

Resolution
Change the taxonomy to the correct taxonomy as submitted on the provider's enrollment application, correct all other errors and resubmit the claim.

EOB Description

1906 Header billing provider's taxonomy is not valid

Cause
The billing provider's taxonomy submitted on the claim does not exist as a valid taxonomy on the provider's file as submitted via provider enrollment. The provider's correct taxonomy should be on both the provider's file and the submitted claim.

Resolution
If the taxonomy submitted on the claim is incorrect, correct the taxonomy and all other errors and resubmit the claim.

If the taxonomy submitted on the claim is correct, submit a NPI Submission Form to the Gainwell Technologies Provider Enrollment Unit to add the correct taxonomy to the provider's file. This form is located on www.ctdssmap.com -> Information -> Publications and scroll down to Provider Enrollment/Maintenance Forms. This request must be sent to the following address:

Gainwell Technologies
Attn: Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06102-5007

Once the taxonomy has been updated on the provider's file, correct all other errors and resubmit the claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1912 Billing provider's taxonomy is missing

Cause

The billing provider's taxonomy was not submitted on the claim. This edit will post on HIPAA 5010 claims at the header if the header billing provider identifier is submitted, and the taxonomy code for the billing provider is blank.

Resolution

On HIPAA 4010 claims, providers could submit either the Rendering Taxonomy or the Billing Taxonomy at the header of the claim. If the provider wanted to send both Billing and Rendering taxonomies, the rendering taxonomy was dropped down to the detail level rather than the header of the claim.

If no billing taxonomy was submitted in the HIPAA 4010 claims, the rendering taxonomy was used to determine the billing provider in situations where the billing provider had multiple provider numbers under the same billing NPI.

With HIPAA 5010 claims, providers must now submit both the billing and the rendering taxonomies at the header. If your vendor has older edits in place which prevent the billing taxonomy from coming over on your electronic files (a possible carryover from HIPAA 4010A submissions), please contact your vendor to make the required changes for 5010 submissions to ensure that both the billing taxonomy and rendering taxonomy are populating at the header of the claim.

Add the billing provider's taxonomy to the claim as submitted on the provider's enrollment application, correct all other errors, and resubmit the claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1927 The billing provider's NPI is missing or invalid

Cause
The provider is required to submit a National Provider Identifier (NPI) on the claim and the provider's NPI was not properly submitted on the claim.

Resolution
Enter the ten digit NPI on the claim. When submitting an electronic claim, it is important to include the Identification Code Qualifier of **XX** to identify the provider ID as being an NPI.

Tip: A common mistake is to enter the Identification Code Qualifier of **1D**, previously used to identify a Medicaid provider ID. This is no longer acceptable when the provider is required to submit an NPI.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

1945 Claim/detail denied. Billing/performing provider could not be determined

Note: In order for a claim to successfully process in interChange, the National Provider Identifier (NPI) and associated claim data submitted on the claim must be associated with one single provider record/Automated Voice Response System (AVRS) ID. When a provider has one NPI associated to multiple provider records/AVRS ID's, additional claim data such as the billing provider's taxonomy code or 9 digit zip code must be used to determine the correct provider record/AVRS ID to associate to the claim. This error condition will be present when the claim cannot identify a unique provider record/AVRS ID with which to process the claim.

Cause
The 9 digit zip code submitted on the claim does not uniquely match the provider address provided at the time of enrollment.

Resolution
Correct the 9 digit zip code on the claim and resubmit the claim.

Cause
The billing provider's taxonomy code submitted on the claim does not uniquely match any of the taxonomy codes provided at the time of enrollment.

Resolution
Correct the billing taxonomy code on the claim and resubmit the claim.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

2002 Client ineligible for dates of service

Cause
The client is not eligible for pharmacy benefits on the dispense date.

Resolution
The claim is not payable.

Cause

The client is not eligible on the Inpatient or Outpatient crossover claim's date of service.

Resolution
The claim is not payable.

EOB	Description

2003 Client ineligible for dates of service

Cause
The client is not eligible on the detail date of service.

Resolution
The claim detail is not payable.

For Medicaid with Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) or Personal Care Assistant (PCA) Waiver eligibility issues, providers should send a secure e-mail to Waiver.DSS@ct.gov with the client's first and last name, Medicaid ID and dates of service rejected.

For State Funded CT Home Care only eligibility issues, providers should send a secure e-mail to ACUFinancial.DSS@ct.gov with the client's first and last name, Medicaid ID and dates of service rejected.

Cause

The client is not eligible on the Inpatient or Long Term Care header date of service.

Resolution
The claim is not payable.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

2010 Client has not satisfied spend-down

Cause
The client is deemed ineligible due to spend-down. Spend-down is a DSS determined dollar amount that the client is financially responsible to pay for medical expenses before DSS will grant the client eligibility.

Resolution
The claim is not payable.

Tip: Questions related to the amount of spend-down that still remains the client's responsibility to pay can only be obtained from DSS' Regional Office. Gainwell Technologies does not have access to this data.

EOB	Description

2057 Client ineligible for portion of claim. Resubmit for covered days only

Cause
The client is partially eligible on the Inpatient, Inpatient crossover or Long Term Care claim's header date of service.

Resolution
Perform a client eligibility verification transaction to determine the client's eligibility during the stay.

Resubmit the claim for only those dates of service in which the client was eligible.

Note: This EOB will not post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals. Providers are required to bill the entire stay on hospital modernization claims, regardless of the client's period of eligibility.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB Description

2102 Client eligibility system is not currently available

Cause
The Department of Social Service's Eligibility Management System (EMS) stores client eligibility information that is used to process claims.

If the claim is a pharmacy claim or a claim submitted via the provider's secure Web account, the claim will be denied when EMS is unavailable to verify the client's eligibility.

Resolution

Resubmit the claim when EMS access is restored. EMS will likely be restored immediately, or in rare circumstances, later in the day if the issue takes longer to resolve.

Cause
If the claim is not a pharmacy claim or a claim submitted via the provider's secure Web account, the claim will be placed in a suspended status by Gainwell Technologies.

Resolution
No action is necessary to resolve this error when the claim is in a suspended status. When EMS becomes available, Gainwell Technologies will remove this error from the claim and allow the claim to continue to process.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

2504 Bill private carrier first

Cause

The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage, the benefits of these policies must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to the claim when a private insurance policy is present on the client's file which contains a type of coverage that may cover the claim and the claim was submitted without the response from this specific insurance carrier.

Resolution

1. Perform a client eligibility verification transaction for the date of service on the claim to determine the other insurance carrier to which the claim should be billed.
2. Bill the claim to the other insurance carrier.
3. Once a response has been received from the carrier, resubmit the claim to Gainwell Technologies, indicating either the payment or denial from the insurance carrier, using the same three digit carrier code returned in the client eligibility verification response. These claims can be submitted electronically and the other insurance Explanation of Benefits should not be submitted to Gainwell Technologies. For complete instructions for submitting claims with other insurance, refer to Chapter 11 of the Provider Manual found on www.ctdssmap.com.
4. If the insurance carrier refuses to respond to your claim, follow the Legal Notice of Subrogation procedures located in Chapter 5 of the Provider Manual found on www.ctdssmap.com.

Tip: It is important that the correct three digit carrier code be submitted on the claim. The carrier code is returned in the client eligibility response and represents the specific other insurance carrier. If a different carrier code is entered on the claim than what exists on the client's file, the claim will continue to deny.

Tip: Discrepancies regarding other insurance (such as private or employee sponsored health insurance) should be reported to Health Management Systems, Inc. (HMS) via toll-free telephone number 1-866-277-4271 or via e-mail at ctinsurance@hms.com. Client third party liability update procedures can be found in Chapter 5 of the Provider Manual found on www.ctdssmap.com.

Tip: Claims can very easily be resubmitted via the provider's secure Web account by retrieving the denied claim via a claim inquiry and adding the other insurance information in the TPL panel, then click the resubmit button. The TPL panel also conveniently lists the client's insurance policies via the drop down list within the Client Carriers field.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

EOB	Description

2509 Bill Medicare first

Cause

The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to a pharmacy or compound claim when Medicare coverage is present on the client's file **for an NDC covered by Medicare Part B** and the claim was submitted without the response from Medicare.

Resolution

1. Bill the claim to Medicare Part D and/or Part B.

   Once a response has been received from Medicare, resubmit the claim to Gainwell Technologies. These claims should be submitted electronically. When submitting an electronic claim for a Medicare Part B or Medicare Part D paid claim, the professional claim format must be used. When billing through the Web portal, please refer to Provider Bulletin PB09-36 "Clarification of Billing Requirements for Medications Covered by Medicare Part D and Medicare Part B" for complete billing instructions.

   For complete instructions for submitting claims when the client has Medicare, refer to Chapter 11 of the Provider Manual found on www.ctdssmap.com.

   Please note that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. If one of these exceptions, when submitting the claim on paper, the CMS 1500 claim form must be utilized and the Medicare Explanation of Benefit (EOMB) must be sent to Gainwell Technologies when Medicare has allowed the claim.

   When both Medicare Part D and Medicare Part B have denied the claim for a date of service less than a year from the present date, the claim must be submitted via Point of Sale (POS) with an Other Coverage Code (OCC) of 3- Other Coverage Exists – Service Not Covered and with the Carrier Code MPB. The Medicare EOMB must be retained in case of a future audit.

   For Medicare Part B denials for dates of service over a year from the current date, the NCPDP paper claim form may be submitted with a copy of the Medicare EOMB to override timely filing. For complete instructions for completing the NCPDP paper claim form, refer to Chapter 8 of the Provider Manual by choosing Pharmacy from the dropdown menu.

Tip: If Medicare Part B allowed the claim, Medicare should automatically submit the claim to Gainwell Technologies on behalf of the provider when the client is a Medicaid client. If this is not occurring on a regular basis, please contact the Provider Assistance Center for assistance in determining the cause.

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EOB	Description

2513 Other payer adjudication date is invalid

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance or Medicare coverage, the benefits of these policies must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to a claim when other payer information, such as a paid amount, is submitted on the claim but the claim contains an invalid other payer adjudication date, a future date, or no date.

Resolution
Resubmit the claim with a valid other payer adjudication date(s). Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment on denied a claim.

EOB	Description

2515 Claim other payer carrier code is not on file

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. The payment or denial from another insurance company or Medicare must be reported on the claim submitted to CMAP, using the appropriate CMAP specific three-digit carrier code. This EOB will set when the carrier code submitted on the claim is not one of those specific CMAP carrier codes.

Resolution
The claim must be submitted using the CMAP specific carrier code, including MPA or MPB for Medicare crossover claims when appropriate. To ensure a valid CMAP carrier code is submitted, providers should use the carrier code(s) returned on the client's eligibility verification response. For further information on carrier codes, providers may refer to Chapter 5 of the Provider Manual, available on the www.ctdssmap.com Web site. Providers are reminded that this chapter also contains information on what to do in the instance of discrepancies with a client's other insurance information, including contact information for HMS. Providers are strongly encouraged to submit a valid CMAP specific carrier code in the primary identifier field (qualifier = PI). However, providers may also submit a valid CMAP specific carrier code in the secondary identifier field (qualifier = 2U).

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EOB Description
2516 Claim adjustment reason code is invalid **Cause** The claim adjustment reason code submitted on the claim is not a valid code found on the HIPAA claim adjustment reason code list published by the Washington Publishing Company located at www.wpc-edi.com. **Resolution** Correct the claim adjustment reason code and resubmit the claim. Tip: The claim adjustment reason code is not required on Web claims.

EOB Description
2517 Claim other payer adjudication information is incomplete **Cause** The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to a claim when there is a valid carrier code present to represent the other payer(s), the total of the header and detail paid amounts are greater than $0, but there is not a valid paid date at the header or detail for the other payer(s). **Resolution** Resubmit the claim with valid carrier codes, paid amounts, and paid dates. Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment on denied a claim.

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EOB Description

2522 Bill Medicare first or provide appropriate adjustment reason code and date of ABN, HHABN* or NOMNC

Cause

Medicaid is payer of last resort. The client's eligibility file indicates that the client has Medicare coverage and the Home Health claim was submitted without reference to a Medicare payment, Medicare denial or the reason an Advanced Beneficiary Notice (ABN), Home Health Advanced Beneficiary Notice (HHABN)* or MCO Notice of Medicare Non-Coverage (NOMNC) was issued.

Resolution

The claim must either be billed to Medicare, or the ABN, HHABN* or NOMNC must be issued to the client indicating the reason the client's care does not meet Medicare coverage criteria.

The claim must then be resubmitted to Gainwell Technologies indicating either Medicare made a payment or denied the claim. If the denial is due to a ABN, HHABN* or NOMNC, the appropriate claim adjustment reason code must be entered to identify the reason the ABN, HHABN* or NOMNC was issued.

Detailed billing instructions for each of these examples are located in Chapter 11 of the Provider Manual, the Institutional Other Insurance/Medicare Billing Guide found on www.ctdssmap.com.

Tip: Refer to Provider Bulletin PB10-06 found on www.ctdssmap.com for more information regarding Medicare Cost Avoidance of Home Health claims.

*Please note that HHABNs can only be issued through December 8, 2013. Effective December 9, 2013, Home Health Agencies must use the ABN. HHABNs issued **prior** to December 9, 2013 for ongoing, repetitive services will remain in effect for the time period indicated on the notice, up to one calendar year from the date of issuance.

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EOB	Description

2531 Claim payment or adjudication date missing

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to the claim when a valid other payer carrier code is present, the claim contains header and/or detail claim adjustment (CAS) information, but there is not a payment amount AND payment date indicated at the header and/or detail of the claim.

Resolution
Resubmit the claim with valid carrier codes, paid amounts, paid dates, and claim adjustment information. Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment on denied a claim.

EOB	Description

2532 Header payment CAS segment missing

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to the claim when a valid other payer primary carrier code is present at the header of the claim, but there is no other payer payment indicated at the header or the detail and there is no header or detail claim adjustment (CAS) information for that payer.

Resolution
Resubmit the claim with valid carrier codes, paid amounts, paid dates, and claim adjustment information. Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment on denied a claim.

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EOB	Description

2533 Detail CAS segment or payment missing

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to the claim when a valid other payer carrier code is present at the detail of the claim or a valid other payer carrier code is present at the header as the secondary payer ID, but the claim detail paid amount is $0, all of the claim adjustment (CAS) details are invalid, and there is no header claim adjustment (CAS) information for that payer.

Resolution
Resubmit the claim with valid carrier codes, paid amounts, paid dates, and claim adjustment information. Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment on denied a claim.

EOB	Description

2534 Detail payment/CAS segment missing when required

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. This EOB will post to the claim when a valid other payer carrier code is present at the detail of the claim or a valid other payer carrier code is present at the header as the secondary payer ID, but the claim detail paid amount is $0, all of the claim adjustment (CAS) details are invalid, and there is no valid header claim adjustment (CAS) information for that payer.

Resolution
Resubmit the claim with valid carrier codes, paid amounts, paid dates, and claim adjustment information. Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment on denied a claim

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EOB	Description

2535 No valid other payer ID submitted at the detail

Cause
The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage or Medicare coverage, this benefit must be fully exhausted prior to submitting the claim to Gainwell Technologies. The payment or denial from another insurance company or Medicare must be reported on the claim submitted to CMAP, using the appropriate CMAP specific three-digit carrier code. This EOB will set when another insurance or Medicare payment is indicated on the claim, but the claim does not include a valid specific CMAP carrier code(s).

Resolution
The claim must be submitted using the CMAP specific carrier code, including MPA or MPB for Medicare crossover claims when appropriate. To ensure a valid CMAP carrier code is submitted, providers should use the carrier code(s) returned on the client's eligibility verification response. For further information on carrier codes, providers may refer to Chapter 5 of the Provider Manual, available on the www.ctdssmap.com Web site. Providers are reminded that this chapter also contains information on what to do in the instance of discrepancies with a client's other insurance information, including contact information for HMS. Providers must submit a valid CMAP specific carrier code in the primary identifier field (qualifier = PI).

EOB	Description

2536 Ineligible for Payment as No Medicare Payment Submitted on Detail

Cause
This EOB will set when Medicare paid amount on the claim is $0.00 and the Medicare detail deductible and copay are both zero.

Resolution
Please resubmit claim with valid Medicare paid, deductible, copay amount on the detail on the claim. Providers may refer to Chapter 11 for their claim type for important instructions related to claim submission to CMAP after Medicare.

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EOB Description
3003 Prior Authorization is required for payment of this service **Cause** If the claim is for a client enrolled in the Connecticut Home Care for Elder's program, the client does not have any remaining units authorized by the client's care manager for the service billed on the claim. **Resolution** The service is not payable unless the care manager increases the number of units for the date(s) of service being billed. **Cause** If the claim is for a client enrolled in any benefit plan other than the Connecticut Home Care for Elder's program, prior authorization is required for payment of the service billed. **Resolution** Refer to Chapter 9 of the Provider Manual for information on requesting prior authorization.

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EOB Description

3004 Inpatient claim requires prior authorization

Cause
The Inpatient claim requires prior authorization (PA) and there is no PA record on file in an approved status that has the same provider ID, client ID and approved dates of service that match the claim's billing provider, client ID and admit date. The admit date must fall within the dates of service approved by Community Health Network of Connecticut (CHNCT).

Resolution
Perform a PA inquiry on the provider's Web account to determine if the PA record has been added to interChange, and if so, if the client ID is correct and if the admission date falls within the approved dates of service.

If the PA has been either entered or corrected since the claim was denied, resubmit the claim.

If the PA is not present and CHNCT has indicated that they approved the PA more than two days ago, contact CHNCT to determine the cause of the delay. The PA may have contained an error that CHNCT needs to correct.

Tip: Once CHNCT approves a PA, it takes at least 24 hours before the PA will be present in interChange, as long as there were no errors on the PA, such as an invalid client ID.

Cause
The Inpatient claim does not require PA when the claim is for a newborn, but the claim's Admit Type does not indicate newborn.

Resolution
Change the Admit Type to 4 (Newborn) and resubmit the claim.

Cause
The Inpatient claim does not require PA when the claim is due to a delivery, but the claim's primary diagnosis code does not indicate a delivery.

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Resolution
If the primary diagnosis is related to a delivery, change the primary diagnosis to the delivery diagnosis and resubmit the claim. If the delivery is not the primary diagnosis, the claim will require PA.

Cause
The Inpatient claim does not require PA when the claim is considered an emergency by the out of state hospital.

Resolution
If the claim was considered an emergency, change the Admit Type to 1 (Emergency) and resubmit the claim. If the claim is not an emergency, PA must be requested by submitting the out of state paper claim to the following address:

Gainwell Technologies
Written Correspondence
P.O. Box 2991
Hartford, CT 06104

EOB Description

3013 Service requires a professional prior authorization

Cause
The outpatient claim was submitted with a procedure code that requires a professional Prior Authorization (PA) and there is no PA record on file in an approved status.

Resolution
Determine whether the service billed requires PA by reviewing the provider fee schedules located at www.ctdssmap.com. If PA is required, the hospital should verify that the physician will obtain PA. If the physician does not obtain PA, the service is not payable.

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EOB Description

3015 CHC care plan required

Cause
The claim is for a client enrolled in the Connecticut Home Care for Elder's benefit plan and a care plan has not yet been established for this client.

Resolution
The service is not payable unless the care manager creates a care plan and adds the service to the care plan. Contact the care manager for assistance.

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EOB Description

3016 Service not covered under CHC care plan

Cause
The claim is for a client enrolled in the Connecticut Home Care for Elder's benefit plan and the service billed is not an authorized service on the client's care plan.

Resolution
The service is not payable unless the care manager adds the service to the client's care plan. Contact the care manager for assistance.

Cause
The claim is for a client enrolled in the Connecticut Home Care for Elder's benefit plan and the service billed is not an authorized service on the client's care plan because the service provider's National Provider Identifier (NPI) or Automated Voice Response System (AVRS) ID was not entered correctly on the care plan. For example, many Home Health Agencies have both a CHC Service Provider AVRS ID and a Home Health Agency AVRS ID. This EOB will be displayed on the claim if the wrong AVRS ID is entered on the care plan.

Resolution
The care plan must be updated with the correct AVRS ID. Contact the care manager for assistance.

Cause
The claim is for a client enrolled in the Connecticut Home Care for Elder's benefit plan and the service billed is not an authorized service on the client's care plan because the claim was submitted with the wrong procedure code/RCC.

Resolution
The procedure code/RCC on the claim must be changed and the claim may be resubmitted. If the procedure code/RCC on the claim is correct, the care plan must be updated with the correct procedure code/RCC. Contact the care manager for assistance.

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EOB Description
3327 Confirmed Visit Not Found **Cause** The claim contains an EVV mandated service for which there is no matching confirmed visit in the Santrax system that contains the same client ID, provider ID, date of service, service code and modifier(s). **Resolution** Provider must verify that the visit that they are trying to bill is in a confirmed status in the Santrax system prior to rebilling. It may take up to 24 hours for a confirmed visit to be communicated to Gainwell Technologies, so the visit may not be able to be billed immediately following visit confirmation. Provider should also ensure that the claim details match the confirmed visit's details or this EOB may set again. **Cause** If a claim has a modifier that is not present on the confirmed visit or lacks a modifier that is present on the confirmed visit, the claim will deny payment. **Resolution** Provider should ensure that the claim being exported for adjudication matches the confirmed visit in Santrax. Provider should make sure the visit has the same client ID, provider ID, date of service, service code and modifier(s) as the claim.

EOB Description
3328 Confirmed Visit Units are Exhausted **Cause** A claim containing an EVV mandated service contains the same client ID, provider ID, date of service, service code and modifier(s) as the confirmed visit, however, the visit units have been exhausted due to a previously paid claim. There are no more units on the confirmed visit to pay the denied units. **Resolution** The units on the confirmed visit in Santrax must be increased prior to claim resubmittal.

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EOB Description
3329 Detail Date of Service Range that Exceeds 31 Days Cannot Be Verified **Cause** Spanned dates on a claim cannot exceed 31 days. **Resolution** The number of days on the claim detail must be reduced to 31 days or less and then the claim can be resubmitted for adjudication.

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EOB	Description

4021 The procedure billed is not a covered service under the client's benefit plan

Cause

If the claim is an Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) or Personal Care Assistant (PCA) Waiver Program claim and the client does not have an active ABI, Autism, CHC or PCA benefit plan in effect yet for the date of service submitted on the claim.

Resolution

For Medicaid with ABI, Autism, CHC or PCA clients, the Community Options Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the client's eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to Waiver.DSS@ct.gov. The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "ABI, Autism, CHC, or PCA Client Eligibility Issue" in the subject line of the email.

DSS' Community Options Unit also receives a report of claim denials due to client ineligibility. Providers who identify an eligibility issue at the point of claim denial and the issue has not been resolved within one month of the claim denial should send an encrypted email to Waiver.DSS@ct.gov and provide the client's name, client ID and the dates of service that remain unpaid due to the client's lack of CHC eligibility. Place the words "ABI, Autism, CHC or PCA" Client Eligibility Issue" in the subject line of the email.

For CHC Program only clients, the Community Options Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the client's eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to ACUFinancial.DSS@ct.gov. The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "CHC" Client Eligibility Issue" in the subject line of the email.

DSS' Community Options Unit also receives a report of claim denials due to client ineligibility. Providers who identify an eligibility issue at the point of claim denial and the issue has not been resolved within one month of the claim denial should send an encrypted email to ACUFinancial.DSS@ct.gov and provide the client's name, client ID and the dates of service that remain unpaid due to the client's lack of CHC eligibility. Place the words "CHC Client Eligibility Issue" in the subject line of the email.

Cause

If the claim is a dental claim, the client does not have an active HUSKY A, HUSKY B, HUSKY C, or HUSKY D benefit plan in effect for the date of service submitted on the claim.

Resolution

The claim is not payable.

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Cause
The claim was submitted for a non CADAP client and the Processor Control Number (PCN) submitted on the claim equals CTPCNPTD.

Resolution
Change the PCN to the vendor's specific PCN and resubmit the claim.

EOB	Description

4027 Diagnosis code not covered for date of service

Cause
A claim is submitted where a header diagnosis code is present, but the claim date of service is outside of the effective and end date for the diagnosis code per DSS policy.

Resolution

If the ICD-10 diagnosis code on the claim is not a valid diagnosis code and has been terminated by CMS, resubmit the claim with a valid diagnosis code.

EOB	Description

4039 Diagnosis cannot be used as principal diagnosis

Cause
A non-pharmacy claim is submitted with a principal diagnosis code that cannot be used as the principal diagnosis code according to coding guidelines.

- On a professional or dental claim, if a diagnosis pointer is filled in at the detail, the primary diagnosis is the one designated by the first occurrence of the pointer
- On a professional or dental claim, if there is no diagnosis pointer filled in at the detail, the primary is considered the first header diagnosis code

Resolution
Resubmit the claim with a principal diagnosis code that is acceptable as a principal diagnosis according to coding guidelines.

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EOB Description

4067 Non-covered ICD-9-CM procedure code (inpatient claims only)

Cause

An inpatient claim is submitted where an ICD surgical procedure code is present, but the claim header date of service is outside of the effective and end date for the surgical procedure code per DSS policy

Resolution

If the claim header Through Date Of Service (TDOS) is on or after 10/1/2015 and the claim was submitted with an ICD-9 surgical procedure code(s), resubmit the claim with the appropriate ICD-10 procedure code(s).

If the claim header TDOS is before 10/1/2015 and the claim was submitted with an ICD-10 surgical procedure code(s), resubmit the claim with the appropriate ICD-9 procedure code(s).

If the surgical procedure code on the claim is not a valid procedure code and has been terminated by CMS, resubmit the claim with a valid procedure code.

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation.

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EOB Description

4140 The service submitted is not covered under the client's benefit plan.

Cause

The claim was submitted with a billing provider who is restricted from submitting the procedure based on the client's benefit plan.

Resolution

Either the billing provider on the claim needs to be changed, or the client's benefit plan must be changed, otherwise the claim is not payable.

If the benefit plan is incorrect and the client has Medicaid with ABI, Autism, CHC or PCA clients, the Community Options Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the client's eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to Waiver.DSS@ct.gov. The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "ABI, Autism, CHC, or PCA Client Eligibility Issue" in the subject line of the email.

DSS' Community Options Unit also receives a report of claim denials due to client ineligibility. Providers who identify an eligibility issue at the point of claim denial and the issue has not been resolved within one month of the claim denial should send an encrypted email to Waiver.DSS@ct.gov and provide the client's name, client ID and the dates of service that remain unpaid due to the client's lack of CHC eligibility. Place the words "ABI, Autism, CHC or PCA" Client Eligibility Issue" in the subject line of the email.

For CHC Program only clients, the Community Options Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the client's eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to ACUFinancial.DSS@ct.gov. The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "CHC" Client Eligibility Issue" in the subject line of the email.

DSS' Community Options Unit also receives a report of claim denials due to client ineligibility. Providers who identify an eligibility issue at the point of claim denial and the issue has not been resolved within one month of the claim denial should send an encrypted email to ACUFinancial.DSS@ct.gov and provide the client's name, client ID and the dates of service that remain unpaid due to the client's lack of CHC eligibility. Place the words "CHC" Client Eligibility Issue" in the subject line of the email.

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EOB	Description

4260 Patient reason for visit not on file

Cause
The patient reason for visit diagnosis code submitted on the institutional claim is not valid.

Resolution
Correct the patient reason for visit diagnosis code and resubmit the claim

EOB	Description

4227 The RCC Billed is not a covered service under the client's benefit plan

Cause
The claim was submitted with an RCC for a client with multiple benefit plans, such as HUSKY C, Connecticut Home Care (CHC) Program and QMB (Qualified Medicare Beneficiary). The claims processing system will attempt to make payment for the RCC under each benefit plan. If the claim was submitted with the intent to be paid under the client's HUSKY C or the CHC benefit plan, but denied for other edit messages under that benefit plan, the system will then attempt to make payment under the QMB benefit plan. Edit 4227 will post under the QMB benefit plan when Medicare has denied the claim. A denied claim will contain all edit/audits associated to all benefit plans.

Resolution
In this example, no action is required to resolve edit 4227. Action should be taken on any other edit that might set on the claim. Once the error code which caused the original claim denial against the HUSKY C or CHC benefit plan is resolved and the claim is resubmitted, the claim should pay and the system will not attempt to process the claim under any other benefit plan the client may have, and edit 4227 will no longer be posted to the claim.

This is only one example of a valid combination of benefit plans (HUSKY C, CHC and QMB) that can cause this edit to be posted to a claim. It is strongly recommended that edits other than 4227 be resolved first, no matter what combination of benefit plans exist.

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Cause

The claim was submitted with an RCC payable under HUSKY or the Connecticut Home Care (CHC) Program benefit plan for a client with only one benefit plan on file, such as QMB (Qualified Medicare Beneficiary). RCC's are not payable under the QMB benefit plan.

Resolution

Verify the client's eligibility and refer to the Eligibility Response Quick Reference Guide located at www.ctdssmap.com under–Information-Publications-Claims Processing Information, for covered services under the clients benefit plan.

If the client has a benefit plan other than CHC and there is an issue with eligibility, either contact the client's case worker or have the client contact their case worker themselves for more information regarding eligibility.

If the client should have a CHC benefit plan but the eligibility is not on file, providers should contact the Alternate Care Unit at the Department of Social Services at: Waiver.DSS@ct.gov to update the client's eligibility. Providers should send an encrypted e-mail containing the clients name, client ID and the start of care or dates of service that remain unpaid to the e-mailbox indicated. The subject line of the e-mail should indicate "CHC Eligibility Issue".

If the client's benefit plan does not cover services billed with an RCC at all, then the claim is not payable.

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EOB	Description

4742 The Procedure is not Consistent with the Header Diagnosis Based on the Client's Benefit Plan

Cause
Procedure code billed is not covered under the client's benefit plan based on the diagnosis being billed.

Resolution
Verify the diagnosis code submitted on the claim. If it is incorrect, correct the claim and resubmit. If the diagnosis code on the claim is correct, based on the diagnosis it is not a payable service under the client's benefit plan (i.e. Family Planning benefit plan).

EOB	Description

4801 Procedure not covered. Check: Prior Authorization, FTC, Referring Provider, Quantity Restrictions

Note: EOB 4801 will set if any one of the following conditions exists when the client's eligibility file indicates the client has multiple benefit plans. If after reviewing this list of conditions, no claim data is deemed incorrect or Prior Authorization is not required, contact the Provider Assistance Center to determine if the cause is related to client age, the Facility Type code, procedure code or Provider contract.

Cause
The referring provider is missing on the professional claim. The referring provider is required when:

- The billing provider is a provider type 28 (laboratory) or 29 (radiology).
- The service billed is a consultation.
- The service billed is an eye examination performed at a nursing facility or skilled nursing facility.

Resolution
Enter the referring provider on the claim and resubmit the claim.

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Cause
Admission date is missing on the professional claim. The admission date is required when:

- The following services are performed at facility type codes 21 (inpatient hospital), 55 (residential substance abuse treatment facility) or 56 (psychiatric residential treatment center): 90200, 90215, 90220, 99221, 99223, 99231-99233, 99251-99255, 99271-99275, or 99291-99299.
- The service billed is H0011 or 1600W.

Resolution
Enter the admit date on the claim and resubmit the claim.

Cause
The procedure billed is not permitted to be paid to the billing provider on the date of service.

Resolution
If the procedure billed is not a covered procedure on the provider's fee schedule for the date of service, the service is not payable.

If the procedure billed is present on the provider's fee schedule, contact the Provider Assistance Center to request an update to the procedure code in question.

Cause
Prior Authorization is required and either there is no Prior Authorization on file, or it is on file but it is either exhausted or it does not contain the same client ID, procedure code, modifier, or authorized dates of service as submitted on the claim.

Resolution
Determine whether the service billed requires Prior Authorization by reviewing Chapter 7 of the Provider Manual or the Fee Schedule located at www.ctdssmap.com. If Prior Authorization is required, review Chapter 9 of the Provider Manual for Prior Authorization instructions.

Cause
The Facility Type Code (FTC) submitted on the professional claim is not allowed for the billing provider.

Resolution
If the FTC is incorrect, enter the correct FTC on the claim and resubmit the claim.

If the FTC is correct, the service is not payable at that location.

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Cause
The service is not payable based on the client's age.

Resolution
If the client ID is incorrect, enter the correct client ID on the claim and resubmit the claim.

If the client ID is correct, the service is not payable.

Cause
The provider's enrollment does not allow payment for the service rendered.

Resolution
If the service billed is not a covered procedure on the provider's fee schedule for the date of service billed, the service is not payable.

If the procedure billed is a covered procedure on the provider's fee schedule, contact the Provider Assistance Center to request an update to the provider's contract.

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EOB	Description

4951 Condition code restriction for billed ICD

Cause
An inpatient, outpatient or professional claim for an abortion procedure code for date of service 10/1/2015 forward is submitted without an appropriate abortion condition code and there is a condition code restriction under the provider's contract for the procedure code.

Resolution
Include one of the below condition codes along with the abortion procedure code and resubmit the claim:
AA - Abortion Performed due to Rape
AB - Abortion Performed due to Incest
AC – Abortion Performed due to Genetic Defect, Deformity, or Abnormality
AD - Abortion Performed due to Life Endangering Physical Condition
AE – Abortion Performed due to Physical Health of Mother that is not Life Endangering
AF – Abortion Performed due to Emotional/Psychological Health of the Mother
AG – Abortion Performed due to Social or Economic Reasons
AH – Elective Abortion

EOB	Description

4970 RCC Restricted under the client's benefit plan

Cause
This edit will set if the provider is a Home Health Agency and the client has both HUSKY and CHC with or without a Care Plan on file. The claim will first process under the HUSKY benefit. As the client also has CHC, the RCC, such as 421, 431 or 441 for therapy services, though payable under the HUSKY benefit, is restricted from paying as the client has a CHC benefit plan.

Resolution
No action need be taken on edit 4970. Action should be taken on any other edit that that might set on the claim. If edit 4021 sets and another edit/audit, other than 4970, also sets on the claim, disregard 4021 for the time being and take action to resolve the other edit/audit that set on the claim. Once the error code which caused the original claim denial against the CHC benefit plan is resolved and the claim is resubmitted, the claim should pay and the system will not attempt to process the claim under any other benefit plan the client may have, which if not a covered service under the benefit plan would result in a 4021 denial.

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EOB	Description

4980 Procedure Restricted under the client's benefit plan

Cause
This edit will set if the provider is a Home Health Agency and the client has both HUSKY and CHC with or without a Care Plan on file. The claim will first process under the HUSKY benefit. As the client also has CHC, the procedure, such as S9123, T1502 or T1004, though payable under the HUSKY benefit, is restricted from paying as the client has a CHC benefit plan.

Resolution
No action need be taken on edit 4980. Action should be taken on any other edit that that might set on the claim. Once the error code which caused the original claim denial against the CHC benefit plan is resolved and the claim is resubmitted, the claim should pay and the system will not attempt to process the claim under any other benefit plan the client may have.

EOB	Description

4991 Condition code restriction for billed procedure

Cause
An outpatient claim for an abortion procedure code for date of service 10/1/2015 forward is submitted without an appropriate abortion condition code and there is a condition code restriction under the provider's contract for the procedure code.

Resolution
Include one of the below condition codes along with the abortion procedure code and resubmit the claim:
AA - Abortion Performed due to Rape
AB - Abortion Performed due to Incest
AC – Abortion Performed due to Genetic Defect, Deformity, or Abnormality
AD - Abortion Performed due to Life Endangering Physical Condition
AE – Abortion Performed due to Physical Health of Mother that is not Life Endangering
AF – Abortion Performed due to Emotional/Psychological Health of the Mother
AG – Abortion Performed due to Social or Economic Reasons
AH – Elective Abortion

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EOB Description

5007 Exact duplicate – Header of a paid claim or a claim that is currently in process

Cause

A claim was previously submitted containing the same provider ID, the same client ID and the same date of service that has either been paid or is in the process of being considered for payment.

Resolution

Perform a claim inquiry using client ID and date of service to identify the claim causing the conflict.

If the claim causing the conflict was properly paid, no additional action is necessary.

If the claim causing the conflict is currently in a suspended, resubmit or a super-suspend status, no additional action is necessary. This claim is being manually reviewed by either DSS or Gainwell Technologies. The claim's status will soon change to either paid or denied.

If the claim causing the conflict was denied, the claim can be corrected, if applicable, and resubmitted.

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EOB Description

5008 Duplicate of a paid claim or a claim that is currently in process.

Cause

A claim was previously submitted by the same or different provider containing the same client ID and overlapping dates of service.

Resolution

Perform a claim inquiry using client ID and date of service to identify the claim causing the conflict. This will only return the claim if the previous claim was submitted by the same provider.

If the claim was submitted by the same provider:

If the claim causing the conflict was properly paid, no additional action is necessary.

If the claim causing the conflict is currently in a suspended, resubmit or in a super-suspend status, no additional action is necessary. This claim is being manually reviewed by either DSS or Gainwell Technologies. The claim's status will soon change to either paid or denied.

If the claim causing the conflict was denied, the claim can be corrected, if applicable, and resubmitted.

If the claim is not returned in the claim search results, it was likely submitted by another provider.

Confirm the claim's client ID and the date of service is correct. If the client ID or date of service is incorrect, correct the claim and resubmit.

If all claim data is correct, contact the Provider Assistance Center to request an audit be performed to determine the appropriate payee of the claim.

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EOB Description
5025 APC duplicate claim – APC Service must be on same claim for Date of Service **Cause** The outpatient claim denied because another claim for the same client on the same date of service was paid previously and it contained an APC payable code. **Resolution** Hospitals should bill all outpatient services for a single date of service on one claim to process using CMAP OPPS methodology. Exception: Multiple Outpatient Hospital E/M Encounters on the Same Date can be billed on a different claim.

EOB Description
5040 No paid routine home care service **Cause** Claims that contain either the Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have a paid detail with RHC on the same claim. If there isn't a paid detail for RCC 651 on the same claim the SIA detail will deny. **Resolution** Resubmit the claim adding the RHC detail and/or adjust a previously paid claim that contains a paid RHC detail to add the SIA detail.

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EOB	Description

5075 Only one interim claim allowed per stay

Cause
An interim claim currently exists in a paid status for the same client, same billing provider, and same admission date. This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Resolution
Only one interim claim can be paid per admission. The existing interim claim must either be recouped or adjusted and replaced with either an extended interim claim or for the entire inpatient stay.

EOB	Description

5076 Paid interim and final claim for same admission not allowed

Cause
An interim claim currently exists in a paid status for the same client, same billing provider, and same admission date. This EOB will post on hospital modernization claims which are identified as an inpatient claim type, billing provider type and specialty 01/001, admit date is 1/1/2015 and forward, including border and out of state hospitals.

Resolution
Once the client is discharged, the interim claim must be either recouped or adjusted, and resubmitted for the entire inpatient stay.

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EOB	Description

5077 Inpatient stay denied due to a paid outpatient claim within 3 days prior to inpatient admission

Cause
The inpatient claim was denied due to a paid outpatient claim with services provided on the day of admission or the two days prior to the day of admission on the inpatient claim.

Resolution
Recoup the outpatient claim and resubmit the inpatient claim. If the outpatient claim is unrelated to the inpatient hospital, hospitals should adjust the outpatient claim to submit with condition code 51 “Attestation of Unrelated Outpatient Services” and then resubmit the denied inpatient claim. Refer to Provider Bulletin 2015-82 for more information on this rule.

EOB	Description

5078 Outpatient claim denied due to a paid inpatient claim on or within 3 days after an outpatient claim

Cause
The outpatient claim was denied due a paid inpatient claim on or within 3 days after outpatient claim submitted- follows the “Three (3) Day Rule”.

Resolution
Correct the claim and bill on the inpatient claim if the claim was on or within 3 days of the admission date. If the outpatient claim is unrelated to the inpatient hospital, hospitals should submit the outpatient claim with condition code 51 “Attestation of Unrelated Outpatient Services”. Exceptions to the Three Day Rule are: maintenance renal dialysis RCC 82X, 83X, 84X, 85X; physical therapy, occupational therapy, speech therapy and audiology services RCC 42X, 43X, 44X, 47X; behavioral health services RCC 905-906, 913 and 914-916. Refer to www.ctdssmap.com under “Information”, “Publications” Bulletin 2015-82 for more information on this rule.

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EOB	Description

5151 Units billed were cutback or denied as they exceed the frequency of service allowed on the care plan

Cause

The claim was submitted with units that exceed the frequency on the care plan established by the care manager. If only a portion of the units billed remain authorized, the claim will make payment on the available units.

Resolution

The service is not payable unless the care manager increases the frequency for the date(s) of service submitted on the claim. Providers should first check paid dates of service within the frequency of the denied service line detail to be sure the appropriate procedure code and/or units of service were billed. For example: procedure code 1210z on 10/10/14 was billed for 12 units. The system cut back and paid 4 units. The service order/PA indicates 1210z has a weekly frequency of 20 units. Providers should check paid dates for the week of 10/5-10/11/14 to be sure dates of service billed were for the correct procedure code and units as serviced. Claims with billing discrepancies should be corrected via a claim adjustment. If no discrepancies exist contact the care manager for additional service authorization.

EOB	Description

5220 RHC RCC Must be Billed with RN-SW SVC For the Same Client/Provider/Date of Serv

Cause

Claims that contain either the Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must be billed with RHC on the same claim, same client, same provider and date of service. The SIA detail will deny, when claims with either the RN G0299/551 and/or social worker service G0155/561 are billed without RHC.

Resolution

Resubmit the claim adding the RHC detail.

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EOB	Description

5454 COVID 19 Admin Must be Billed with COVID 19 Vaccine

Cause
A claim was submitted with procedure code 0001A, 0002A, 0011A, 0012A or 0031A without the procedure code for the vaccine product administered, including the National Drug Code (NDC).

Resolution
Verify the coding on the claim and re-submit the claim.

EOB	Description

5455 APC – COVID 19 Lab Add-On Code Reported W/O Primary Proc

Cause
An outpatient claim was submitted with procedure code U0005 without one of its primary procedure U0003 or U0004 on the same date of service.

Resolution
Verify the coding on the claim and re-submit the claim.

EOB	Description

5456 E & M Add on code billed w/o primary code

Cause
A professional claim was submitted with procedure code 99417 with an Evaluation & Management code 99205 or 99215 on the same date of service.

Resolution
Verify coding on the claim and re-submit with applicable primary procedure code.

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EOB	Description

5460 Service Only Reimbursed Separately When Non-Patient, Otherwise Considered Packaged

Cause
This sets when the client is present during lab testing when billing for payable lab test that would normally be reimbursed if the client was considered a non-patient.

Resolution
Verify the status of the client on the claim. If the client was considered a non-patient, please verify the procedure code(s) on the claim was keyed correctly. If not, make the necessary corrections and resubmit the claim. If the client was present at the hospital and the services were considered packaged, the claim processed correctly.

EOB	Description

5500 Cannot have multiple E/M claims on the same date of service

Cause
This sets when there are multiple Evaluation and Management (E/M) claims on the same day in connection with RCCs 45X, 51X or 981 and the second one does not have a modifier 27 "Multiple Outpatient Hospital E/M Encounters on the Same Date". E/M codes are identified by procedure codes 92014 and 99201-99499, and Healthcare Common Procedure Coding System (HCPCS) codes G0463 and G0380-G0384.

Resolution
Modifier 27 should be added to the second distinct / separate E/M service codes.

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EOB Description
5501 Condition code G0 required when modifier 27 billed with an E/M code **Cause** The hospital failed to bill condition code G0 on an outpatient claim when modifier 27 is used to identify a distinct/separate E/M encounter performed for the same department (i.e. RCC 450/456 emergency room department), on the same date of a separate encounter on a current claim. **Resolution** Condition code G0 “Distinct Medical Visit” should be added to the current claim.

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EOB Description
5502 Claim requires condition code G0 - required when E/M code is billed with modifier 27 **Cause** A previous outpatient claim had a modifier 27 billed with an E/M code, but the provider failed to bill with condition code G0. **Resolution** The previous claim needs to be adjusted and condition code G0 should be added to the claim. Once adjusted the current claim can be resubmitted for processing.

EOB Description
5924 Claim denied, CCI greater and lesser procedures are not covered on same date of service. **Cause** Greater and lesser CCI procedure codes are not payable for the same date of service. **Resolution** Verify the procedure code and date of service information on the claim. If the data was keyed incorrectly, make the necessary corrections and resubmit the claim. If the data was keyed correctly, the claim is not payable based on a previously paid claim. For detailed information regarding the National Correct Coding Initiative, please review Provider Bulletins PB 2011-12, PB 2011-41, and PB 2012-40.

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EOB	Description

5925 CCI column 1 code or mutually exclusive code was billed on the same date as previous column 2 code.

Cause
A claim containing a CCI column 1 code or mutually exclusive code was submitted for the same date of service as a previously paid CCI column 2 code.

Resolution
Verify the procedure code and date of service information on the claim. If the data was keyed incorrectly, make the necessary corrections and resubmit the claim. If the data was keyed correctly, the claim is not payable based on a previously paid claim.

For detailed information regarding the National Correct Coding Initiative, please review Provider Bulletins PB 2011-12, PB 2011-41, and PB 2012-40.

EOB	Description

5926 CCI column 2 code was billed on the same date as previous column 1 or mutually exclusive code.

Cause
A claim containing a CCI column 2 code was submitted for the same date of service as a previously paid CCI column 1 code or mutually exclusive code.

Resolution
Verify the procedure code and date of service information on the claim. If the data was keyed incorrectly, make the necessary corrections and resubmit the claim. If the data was keyed correctly, the claim is not payable based on a previously paid claim.

For detailed information regarding the National Correct Coding Initiative, please review Provider Bulletins PB 2011-12, PB 2011-41, and PB 2012-40.

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EOB	Description

5927 Code 2 of a Code Pair that is not Allowed by NCCI even if appropriate modifier is present.

Cause
A claim containing a CCI column 2 code was submitted on the same date of service as a CCI column 1 code or mutually exclusive code.

Resolution
Verify the procedure code on the claim. If the data was keyed correctly, the service is not payable.

For detailed information regarding the National Correct Coding Initiative, please review Provider Bulletins PB 2011-12, PB 2011-41, and PB 2012-40.

EOB	Description

6230 Plan of Care Exceeded or PA Required > 2 Nurse Visits Per Week

Cause
This EOB will set when a provider submits claims for a HUSKY Health client for 3 or more Skilled Nursing services performed in a calendar week without prior authorization (PA) to bill against. The standard benefit allows for 2 Skilled Nursing services per week without requiring PA. PA should be obtained prior to performing the service(s) that exceeds the standard benefit by contacting the appropriate Administrative Services Organization (ASO) for PA.

Resolution
The provider needs to obtain PA for the services that exceed 2 skilled nursing visits in the week by contacting the appropriate ASO for PA.

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EOB Description

6250 Dental Annual Benefit Limit Exceeded

Cause

A claim is submitted for a client who has reached their annual Dental Benefit Limit. For any detail that posts EOB 6250, the Remittance Advice (RA) will list the amount for which the client is responsible.

Resolution

Before providing the service(s), the provider should verify the total of each client's accrual of services towards the annual dental benefit limit from their Secure portal account at www.ctdssmap.com by selecting "Claims" > "claim history for specific services" and selecting the "Inquiry Type" of "Dental Benefit Limit". The client may not be billed unless and until they have signed a form indicating that the proposed service is not covered because it exceeds the maximum, but they are willing to assume responsibility for payment. Such consent shall include a specific financial statement describing the service(s) for which he or she accepts responsibility. A client may also consent to partial payment for a service or procedure, if the remaining accrual amount will cover only part of the cost of the service. Again, this consent must be obtained before the procedure(s) is performed.

If the dental services are medically necessary even though the client has reached the annual dental benefit limit, the provider should request prior authorization (PA) for the service(s) through CTDHP. The full remaining treatment plan should be submitted including all supporting documentation required to substantiate reasons of medical necessity, including but not limited to radiographs, photographs, written commentary and statements of medical necessity from the client's primary care provider.

For detailed information regarding the Annual Dental Benefit Maximum policy, please refer to Provider Bulletin 2017-81.

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EOB Description

6290 Hospice RN-SW services are limited to 16 units per day

Cause

A combination of up to four (4) hours (16 units) are allowed for the combination of Skilled Nurs/Visit –551/G0299 and/or Med Soc Servs/Visit –561/G0155 per date of service within the last seven days of life. If more than 16 units are billed for the RN and/or social worker, those units *will not* be included in the SIA payment.

Resolution

No additional action is needed.

EOB Description

6442 Hearing aid coverage limited to $1000 every 24 months for HUSKY B clients

Cause

Hearing aid coverage for HUSKY B clients is limited to $1000 in any given 24 month span; this edit sets when the cumulative allowed amount for hearing aid claims submitted in a 24 month span exceeds $1000.

Resolution

This claim exceeds the benefit limit for the HUSKY B client in question on the date of service submitted and will not pay.

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EOB	Description

6443 HUSKY B eyeglass/contact coverage limited to $100 every 2 calendar years

Cause
Eyeglass/contact lens coverage for HUSKY B clients is limited to $100 every 2 calendar years; this edit sets when the cumulative allowed amount for eyeglass/contact lens claims submitted within 2 calendar years exceeds $100.

Resolution
This claim exceeds the benefit limit for the HUSKY B client in question on the date of service submitted and will not pay.

EOB	Description

6528 6 Units Per Client Every 60 Days

Cause
Service Codes T1001, G0161, G0162, G0163 and G0164 can only be billed for a total of 6 units every 60 days. If more than 6 units is billed without prior authorization, this edit will set and the excess units will not pay.

Resolution
This claim exceeds the limitation of the service code and will not pay unless prior authorization is obtained.

EOB	Description

6720 BH Clinician provider daily limit of 12 hours exceeded

Cause
Behavioral health clinicians can only be reimbursed for up to 12 hours of services provided to Connecticut Medical Assistance Program clients per day. This amount is calculated based on the procedure code and units billed on the claim, which are equated to an hour increment.

Resolution
This claim exceeds the limitation of the service code and will not pay.

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EOB	Description

7501 Denied MUE Detail After Review

Cause
Medically Unlikely Edits (MUE) review process completed and the information did not warrant allowance for additional units, detail denied.

Resolution
The claim exceeded allowable units and will not be reviewed unless the hospital has additional information for DSS to reconsider denial.

EOB	Description

7502 Denied MUE Detail Never Received or Needs Additional Information for Further Review

Cause
Medically Unlikely Edits (MUE) review process completed and the information was not received or the information received was not significant enough to warrant a complete review.

Resolution
Hospital will need to re-submit the claim for review and then submit any information that will support a determination that the service for which payment denied is medically necessary.

EOB	Description

8236 Claim was Recouped Due to PA Change

Cause
This EOB will set when a previously paid claim is systematically voided due to a prior authorization change by the Access Agency or DSS Case Manager This EOB will set on the voided claim which will start with region code 52.

Resolution
This EOB is informational only. No action is needed. A new claim will be created and processed with EOB code 8237 – Claim Systematically Reprocessed Due to a Retro Change – Information Only or code 8328 – Claim Systematically Reprocessed Due to a PA/ Service Order Change.

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EOB Description

8237 Claim Systematically Reprocessed Due to Retro Change – Information Only

Cause

This EOB will set when a systematically reprocessed new day claim (ICN which starts with region code 24) results in neither an increase nor a decrease to the reimbursement amount. The affected claim will follow the voided claim which starts with region code 52 and posts EOB 8236 – Claim was Recouped Due to a PA Change. This EOB code will not appear on the remittance advice (RA) and will only be displayed on the DSS Web portal.

Resolution

This EOB is informational only. No action is needed. A claim with this EOB would be proceeded by a voided claim that posted EOB 8236, and the new day claim paid the same amount, resulting in no financial impact.

EOB Description

8238 Claim Systematically Reprocessed Due to a PA/Service Order Change

Cause

This EOB will set when a new day claim (region code 24) is systematically reprocessed due to a prior authorization (PA) change and there was a change to the reimbursement amount, whether an increase or a decrease to the reimbursement. The affected claim will follow the voided claim which starts with region code 52. This EOB confirms that there has been either a positive or negative change to the claim that was reprocessed.

Resolution

In the case of a negative impact, the provider should investigate the reprocessed claim to determine if the appropriate level of care was provided, if the updated PA matches the service order and if the payment of the entire week, month or date span on the PA have paid as previous. Providers should report any PA/service order discrepancies to the Access Agency or DSS Case Manager for assistance. The claim should not be resubmitted until the PA has been increased.

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