



Connecticut interChange MMIS

Provider Manual

Chapter 5 - Claim Submission Information

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Connecticut Department of Social Services (DSS)
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Hartford, CT 06105

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Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	01/01/2008	Initial Release.	All	All
1.1	09/17/2008	Updated for Internet static content changes, changes to TPL Information Form and process, RA sort order, CMS 1500 RA layout, reimbursement for medical eligibility determination, and general maintenance. Updated PCAR form, inserted procedures from bulletin 2004-78, and other general content changes. Incorporated changes as a result of Charter Oak Health Plan Program, removed W80 form.	5.1 – 5.15, 5.17	Multiple pages in each section have been revised.
1.2	05/18/09	Incorporated updates to timely filing exceptions for other insurance denials, incorporated revisions to EPSDT information, inserted revised versions of W-300 and W-300A forms, deleted list of WIC local agency coordinators, added instructions for completion of the W80 form, incorporated updates to EFT information and Medicare billing.	5.1 5.3 5.6 5.7 5.9 5.11 5.12	2 29-31 47 51-52 133 138-140, 147-151 182 - 193
1.3	07/09/2009	Updated list of EPSDT vaccines, clarified timely filing instructions, added detailed procedures for accessing the carrier code list on the Web portal.	5.2 5.3 5.6 5.11	4, 6 18, 29 47-48 144-145
1.4	12/07/2009	Updated PCAR and Timely Filing instructions, revised EFT instructions, updated EPSDT Vaccines list and inserted revised immunization schedules, inserted revised W-416 form, inserted links to OI/Medicare billing guides.	5.2 5.3 5.4 5.6 5.7 5.9 5.11	4-8 15-19, 26 39 47-49 52-57 136 146-152

Version	Version Date	Reason for Revision	Section	Page(s)
			5.16	219-220
1.5	02/04/10	Inserted revised CMS 1500 RA layout, added Home Health RA layout, added e-Prescribing section, added hyperlinks from the section numbers on page 2 to the sections, added references to forms available on the Web portal, added acceptable documentation in lieu of Medicare “Suppliers Not Eligible to Participate” denial letter for clinic services.	5.1 5.9 5.13 5.14 5.15 5.17	2 102-105, 107-110 204 214 218 229-233
1.6	06/30/10	Inserted revised PCAR form; replaced references to OI/Medicare links with Chapter 11; inserted revised RA layouts to include Charter Oak coinsurance and deductible; updated list of EPSDT vaccines; added W-538 form.	5.2 5.3 5.6 5.7 5.9 5.11 5.12	9 15, 17-19 47 52 90-97, 99-100, 105-108, 137-139 150 185, 201- 202
1.7	07/21/10	Inserted revised EFT form, updated to reflect discontinuation of SAGA program and the implementation of the Medicaid Low Income Adults program, added TDD/TTY number, inserted revised CMS-1500 layout for HUSKY B co-pay, added new section for co-pay information.	5.1 5.2 5.5 5.7 5.8 5.9 5.13 5.14 5.15	2 4, 6-8 46 55-58 60-61. 65 87, 92, 99, 104, 107-110, 112, 115, 119, 122, 137, 141,144 207, 211 217 221, 225

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			5.17	233
			5.18	238-240
1.8	09/22/2010	Added fund payer codes to RA section for Medicaid Low Income Adults and Multiple Programs, revised EFT instructions.	5.9	92, 99, 104, 108, 112, 115, 119, 122, 137, 141, 143
1.9	01/18/2011	Updated list of immunization tracking codes.	5.11	151-153
2.0	10/14/2011	Updated list of immunization tracking codes, removed references to SAGA Program, inserted updated presumptive eligibility form, revised CHC cost sharing percentage, inserted revised RA layout due to EHR implementation, misc other updates.	All	All
2.1	06/08/2012	Implementation of Family Planning Benefit and Tuberculosis Waiver, as well as transition to the ASO.	All	All
2.2	07/09/2012	Updated Family Planning Diagnosis Code List, updated instructions for presumptive eligibility, updated list of EPSDT vaccination codes, and removed references to local phone numbers.	5.2 5.5 5.11 5.12 5.15 5.19	6 42 127 177 198 216-223
2.3	08/13/2012	Removed EFT form, as EFT updates are now done via the Secure Web portal.	5.9	117
2.4	08/27/2013	Revised EPSDT section, and updated/added pointers to Family Planning diagnosis code list. Added timely filing clarification, as well as new EFT letter process. Removed references to MCOs.	5.6 5.9 5.11 5.18 5.19	46-47 117 All 206 208-210
2.5	1/3/2014	Inserted new TPL form, Added language for claims with dates of service through December 31, 2013, updated access to RAs section, incorporated information to reflect that ConnPACE and Charter Oak will no longer be	5.4 5.6, 5.8 5.9	38 47,58-9 61 & 65

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		supported programs as of January 1, 2014, updated Remittance Advice language and added an RA in a excel format for NEMT provider, spreadsheet, updated Consent to Sterilization, Federal Form OMB No. 0937-0166 (formerly DSS form W-612), removed 2004 effective date, removed 2011 effective date, Connecticut Home Care Cost Sharing section updated & 2012 date removed.	5.10 5.13 & 5.15 5.17 & 5.18 5.18 5.19 5.20	118 148 & 159-166 174 & 177 179 180 -181 183
2.6	02/21/2014	Added new procedures as a result of newly eligible clients under the ACA.	5.12	147, 148
2.7	09/17/2014	Updated to allow Behavioral Health Clinicians to provide services to dual eligible clients with acceptable documentation. Revised as a result of updates for newly eligible client procedures under the ACA, as well as EFT enrollment changes under the ACA. Inserted new DSS address and logo. Removed references to ConnPACE and Charter Oak. Inserted revised W-538 form. Updated list of immunization tracking codes. Misc additional updates.	All	All
2.8	01/01/2015	Updated inpatient RA layouts as a result of the DRG implementation.	5.9	63, 65- 66, 67- 69, 70, 72-74, 112, 114
2.9	06/02/2015	Inserted current version of TPL Information form. Updated name of DSS' Resources and Recovery Division.	5.3 5.4	27 36 - 38
3.0	07/27/2015	Removed references to form availability via fax on demand. Inserted current version of the TPL Information Form.	5.2 5.4	6 36-40

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3.1	09/28/2015	Updated PES references. Updated with ICD-10 related information. Updated timely filing information.	5.2	4
			5.3	14-15, 18, 25, 28
			5.6	44-47
			5.7	51-52, 54
			5.11	125-127
			5.19	186-187
			5.20	190-191
3.2	11/01/2015	Updated to replace HP references/logo with Hewlett Packard Enterprise reference/logo.	All	All
3.3	02/02/2016	Additional updates to replace HP references/logo with Hewlett Packard Enterprise reference/logo. Updated links to EPSDT information. Insertion of updated Third Party Liability (TPL) Provider Accident Questionnaire, and updated Consent for Sterilization form	5.2	7
			5.3	32-34
			5.11	123, 126-127
			5.15	167-169
3.4	08/15/2016	Updated as a result of the elimination of paper claims.	5.1	2
			5.2	5
			5.3	14-17
			5.5	43
			5.6	45-46
			5.7	53-55
			5.8	57
			5.12	131
3.5	04/18/2017	Updated to replace Hewlett Packard Enterprise references/logo with DXC Technology references/logo, as well as updated hyperlinks to Husky Health.	All	All
3.6	03/01/2018	Updated version of the Trauma Questionnaire as well as updated information on submission of Hysterectomy Forms and PO Box addresses.	5.3	34
			5.13	157, 167
3.7	08/07/2018	Updated Timely Filing Limits for HUSKY A and B Behavioral Health Services	5.6	45, 47
3.8	11/01/2018	Updated as a result of changes in CADAP program administration. Also updated to reflect changes in EHR program name to the Promoting	5.9	65, 72, 77, 81,

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		Interoperability Program.	5.17	88, 92, 95, 110, 114 178, 181
3.9	09/10/2019	Update in Timely Filing and Direct Observational Therapy Guidance.	5.6 5.20	All All
4.0	09/25/2019	Updated version of the Trauma Questionnaire.	5.3	33
4.1	10/01/2020	Updated Trauma Questionnaire wording. Updated to replace DXC Technology references/logo with Gainwell Technologies references/logo.	5.3 All	33 All

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5.1 Overview

Chapter 5 contains the general claim submission information, claim related correspondence, behavioral health program guidelines, remittance advice, electronic funds transfer, Medicare/insurance carrier information and program forms applicable to most providers participating in the Connecticut Medical Assistance Program.

Please note, effective October 1, 2016, the Department of Social Services (DSS) no longer accept paper claims. The only exceptions to this mandate are claims submitted on paper from Out of State (OOS) providers as well as special handled claims.

Section	Description
5.2	Addresses the specific requirements for providers to submit adjustments and/or recoupment of paid claims adjudicated within the Medicaid Management Information System (MMIS).
5.3 and 5.4	Addresses the third party liability procedures and claim submission requirements for clients with insurance primary to the Connecticut Medical Assistance Program.
5.5	Addresses the Return to Provider letter that notifies a provider to correct and/or add information to a form.
5.6	Addresses the timely filing requirements for claims submitted to the Connecticut Medical Assistance Program.
5.7	Provides information and procedures for submitting claims for Medicare coinsurance.
5.8	Addresses the program guidelines for the Connecticut Behavioral Health Partnership (CT BHP) for HUSKY A, HUSKY B, HUSKY C – previously referred to as Medicaid, HUSKY D – previously referred to as Medicaid LIA, and the Department of Children and Families children with complex behavioral health needs clients.
5.9	Addresses the function and description of the Remittance Advice (RA) and Electronic Funds Transfer (EFT).
5.10	Provides information on accessing the comprehensive list of current insurance carriers.
5.11	Provides information regarding the State of Connecticut's Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
5.12 , 5.13 , 5.14 , 5.15 , 5.16	Provides forms used by the provider community.
5.17	Provides information regarding the e-Prescribing program.
5.18	Provides information regarding co-pays and cost sharing.

5.19	Provides information regarding the family planning benefit.
5.20	Provides information regarding the tuberculosis waiver.

5.2 Paid Claim Adjustment Request

Overview

The Paid Claim Adjustment Request (PCAR) is used to change information on a claim or for recoupment. Providers submitting a PCAR on paper should be specific and concise when describing the information to change. PCARs may be submitted either electronically or on paper.

The Paid Claim Adjustment Request (PCAR) process is used by providers or the Department of Social Services to:

- Change information on a paid or partially paid claim
- *Recoup* an entire claim

NOTE: PCARs are also subject to timely filing. Please be sure to carefully review Section 5.6 Timely Filing Guidelines to understand the submission criteria.

Submission	PCAR Information
Electronic	Paid claim adjustment requests or full claim recoupments may be submitted electronically using any one of the following electronic methods: The secure Provider Web portal at www.ctdssmap.com. A Web Claim Submission Guide is also located on each claim submission panel in the upper left corner of the Web page. Electronic adjustments and recoupments may be submitted for claims originally submitted on paper. As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims. ASC X12N 837 Health Care Claim. Instructions for submitting ASC X12N Health Care Claims and adjustments may be found in the Implementation Guide and Companion Guide for format and code set information located at www.ctdssmap.com > Trading Partner > EDI. Provider Electronic Solutions Software. Instructions for submitting adjustment claims via Provider Electronic Solutions are located at www.ctdssmap.com > Trading Partner. Adjustments can only be done via Provider Electronic Solutions software for Long Term Care claims.
Adjust a Previously Paid Claim Via an Electronic PCAR	The frequency code of “7” is submitted to adjust a previously paid professional or dental claim. A “7” in the third digit of the Type of Bill is submitted to adjust a previously paid institutional claim.

Submission	PCAR Information
	The adjustment claim must be submitted in its entirety, including those changes necessary to adjust the claim properly. An adjustment cannot be made on a claim that has not been paid.
Recoup a Prior Claim Via an Electronic PCAR	The frequency code of “8” is submitted to recoup a previously paid professional or dental claim. An “8” in the third digit of the Type of Bill is submitted to recoup a previously paid institutional claim.
Requirements	Providers must note the following points: • The Internal Control Number (ICN) of the claim to be adjusted or recouped must be submitted. • Neither the client Connecticut Medical Assistance Program ID number nor the NPI/Taxonomy or non-medical provider identifier(s) can be changed on a paid claim. • A PCAR may not be used to resubmit a claim that has been denied, or details on a claim that have denied. • The PCAR form should not be used to appeal a payment. • Pharmacy providers and providers adjusting a Medicare coinsurance or deductible claim must recoup the entire claim when submitting a PCAR. • PCAR forms, which are incomplete or incorrect, will be returned to the provider for correction and resubmission. • PCARs appear in the body of the RA following the claim that has been adjusted and the adjustment Internal Control Number will begin with the number “5”. • If some details on a paid claim have been denied but subsequently become payable, the provider must recoup the original claim and resubmit all payable details.
Exceptions to Adjustments or Partial Recoupments	The following claims cannot be adjusted or partially recouped. They must be recouped entirely and resubmitted with the correct information: • Medicare crossover claims. • Claims with an ICN that begins with either 12 or 13. These claims were specially handled by Gainwell Technologies. An adjustment to these claims may need to be specially handled. The provider should contact Gainwell Technologies before attempting to adjust these claims.

Submission	PCAR Information
How to Obtain the Form	Providers may obtain PCAR forms: • Through the Connecticut Medical Assistance Program Web site at www.ctdssmap.com under Information > Publications. • By writing to the following address: Gainwell Technologies Provider Assistance Center P.O. Box 2991 Hartford, CT 06104
Where to Send Completed Forms	Providers mail the forms to the following address: Gainwell Technologies Connecticut Medical Assistance Program P.O. Box 2981 Hartford, CT 06104
Instructions for Completing the Form	The following pages provide detailed instructions for completing the PCAR form.

CONNECTICUT MEDICAL ASSISTANCE PROGRAM
PAID CLAIM ADJUSTMENT REQUEST (PCAR)

Please Return To:

DXC Technology
Connecticut Medical Assistance Program
PO Box 2981
Hartford, CT 06104

1) NPI/Non-Medical Provider Identifier 									
2) Remittance Advice Date 					3) Remittance Advice Number 				
4) Client ID 									

5) Client Name (Last, First)

6) Internal Control Number

7) Reason for Request ☐ RECOUP ENTIRE CLAIM ☐ RECOUP DETAIL NUMBER(S) _____ ☐ ADJUST CLAIM: PLEASE EXPLAIN: _____ _____ _____ If recouping detail(s), please complete boxes 8-12 then skip to box 29.
--

**Please copy the information requested in boxes 8 through 12 from the REMITTANCE ADVICE.
For additional details please attach an additional page.**

8) Claim Detail #	9) Dates of Service	10) NDC/RCC/Procedure Code	11) Days/Qty/Units	12) Billed Amount

**Please complete only the boxes in the next two sections that pertain to the changes necessary to
adjust the claim. For additional details please attach an additional page.**

13) Type of Bill	14) Dates of Service	15) Admit Date	16) Total Days	17) Other Insurance Amount	18) Spenddown	19) Patient Status

20) Claim Detail #	21) Dates of Service mm/dd/ccyy	22) FTC	23)NDC/RCC/ Procedure Code	24) Modifier(s)	25) Days/Qty/Units	26) Tooth #/ Surface Code	27) Billed Amount

28) For LTC Providers only, additional data for the requested change:

29) Provider Name
30) Street Address
31) City, State, Zip Code
32) Authorized Signature

33) Date

INTERNAL USE ONLY 34) Initiated By rDXC DSS
--

Instructions for Completing Paper Paid Claim Adjustment Request (PCAR)

Instructions for Completing PCAR	
Field Name	Description
1. NPI/Non-Medical Provider Identifier	Enter the provider's National Provider Identifier or the Non-Medical Provider Identifier that appears on the Remittance Advice (RA).
2. Remittance Advice Date	Enter the date, in MM/DD/CCYY format, that appears in the heading of the RA.
3. Remittance Advice Number	Enter the 9-digit RA number that appears above the date on the RA.
4. Client ID	Enter the client's Connecticut Medical Assistance Program ID number (9 digits) as it appears on the RA.
5. Client Name (Last, First)	Enter the client's name as it appears on the RA.
6. Internal Control Number	Enter the 13-digit internal control number as it appears on the RA.
7. Reason For Request	Indicate the type of adjustment request. If other, please briefly explain. Pharmacy providers must check off the box for "Recoup Entire Claim." A provider adjusting a Medicare coinsurance or deductible claim can only check the box to "Recoup Entire Claim."
8. Claim Detail #	Enter the claim detail line number to be adjusted. The provider determines the claim detail line number by counting down each detail line on the claim displayed on the Remittance Advice (RA).

NOTE: The information submitted in Fields 8 through 12, should represent the claim details to be adjusted. Copy the claim detail information as it appears on the Connecticut Medical Assistance Program RA.

Instructions for Completing PCAR (Cont'd)	
Field Name	Description
9. Dates of Service	Enter the dates of service, in MM/DD/CCYY format, as they appear on the RA.
10. NDC/RCC/Procedure Code	Enter the National Drug Code (NDC), the Revenue Center Code (RCC), or the procedure code as it appears on the claim detail of the RA to be adjusted. When billing a drug procedure code in the J, S or Q series providers are required to submit the corresponding 11-digit NDC.
11. Days/Qty/Units	Enter the days, quantity, or units of service as they appear on the RA.
12. Billed Amount	Enter the billed amount, in \$\$.\$¢ format, as it appears on the RA.
13. Type of Bill	UB-04 claims only: Enter the type of bill as it appears in Field 4 of the UB-04 form.
14. Dates of Service	UB-04 claims only: Enter the dates of service, in MM/DD/CCYY format, as they appear in Field 6 of the UB-04 form.
15. Admit Date	UB-04 claims only: Enter the admission date, in MM/DD/CCYY format, if the claim is for inpatient services.
16. Total Days	UB-04 claims only: Enter the total number of days being billed.
17. Other Insurance Amount	Enter the amount paid, in \$\$.\$¢ format, by the other insurance carrier, followed by the carrier code and the paid or denied date. Attach the appropriate other insurance carrier Explanation of Benefit (EOB) to the PCAR form.
18. Spenddown	UB-04 claims only: Enter the spenddown/excess assets amount, in \$\$.\$¢ format that applies to this claim. This applies to hospital and long-term care providers only.

Instructions for Completing PCAR (Cont'd)	
Field Name	Description
19. Patient Status	UB-04 claims only: Enter the client's status as of the ending service date of the period covered on the bill.
20. Claim Detail #	Enter the claim detail line number, from the RA, to be adjusted.
21. Dates of Service	Enter the dates of service, in MM/DD/CCYY format, that apply to the detail to be adjusted.
22. Facility Type Code	Enter the place of service code that applies to the detail to be adjusted.
23. NDC/RCC/ Procedure Code	Enter the correct National Drug Code (NDC), Revenue Center Code (RCC), or procedure code that applies to the detail to be adjusted. When billing a drug procedure code in the J, S or Q series providers are required to submit the corresponding 11-digit NDC.
24. Modifier(s)	Enter the modifier(s) that applies to the detail being adjusted.
25. Days/Qty/Units	Enter the days, quantity or units of service that apply to the detail being adjusted.
26. Tooth #/Surface Code	Enter the tooth number or surface code that applies to the detail being adjusted. This field applies to dental providers only.
27. Billed Amount	Enter the correct billed amount, in \$\$.\$¢¢ format, that applies to the detail being adjusted.
28. For LTC Providers only, additional data for the requested change	Enter the reason (i.e. patient liability) for the adjustment and any miscellaneous claim data that pertains to the adjustment request. If additional space is necessary, attach an additional page. This field applies to long-term care providers only.
29. Provider Name	Enter the billing provider's name.
30. Street Address	Enter the billing provider's business street address.

Instructions for Completing PCAR (Cont'd)

Field Name	Description
31. City, State, Zip Code	Enter the city, state and zip code of the billing provider's business address.
32. Authorized Signature	Have the provider or other authorized person sign his/her full name.
33. Date	Enter the date the PCAR was completed in MM/DD/CCYY format.
34. Initiated By	Leave blank; for internal use only.

5.3 Instructions and Forms for Third Party Liability

Overview

The Connecticut Medical Assistance Program is the payer of last resort for all covered services. If a Connecticut Medical Assistance Program client has applicable Medicare or other insurance coverage, the benefits of these policies must be fully exhausted prior to claim submission to the Connecticut Medical Assistance Program. Refer to Chapter 2, Provider Participation Policy, for more information.

About this Section

This section contains information regarding claim submission to the Connecticut Medical Assistance Program when the client has Medicare, third-party insurance or other health benefit plan coverage. It also includes the process for submitting Connecticut Medical Assistance Program claims after another insurance company has either made a payment or denied a claim. In addition, this section provides instruction for submitting both paper and electronic claims for the Third Party Liability (TPL) process. Claims for clients with Medicare, third-party insurance, or other health benefit plans are subject to timely filing. For timely filing guidelines and exceptions refer to Chapter 5, Section 5.6.

*As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.

For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.

Determining Other Coverage

Connecticut Medical Assistance Program providers must investigate the possibility that a client has other medical coverage and pursue payment from all other medical insurance plans. In addition to asking the client, providers can determine other insurance coverage by accessing the Automated Eligibility Verification System (AEVS) and/or the Automated Voice Response System (AVRS). See Chapter 4, Client Eligibility, for complete information on accessing these systems.

Other insurance coverage may be (but is not limited to) the following:

- Medicare for persons over the age of 65 or those with disabilities.
 - Medicare supplemental plans.
 - Private health insurance or other health benefit plans, including ERISA, COBRA, and self-funded plans from a client's, spouse's or parent's employer.
 - Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS) or veteran's benefits for active duty or retired
-

military personnel.

If any coverage is available from one or more third parties, the appropriate claim must first be submitted to each carrier for reimbursement for services. Typical other insurance coverage types provided from the AEVS and AVRS include physician, hospital, drug, dental, vision, and long term care.

Submission/Denial	Third Party Claims By Primary Payer
Medicare as Primary Payer	If Medicare reimburses the provider for medical services provided to an eligible Connecticut Medical Assistance Program client, the appropriate coinsurance and/or deductible may be submitted to Gainwell Technologies for payment up to the Connecticut Medical Assistance Program's maximum allowed amount. Claims that are paid by Medicare will be electronically submitted to Gainwell Technologies for processing. Claims will be paid at the lower of the coinsurance and/or deductible amount submitted or the Medicaid allowed amount minus any Medicare payment. Refer to Section 5.7 for further information on Medicare coinsurance and deductible claim processing. Providers who perform services covered by Medicare should refer to Chapter 8 for claim submission instructions for Medicare coinsurance and/or deductible, or to Chapter 11 of the provider manual referenced above. Claims for Medicare coinsurance and/or deductible may be submitted via the provider's secure Web account, electronically with Gainwell Technologies's Provider Electronic Solutions software or on paper. Provider Electronic Solutions software is available free of charge to any providers who wish to perform client eligibility verification, and to Long Term Care providers who wish to submit claims. • When submitting for Medicare coinsurance and/or deductible, the Crossover Indicator field of the Provider Electronic Solutions software must be used. • When submitting a paper claim, a copy of the Explanation of Medicare Benefits (EOMB) indicating a payment from Medicare or a Medicare HMO must be attached to the claim submitted to Medicaid. When Medicare denies the claim, the Medicare EOMB should NOT be attached to the claim. Only one EOMB can be attached to the claim. *As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.

Submission/Denial	Third Party Claims By Primary Payer
	Before a provider submits a claim for Medicare coinsurance and/or deductible to Gainwell Technologies, a thorough review should be made of the client's private insurance resources to determine if a Medicare supplemental policy exists. If the AEVS/AVRS indicates that a policy is available and the claim for coinsurance and/or deductible does not include the required other payer documentation, the claim will be denied.
Electronic Claims with Medicare Denial	Providers submitting electronic claims must indicate the appropriate value on the electronic claim to indicate that Medicare has denied the claim or Medicare is not applicable. The provider is responsible for retaining the Medicare denial in their files for audit purposes.
Private Insurance as Primary Payer	If another insurance carrier reimburses the provider, a Connecticut Medical Assistance Program claim may be submitted for the balance of payment up to the Connecticut Medical Assistance Program maximum allowed amount. Refer to Chapter 8 for claim submission instructions. For paper claims, a copy of the other insurance carrier's explanation of benefits (EOB) is not required to be attached to the claim, unless required to override timely filing. Claims submitted either on paper or electronically require that the provider retain a copy of the EOB in the client's file. *As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims. If a provider receives a third party payment equal to or greater than the Connecticut Medical Assistance Program maximum allowed amount for the same service, no further payment will be made by the Connecticut Medical Assistance Program. <i>In this situation, the provider may not collect the balance from the client, financially responsible relative, or representative of that client.</i> Refer to Chapter 2, Provider Participation Policy, regarding Connecticut Medical Assistance Program payment in full. Detailed billing requirements for other insurance claim submission when a payment has been made can be found in Chapter 11 as referenced above.
Private Insurance Denial	If the provider receives a denial from another insurance carrier, the provider may submit a claim to Gainwell Technologies. However, the provider must indicate that the claim was denied by following the detailed billing requirements found in Chapter 11 as

Submission/Denial	Third Party Claims By Primary Payer
	referenced above. If a claim is received with no other insurance information and the eligibility file indicates that other insurance coverage is available for the services provided, the claim will be denied. Claims submitted electronically require that the provider retain a copy of the EOB in the client's file. *As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.
Third Party Carrier Codes	Third party health insurance companies are identified by a three-digit carrier code. If the Connecticut Medical Assistance Program client has third party liability insurance coverage known to DSS, this coverage information can be found through the AEVS/AVRS. Insurance carrier names and their corresponding 3-digit carrier codes may be obtained through client eligibility verification on the provider secure Web site www.ctdssmap.com. The list of codes can also be found on the public Web site, www.ctdssmap.com, by selecting Information, then Publications and locating the links under Provider Manual Chapter 5, Additional Chapter 5 Information. If the three-digit code for a specific insurance carrier does not appear on the list, the provider should enter "999", along with the paid amount and paid date for a payment, or "0" or "N/A" and the denial date for a denial in field 9d on a CMS-1500 claim form and field 50 on a UB-04 claim form.
Electronic Claims with Private Insurance	Providers submitting electronic claims must indicate the appropriate value on the electronic claim to indicate that the other insurance carrier denied the claim or the other insurance is not applicable. The provider is responsible for retaining the other insurance denial in their files for audit purposes.
Prior Payment Audits	DSS periodically audits claims submitted when "other insurance" is indicated. Providers are required to retain insurance vouchers and, upon request, send a copy to Gainwell Technologies. Providers receive a written request to provide the vouchers for specific paid claims within a specified time frame. Claims for which appropriate documentation cannot be produced are subject to recoupment.

Legal Notice of Subrogation (W81)

Submission	About the W81 Form
Direct Payment Request	To facilitate utilizing third party resources prior to pursuing Medicaid payment, Medicaid providers under the law have a subrogated right of recovery to a client's other insurance resources. This means the provider has the right to instruct the insurance carrier to send payment directly to the provider, rather than the insurance carrier paying the client and then the provider pursuing payment from the client. To receive a direct payment: 1. Attach a completed Legal Notice of Subrogation, W-81 to a paper claim. 2. Submit the information to the insurance carrier with the words "Subrogated Claim, CT Law 38a-472" in the Remarks Field on the claim. The provider is thus guaranteed the third party response. Failure to use a Legal Notice of Subrogation form to request direct payment results in the loss of the provider's right to request a Connecticut Medical Assistance Program payment for the service.
How to Obtain the Form	Providers may obtain the Legal Notice of Subrogation, W-81 from the following address: Department of Social Services Supervisor, Duplicating 55 Farmington Avenue Hartford, CT 06105 Facsimile requests for forms may be submitted to (860) 424-4954.
Where to Send the Form	Providers mail the completed form along with the claim form to the other insurance carrier.
Instructions for Completing the Form	The following pages provide detailed instructions for completing the Legal Notice of Subrogation, W-81.



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105-3725

W-81 (Rev. 9/15)

LEGAL NOTICE OF SUBROGATION UNDER CONNECTICUT GENERAL STATUTE 38a - 472

DATE: _____

INSURER'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Dear Insurer:

Pursuant to State of Connecticut General Statutes Sections 38a-472 (b), formerly 38-174a(b) and 17-134f, this notice informs the insurer that any benefits payable for services rendered as set forth on the attached claims have been assigned and/or subrogated to the provider indicated below. By a provider notifying an insurer, the insurer shall be liable to the provider for any amount payable under the contract. Further, if the insurer inadvertently pays anyone else, the insurer is still legally obligated to pay the contractual amount owed under the contract to the provider.

The claims covered by this notice are either listed below, on an attached list, or on an enclosed tape.

NAME	DATE OF SERVICE	NAME	DATE OF SERVICE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Connecticut General Statutes, Section 38a-816 (15), formerly 38-61(15), provides that an insurance carrier is under an obligation to pay accident and health claims within forty-five (45) days of receipt unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss. Any insurer who fails to pay such a claim within forty-five days may be liable for the amount of the claim plus interest at the rate of fifteen percent per annum, in addition to any other penalties, which may be imposed.

Please remit your payment to the provider at the address below.

 Provider Name / Telephone Number

 Address

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Instructions for Completing Legal Notice of Subrogation (W-81)

Instructions for Completing the W-81 Form	
Field Name	Description
Date	Enter the current date.
Insurer's Name	Enter the name of the other insurance carrier involved in the subrogation.
Address, City, State Zip Code	Enter the other insurance carrier's address, city, state, and zip code.
Name	List the name(s) of the client(s).
Date of Service	Enter the date of service for the claim(s) being submitted.
Provider Name, Telephone Number, Address	Enter the provider's name, telephone number, practice location address, city, state, and zip code.

Request for Assistance in Obtaining Payments Under 38a-472 of the Connecticut General Statutes (W-82)

Submission	About the W82 Form
Request for Assistance in Obtaining Payments	When an insurer fails to pay or respond, the provider should complete the Request for Assistance in Obtaining Payments Under 38a-472 of the Connecticut General Statutes, W-82. Connecticut General Statute 38a– 816(15) provides that an insurance carrier is obligated to process health or accident claims within forty-five days of receipt or pay interest at the rate of 15 percent per annum. A provider who does not receive payment within forty-five days should fully document that every reasonable attempt was made. The provider must file a request for assistance with the Connecticut Department of Insurance using form W-82, Request for Assistance in Obtaining Payments.
How to Obtain the Form	Providers may obtain the Request for Assistance in Obtaining Payments under 38a-472 of the Connecticut General Statutes, W-82 from the following address: Department of Social Services Supervisor, Duplicating 55 Farmington Avenue Hartford, CT 06105 Facsimile requests for forms may be submitted to (860) 424-4954.
Where to Send the Form	Providers mail the completed form to the following address: The Connecticut Department of Insurance Consumer Affairs Division P.O. Box 816 Hartford, CT 06142-0816 The Department of Insurance will review the form and facilitate an insurance payment to the provider. The Department of Insurance will send an acknowledgment of the W-82 form and give the provider a file number for the subrogated claim. The provider should maintain that file number for subsequent claims submission to the Connecticut Medical Assistance Program if a Third Party Billing Attempt form, W-1417 is required.
Instructions for Completing the Form	The following pages provide detailed instructions for completing the Request For Assistance in Obtaining Payments Under 38a-472 of the Connecticut General Statutes, W-82.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
W-82 (Rev. 5/95)

**REQUEST FOR ASSISTANCE IN OBTAINING PAYMENTS UNDER 38a - 472
OF THE CONNECTICUT GENERAL STATUTES**

Connecticut Insurance Department
Consumer Affairs Division
P.O. Box 816
Hartford, CT 06142-0816

On _____ the undersigned provider, under Connecticut General Statutes 38a-472(b)
(Date)

[formerly 38-174(b)] transmitted the attached Legal Notice and claims for a Medicaid client

to: _____

To date, no remittance for the claim has been received. As 38a-472(b) guarantees the payment for these claims to the provider and 38a-816 (15), formerly 38-61 (15), requires the payment of legitimate claims made in forty-five (45) days, your assistance in obtaining a prompt remittance is requested and appreciated.

Sincerely,

Provider Name _____

Provider Telephone No. () _____

Enclosures:
Dated Subrogation Notice
Claim

Instructions for Completing the Request for Assistance in Obtaining Payments Under 38a-472 of the Connecticut General Statutes (W-82)

Instructions for Completing the W-82 Form	
Field Name	Description
Date	Enter the date that the Legal Notice of Subrogation was sent to the other insurance carrier involved in the subrogation.
To:	Enter the name and address of the other insurance carrier involved in the subrogation.
Provider Name	Enter the provider's name.
Provider Telephone No.	Enter the provider's business telephone number.
NOTE: Enclose a copy of the appropriate dated Legal Notice of Subrogation form and claim	

Third Party Billing Attempt (W-1417)

Submission	About the W-1417 Form
Document Attempts to Obtain Payment	Connecticut Medical Assistance Program payment may be obtained when all reasonable attempts to collect third party payments fail. DSS is aware that other insurance carriers never cover some services. In addition, there are some insurance companies that do not provide an actual denial statement or, in some cases, never respond to written requests. To address these problems and to alleviate any unnecessary burden on the provider, DSS implemented the Third Party Billing Attempt, (W-1417). This form documents that the provider has made every attempt to obtain payment from the other insurance carrier prior to claim submission to the Connecticut Medical Assistance Program. The form may be used in place of a denial voucher for the other insurance carrier, but may not be used in place of a Medicare denial.
How to Obtain the Form	Providers may obtain the Third Party Billing Attempt, W-1417 from the following address: Department of Social Services Supervisor, Duplicating 55 Farmington Avenue Hartford, CT 06105 Facsimile requests for forms may be submitted to (860) 424-4954.
To Use the Form	To use this form, the provider must first have sent a Legal Notice of Subrogation, W-81 with the claim form to the other insurance carrier and must have filed a Request for Assistance in Obtaining Payments, W-82 with the Department of Insurance. The Department of Insurance will acknowledge the provider's subrogated claim and furnish the provider with a file number. If the provider has not received any insurance payment within ninety days of the date of the initial claims submission, then the provider may bill the Connecticut Medical Assistance Program. The Department of Insurance file number is required on the W-1417 form and this form must be retained by the provider. If payment is received from an insurance carrier after the provider has submitted a claim to Gainwell Technologies with a Third Party Billing Attempt form, the provider must refund DSS the amount of the Connecticut Medical Assistance Program payment, perform a Web adjustment or submit a Paid Claim Adjustment Request (PCAR) or an electronic adjustment to have the claim recouped.

Submission	About the W-1417 Form
Instructions for Completing the Form	The Third Party Billing Attempt form pertains only to other insurance and cannot be used in place of a Medicare denial. All of the fields on this form should be completed. Failure to do so will result in a claim recoupment if the claim is audited. Indicate the other insurance carrier code, followed by "Not Applicable" and the date the Department of Insurance furnished the provider with a file number in the appropriate field on the claim form and submit it to Gainwell Technologies. The one (1) year timely filing limit will begin from the date the Department of Insurance furnished the provider with a file number. The following pages provide detailed instructions for completing the Third Party Billing Attempt, W-1417.



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105-3725

THIRD PARTY BILLING ATTEMPT

W-1417
(Rev. 9/15)

Please complete this form when other insurance has been billed, but you have not received a response within 90 days of the date the claim was billed and you have not received a denial statement.

DATE: _____

DATE SUBMITTED TO INSURANCE: _____

PROVIDER NAME: _____

NPI/PROVIDER IDENTIFIER #: _____

CLIENT NAME: _____

CLIENT MEDICAID #: _____

CLAIM DATES: _____

OTHER INSURANCE NAME AND CARRIER CODE: _____

PLEASE CHECK APPROPRIATE SITUATION

BILLED BUT NO RESPONSE _____

BILLED BUT DENIED WITH NO DENIAL RETURNED _____

OTHER _____ (Explain below)

EXPLANATION: _____

In requesting a Medicaid payment, the undersigned provider certifies that a dated notice of subrogation exists with Insurance Department File Number _____.

Provider Authorized Signature _____

Date _____

If an insurance payment for the service is received after Medicaid's payment is received, the provider agrees to remit the duplicate payment to DSS within thirty calendar days.

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Instructions for Completing the Third Party Billing Attempt (W-1417)

Instructions for Completing the W-1417 Form	
Field Name	Description
Date	Enter the current date.
Date Submitted To Insurance	Enter the date the claim was sent to the other insurance carrier.
Provider Name	Enter the provider's name.
NPI/Provider ID #	Enter the provider's NPI or non-medical provider identifier number.
Client Name	Enter the client's name as it is on the claim.
Client Medicaid #	Enter the client's Connecticut Medical Assistance Program ID number.
Claim Dates	Enter the date(s) of service from the claim.
Other Insurance Name And Carrier Code	Enter the other insurance carrier name and 3-digit carrier code. The list of carrier codes can be found through client eligibility verification on the provider secure Web site www.ctdssmap.com . The list of codes can also be found on the public Web site, www.ctdssmap.com , by selecting Information, then Publications and locating the links under Provider Manual Chapter 5, Additional Chapter 5 Information.
Please Check Appropriate Situation	Check one of the following situations: the carrier was billed and no response was received; the carrier was billed and the claim was denied with no denial returned; or another situation occurred. If another situation occurred, give a brief explanation in the Explanation space provided.
Insurance Department File Number	Enter the file number assigned to the subrogation notice on file with the Department of Insurance.
Provider Authorized Signature	Have the provider sign his/her full name.
Date	Enter the date the form is signed.

Potential Lawsuit Notification (W-80)

Submission	About the W-80 Form
Potential Lawsuit Notification	Providers are required to notify DSS of any request by a Connecticut Medical Assistance Program applicant, client, legally liable relative, or legal representative for copies of medical records for which the Connecticut Medical Assistance Program paid all or part of the bill. If this request occurs, the provider should complete Potential Lawsuit Notification, W-80.
How to Obtain the Form	Providers may obtain the form from the following address: Department of Social Services Supervisor, Duplicating 55 Farmington Avenue Hartford, CT 06105 Facsimile requests for forms may be submitted to (860) 424-4954.
Where to Send the Completed Form	Providers mail the completed Potential Lawsuit Notification, W-80 to the following address: Department of Social Services Resources and Recovery Division 55 Farmington Avenue Hartford, CT 06105
Instructions for Completing the Form	The following pages provide detailed instructions for completing the Potential Lawsuit Notification, W-80.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
W-80 (Rev. 9/15)

POTENTIAL LAWSUIT NOTIFICATION

Date _____

S.S. # _____

Department of Social Services
Fraud & Recoveries Unit
55 Farmington Avenue, 4th Floor Hartford, CT 06105-3725

To whom it may concern,

Pursuant to Connecticut General Statutes 17b-265, on the above date, the provider named below was contacted by:

NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

For Medical records of (Name of Medicaid client):

Medicaid ID # _____ for service date(s) _____ on which our records show Medicaid paid all or part of the bill. In the conversation, the contact indicated the records were to document a claim for (*check all that apply*):

_____ Automobile Insurance _____ Workers' Compensation _____ Other

The records have been provided to the requester.

Sincerely,

Provider Name

Provider Phone #

Printed on recycled or recovered paper

Instructions for Completing the Potential Lawsuit Notification (W-80)

Instructions for Completing the W-80 Form	
Field Name	Description
Date	Enter the current date.
S.S. #	Enter the social security number of the Medicaid client.
Name, Address, Telephone Number	Enter the name, address, and telephone number of the party who contacted the provider about obtaining copies of medical records for services paid by the Connecticut Medical Assistance Program.
For Medical Records Of (Name of Medicaid client)	Enter the client's name for which medical records were requested.
Medicaid ID #	Enter the client's Connecticut Medical Assistance Program ID number.
Service Date(s)	Enter the date(s) of service on which claims were paid by the Connecticut Medical Assistance Program.
(Check All That Apply): Automobile Insurance Workers Compensation Other	Indicate the type of insurance. If "Other," please specify.
Provider Name	Enter the provider's name.
Provider Phone #	Enter the provider's business telephone number.

Third Party Liability (TPL) Provider Accident Questionnaire

Submission	About the Accident Questionnaire
Accident Associated with a Claim	A TPL Provider Trauma Questionnaire is sent to a provider based on: • presence of an accident-related diagnosis on a paid claim or, • accident indicated by an occurrence code on a UB-04 claim form or, • accident indicator checked in Field 10 on the CMS-1500 claim form. When providers complete and return the TPL Provider Accident Questionnaire, DSS can investigate accident cases and identify third party liability insurance sources. If public funds were used to pay the claim, a provider is required to respond to DSS or Gainwell Technologies inquiries regarding potential liability situations. Failure of the provider to respond could result in the recoupment of public funds used to pay the claim.
Instructions for Completing the Form	The following pages provide detailed instructions for completing the TPL Provider Accident Questionnaire.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
TRAUMA QUESTIONNAIRE

DATE - MM/DD/CCYY

PROVIDER NAME - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER ADDRESS 1 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER ADDRESS 2 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CITY, STATE ZIP CODE - XXXXXXXXX, XX XXXXX-XXXX

PROVIDER NUMBER - XXXXXXXXXX ICN - XXXXXXXXXX DATE OF SERVICE - MM/DD/CCYY

CLIENT NAME - XXXXXXXXXXXXXXXXXXXXXXX,XXXXXXXXXXXXXXXXX,X

CLIENT ID - XXXXXXXXXX DOB - MM/DD/CCYY DIAGNOSIS CODE - XXXXXXXX

PATIENT ACCOUNT NUMBER - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

The Department of Social Services, through its fiscal agent, Gainwell Technologies, an authorized claims processing agent of the Connecticut Medicaid Program, is conducting a Federally mandated analysis of Medicaid Assistance claims that indicated services rendered resulted from:

- An accident related diagnosis,
- A condition related to an accident as indicated by box 10 of the HCFA 1500 claim form,
- A condition related to an accident as indicated by an occurrence code on the UB04 claim form.

Please answer the following question:

1. Were the services rendered as a result of an accident? _____
2. What was the date of the accident? _____
3. What was the cause of the injury/disability? _____

If the answer to question number 1 above is "No", please only return this form to Gainwell Technologies. No additional information is required.

Considering section 1902(a) (27) of the Federal Social Security Act requiring the release of records to a Medicaid agency and our legal status as an agent of the Connecticut Medical Assistance Program, **please send us a written narrative and/or medical record documentation. Other documentation not related to the accident is not required (e.g. EKGs, patient discharge orders, or follow up recommendations).** Return this form and any documentation via fax to 1-833-577-3519 or by mail to P.O. BOX 2981 HARTFORD, CT 06104. YOUR RESPONSE WILL IN NO WAY AFFECT THE PAYMENT OF YOUR CLAIM.

HIPAA PRIVACY NOTE: Pursuant to the HIPAA Privacy Rule, 45 C.F.R. 164.506, you as a covered entity may disclose a client's protected health information for purposes of treatment, payment, or health care operations without first obtaining an authorization from the client. Therefore, you may disclose the requested information to Gainwell Technologies, an agent of the Department of Social Services who is also a covered entity.

If you have any questions or concerns about the release of this information, please contact the Gainwell Technologies Provider Assistance Center at 1-800-842-8440.

Instructions for Completing the TPL Provider Accident Questionnaire

NOTE: The first thirteen fields are completed by Gainwell Technologies.

Information Provided on the Accident Questionnaire	
Field Name	Description
Date	MM/DD/YYYY Format
Provider Name	Lists the provider's name.
Provider Address 1	Lists the provider's address.
Provider Address 2	Lists the provider's additional address information (if applicable).
City, State, Zip Code	Lists the provider's city, state, and zip code.
Provider Number	Lists the provider's 9 digit AVRS ID.
ICN	Lists the 13 digit Internal Control Number (ICN) of the specific claim.
Date of Service	Lists the date the service took place in MM/DD/YYYY format.
Client Name	Lists the client's name.
Client ID	Lists the client's 9-digit Connecticut Medical Assistance Program ID number.
DOB	Lists the client's date of birth (DOB) in MM/DD/YYYY format.
Diagnosis Code	Lists the diagnosis code associated with service.
Patient Account Number	Lists the patient's account number.

NOTE: The next fields are completed by the provider.

Instructions for Completing the Accident Questionnaire

Field Name	Description
Please answer the following questions:	
1 Were the services rendered as a result of an accident?	Enter "yes" or "no".
2 What was the date of the accident?	Enter the date of the accident, in MM/DD/YY format, if "yes" was indicated in Question 1.
3 What was the cause of the injury/disability?	Enter the specific cause of the injury or disability.

5.4 Client Third Party Liability Update Procedures

Overview

If a client has health insurance or Medicare, this third party liability must be utilized prior to billing the Connecticut Medical Assistance Program. When rendering care, providers are encouraged to query clients or use the Automated Eligibility Verification System (AEVS) to identify and then pursue known client third party liability. Nonetheless, there are instances when a provider identifies a discrepancy between the Department's third party liability information (that is as found on AEVS) and what the client tells the provider; or of a difference in third party information for which the provider otherwise knows through their own health insurance verification processes. It is essential that the provider notify the Department's contractor, Health Management Systems, Inc (HMS) of these changes in order to avoid having Connecticut Medical Assistance Program claims unnecessarily denied for health insurance or Medicare reasons.

In this situation, the provider may use the TPL Information Form. HMS receives these forms, verifying the reported client third party information and transmitting to the Department the necessary additions, corrections or deletions that will be made to the client's third party liability record.

How to Obtain TPL Information Forms

Providers may obtain the TPL Information Form:

- Print the TPL Information Form located in the section below.
- Telephone HMS toll-free at 1-866-277-4271. HMS staff either mails or faxes the form to the provider.
- Submit a request via e-mail to ctinsurance@hms.com and the form is sent to the e-mail address supplied by the provider.

Where to Send Completed TPL Information Forms

Providers may mail completed forms to HMS at:

Health Management Systems, Inc.
Attn: CT Insurance Verification Unit
5615 High Point Dr, Suite 100
Irving, Texas 75038

OR

Providers may fax completed forms to HMS with a HIPAA compliant cover letter to 214-560-3932.

OR

Providers may e-mail by scanning a completed form(s) into a PDF file and sending through a HIPAA acceptable, secure/encrypted e-mail system to HMS at ctinsurance@hms.com.

Processing of TPL Information Forms	HMS verifies the client third party liability information and transmits any necessary additions, changes or deletions of the information to the Department. Concurrently, the provider should review the AEVS to confirm the change to a client's third party liability information.
How to Contact HMS	Providers may communicate to Health Management Systems <i>at any time</i> during this process. Providers may direct all operational calls and inquiries regarding the TPL Information Form to Health Management System's Insurance Verification Unit either at 1-866-277-4271, ctinsurance@hms.com, or in writing to: Health Management Systems, Inc. Attn: CT Insurance Verification Unit 5615 High Point Dr, Suite 100 Irving, Texas 75038
How to Communicate Difficulties with this Process or Suggest Changes	If providers are having difficulty with this process or want to suggest changes to this process, providers may supply this information in writing to: State of Connecticut Department of Social Services Division of Resources and Recoveries 55 Farmington Avenue Hartford, CT 06105 quality.dss@ct.gov
Instructions for Completing the TPL Information Form	The following pages provide detailed instructions for completing the TPL Information Form.

Today's Date:

**DEPARTMENT OF SOCIAL SERVICES
Connecticut Medical Assistance Program
TPL Information Form**

This form is used to communicate to the Department of Social Services that a client's health insurance information needs to be added or corrected. This applies to situations where either you believe the Department client health insurance or Medicare information is incorrect or needs a termination date, or you know of client third party information that does not appear to be on the Department's records. It is essential that you notify the Department of these changes in order to avoid having your Medicaid claims unnecessarily denied for health insurance or Medicare reasons.

Please complete as much of the following information as possible.

1 _____ Client's Name 3 _____ Insurance Carrier Name 5 _____ Policyholder First & Last Name 7 _____ Policyholder Date of Birth 8 Client's Relationship to the Insured (select one): ☐ Self ☐ Child ☐ Spouse ☐ Other _____ 10 _____ Policy Number (for client) 13 Medicare Coverage (select all that apply): ☐ Part A ☐ Part B 14 _____ Medicare Policy Number 17 Was this insurance information obtained via AEVS? ☐ Yes ☐ No 18 Please explain any discrepancy: _____	2 _____ Client ID (9 characters) 4 _____ Client Date of Birth 6 _____ Policyholder Social Security Number 9 _____ Group Number 11 ____/____/____ Policy Effective Date 12 ____/____/____ Policy Term Date (if applicable) 15 ____/____/____ Medicare Effective Date 16 ____/____/____ Medicare Term Date 19 _____ Provider Name 20 _____ NPI/Non- Medical Provider Identifier 21 _____ Contact Name 22 (____) ____-____ Contact Telephone Number 23 (____) ____-____ Contact Fax Number 24 _____@_____ Contact Email
---	--

The information on this form will be verified by Health Management Systems, Inc. (HMS). HMS will transmit to the Department of Social Services any necessary additions, changes or deletions, which will be made to this client's third party liability record. You should review the AEVS to check the status of this client's third party liability information.

Fax completed forms to: 214-560-3932 OR

Mail completed forms to:

HMS
Attn: CT Insurance and Verification Unit
5615 High Point Dr, Suite 100
Irving, TX 75038

Version: July 2015

Instructions for Completing the TPL Information Form

Field No.	Field Name	Description
-----	Today's Date	Enter the current date in the upper right hand corner.
1	Client's Name	Enter the client's name in the following format: Last, First, Middle Initial.
2	Client ID (9 characters)	Enter the client's 9-digit Connecticut Medical Assistance Program ID Number.
3	Insurance Carrier Name	Enter the private insurance carrier name.
4	Client Date of Birth	Enter the client's date of birth.
5	Policyholder First & Last Name	Enter the first and last name of the policyholder.
6	Policyholder Social Security Number	Enter the policyholder's social security number.
7	Policyholder Date of Birth	Enter the policyholder's date of birth.
8	Client's Relationship to the insured (select one): Self/Child/Spouse/ Other	Enter an "X" next to the option that describes the relationship of the client to the policyholder.
9	Group Number	Enter the policyholder's group number.
10	Policy Number (for client)	Enter the client's policy number. In many cases this will be the same as the policyholder, however please confirm that there is no difference.
11	Policy Effective Date	Enter the effective date of the policy coverage.
12	Policy Term Date (if applicable)	Enter the term date of the policy coverage.
13	Medicare Coverage (select all that apply): Parts A or B	Enter an "X" next to the type of Medicare coverage applicable to the client.
14	Medicare Policy Number	Enter the client's Medicare Number.
15	Medicare Effective Date	Enter the effective date of the Medicare Coverage.

Field No.	Field Name	Description
16	Medicare Term Date	Enter the end/term date of the Medicare coverage.
17	Was this insurance information obtained via AEVS?	Enter an "X" next to the appropriate response.
18	Please explain any discrepancy:	Enter the information that was in conflict with the AEVS response or other sources of information.
19	Provider Name	Enter the billing provider's name.
20	NPI/Non-Medical Provider Identifier	Enter the billing provider's NPI/Non-Medical provider identifier.
21	Contact Name	Enter the name of the person who should be contacted should questions arise (usually the person filling out the form).
22	Contact Telephone Number	Enter the telephone number of the contact person.
23	Contact Fax Number	Enter the fax number of the contact person.
24	Contact E-mail	Enter the e-mail address of the contact person.

5.5 Return to Provider Letter

Overview

The Return to Provider (RTP) letter is initiated by Gainwell Technologies and sent to providers when the submitted paper claim or paper Paid Claim Adjustment Request (PCAR) form has missing or invalid information and cannot be submitted for processing. As noted in this chapter's overview, as of October 1, 2016, DSS no longer accepts paper claims with exception to OOS providers and special handled claims. All medical provider claims submitted without an NPI and Taxonomy cannot be processed by Gainwell Technologies. Non-medical provider claims must have a Medicaid Provider Identifier in order to be processed. All claims must have a Medicaid Client ID.

Types of Return to Provider Letters

Gainwell Technologies may send one of the following types of RTP letters to the provider, depending on the type of form and its destination.

- PCAR RTP letter
- Claim RTP letter
- RTP letter from the Gainwell Technologies Written Correspondence Unit

Addressing Errors

Before the claim or PCAR can be processed, the provider must correct the error(s) addressed in the RTP letter, which is attached to the returned claim or PCAR.

If the provider cannot resolve the issue(s) by referring to their Provider Manual, Chapter 8 for claim submission or Chapter 5 for PCAR instructions, additional assistance is available by calling the Gainwell Technologies Provider Assistance Center toll free at 1-800-842-8440, Monday through Friday, excluding holidays, 8:00 a.m. – 5:00 p.m. EST.

Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information. The number is 1-866-604-3470.

The claim or PCAR that has been returned with the RTP letter will not appear in the Connecticut interChange Medicaid Management Information System (MMIS), as it cannot be processed. RTP letters cannot be used to override timely filing. Providers should not bill the Medicaid client upon receipt of the RTP letter.

Upon receiving the returned paper claim or PCAR and RTP letter, the provider can:

- submit an electronic claim with all the necessary information by accessing the Web site at www.ctdssmap.com or
- return the paper claim or PCAR to Gainwell Technologies.

If the corrections are not made and the claim is resubmitted, the claim will be returned to the provider with another RTP letter attached.

5.6 Timely Filing Guidelines

Claim Requirements

Provider Responsibility	It is the provider's responsibility to ensure that all claims for services provided to a client are submitted within one (1) year from the actual date of service as described in the following section titled Exceptions to the Timely Filing Limit. Providers are advised to research and resolve all claim issues by reviewing the Connecticut Medical Assistance Program Remittance Advice (RA) each time it is sent to the provider.
Processing Claims Beyond the Timely Filing Limit	Claims sent to Gainwell Technologies beyond the timely filing limit are processed as follows: • If the claim has invalid documentation to override the timely filing limit, the claim will appear on a Remittance Advice (RA) with the Explanation of Benefits EOB message "Claim exceeds timely filing limit". Providers are no longer required to submit claims on paper that exceed timely filing when documentation exists that waive the timely filing limit, such as one year from the paid date (claim cycle date), other insurance carrier's Explanation of Benefits (EOB), or Explanation of Medicare Benefits (EOMB), with the exception of pharmacy services with a valid RA, EOB, or return to provider (RTP) date.
Other Insurance/Medicare	For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.

*As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.

Exceptions to the Timely Filing Limit

DSS has directed Gainwell Technologies to waive the timely filing limit if the following conditions exist. **Claims do not need to be submitted on paper** to override the timely filing rule unless the claim is for pharmacy services. Pharmacy services must be submitted on paper with a valid RA, EOB, or RTP attached. For all other exceptions, Gainwell Technologies will validate that the condition exists to override timely filing via the data submitted on the claim and the provider's past claim submission history. The conditions that waive the timely filing limit are explained below.

*As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.

Benefit Plan	Conditions that Waive the Timely Filing Limit
HUSKY, A, HUSKY B, HUSKY C and HUSKY D	For medical, dental, FQHC, or behavioral health services : - Providers have one (1) year from the paid date (claim cycle date) indicating a denial to resubmit the claim, provided the denial was <u>not</u> for timely filing. - The date of service on the claim must fall within one (1) year of the issue date on the other insurance denial, providing the denial was <u>not</u> for timely filing. A copy of the carrier's Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) must be retained by the provider in the client's file. - The provider has one (1) year from the date the client's eligibility was added to the Connecticut interChange Medicaid Management Information System (MMIS) eligibility file to submit the claim. - The provider has one (1) year from the Nursing Home authorization pay start date if authorization was added to the Connecticut interChange MMIS system after the through date of service. For pharmacy services: - The provider has one (1) year from the dispense date of the medication to resubmit the claim.

Benefit Plan	Conditions that Waive the Timely Filing Limit
All – Retroactive	Providers may contact the Gainwell Technologies Provider Assistance Center to obtain add dates for retroactive client eligibility and retroactive pay start authorizations for Nursing Home providers.
All - Adjustments	A paper PCAR is no longer required to return funds via a claim adjustment. Providers may submit an electronic adjustment or Web claim adjustment to return funds without the claim denying in full for timely filing.

5.7 Medicare Coinsurance and/or Deductible Claim Submission

Overview

A Medicare coinsurance and/or deductible claim is a claim that is submitted to Gainwell Technologies for processing Medicare coinsurance and/or deductible amounts for a Connecticut Medical Assistance Program client. When Medicare has allowed the claim, this type of claim is referred to as a “crossover claim”. When Medicare has denied a claim, it is no longer a “crossover claim”, it is a straight Medicaid claim.

When a client has both Medicare and Medicaid coverage, the provider must submit a claim to Medicare for a covered service **before** submitting the charges to Medicaid. Refer to Chapter 4, Client Eligibility, for instructions on how to determine if a client has Medicare coverage.

For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.

Automated Claims

The Centers for Medicare & Medicaid Services (CMS) has obtained the services of a Coordination of Benefits Contractor (COBC) that will receive claims from all Medicare Part A intermediaries and Medicare Part B carriers and automatically submit a Medicare paid claim for a client who also has Medicaid coverage and an unpaid coinsurance or deductible amount to Gainwell Technologies for processing. Only claims that have been allowed by Medicare will be submitted to Gainwell Technologies for processing. Claims with a Medicare denial will not be automatically sent to Gainwell Technologies for processing.

If a service is covered by Medicare, the provider must submit the claim to the Medicare intermediary or carrier. The claim must be on the appropriate claim form or in the ASC X12N 837 electronic claim submission format specified by the intermediary or carrier.

Requirements for Automated Submission	To ensure that the claim is selected for automated submission to Gainwell Technologies, providers must adhere to their intermediary or carrier's secondary coverage requirements for Medicare claim submission. Providers should identify all secondary coverage information on each Medicare claim submitted on paper or electronically. If this information is not identified on the Medicare claim, the claim may not be selected for automated submission to Medicaid. Questions regarding requirements should be directed to your Medicare intermediary or carrier.
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Processing Automated Claims

Once Medicare processes the claim, the Medicare COBC forwards any coinsurance or deductible portion to Gainwell Technologies for processing. Once the provider receives payment from Medicare, allow at least forty-five (45) days for the coinsurance or deductible claim to appear on the Connecticut Medical Assistance Program Remittance Advice (RA).

Payment of these coinsurance and/or deductible claims is shown on the Connecticut Medical Assistance Program RA the same as non-crossover claims. Crossover claims are identified by the coinsurance and deductible listed on the claim detail. The claim is identified on the RA by the client's name, Connecticut Medical Assistance Program client ID number, the date of service, the billed amount, and the Connecticut Medical Assistance Program paid amount.

A crossover claim from Medicare is denied if an additional third party carrier for the client is known to DSS.

Coinsurance or Deductible Claims Requiring Manual Claim Submission

Claim Type/Payment	Manual Submission Information
Not Processed within 45 Days	If a coinsurance or deductible claim is not processed within forty-five (45) days of the Medicare payment, the provider should submit a claim. Claims for coinsurance and/or deductible may be submitted electronically with vendor or Gainwell Technologies's Provider Electronic Solutions software (long term care claims only), via the www.ctdssmap.com secure Provider Web portal or on *paper. When submitting a *paper claim, providers must submit the claim information on an original (red) *paper claim form, with the Connecticut Medical Assistance Program Client ID and NPI/Taxonomy or non-medical provider identifier in the appropriate fields. A copy of the Explanation of Medicare Benefits (EOMB) must be attached to the claim. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.
Denied Claims	Only paid Medicare claims with coinsurance and/or deductible due are forwarded systematically to Gainwell Technologies for processing. Denied claims must be submitted directly to Gainwell Technologies electronically or on a *paper claim form following the claim submission procedures outlined in Chapter 8. A copy of the Explanation of Medicare Benefits (EOMB) should NOT be attached to the claim. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.
Medicare Claims from Clinic and Behavioral Health Clinician Providers	If Clinic Providers allow performers who are not eligible to enroll in the Medicare program to service dually eligible clients or Behavioral Health Clinicians provide services to dually eligible clients, then the clinic or behavioral health clinician must obtain a denial letter indicating the categories of clinicians who are not eligible to enroll with Medicare. The letterhead of the 'not eligible to enroll' denial

Claim Type/Payment	Manual Submission Information
	letter must clearly state CMS or Medicare. Medicare 'not eligible to enroll' denial letters must be updated annually with the issue date of the letter within one year of the date(s) of service on the claim. The providers' name must also be on the letter for future audit purposes. To request this letter, providers must submit a request in writing to: National Government Services (NGS) PO Box 7052 Indianapolis, Indiana 46207-7052 The 'not eligible to enroll' denial letter must be retained by the provider in the client's file. The provider must indicate Medicare Not Applicable and the date of the letter on the claim form. In lieu of the Medicare 'Not Eligible To Enroll' denial letters for clinic services requested through NGS, providers may submit a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation. The list is documented in the Medicare Provider Integrity Manual, Publication # 100-8, under Chapter 15, Section 15.4.8 which is located on the CMS Web site, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf. A copy of this page must be stored in the client's file for audit purposes and does not need to be submitted with the claim to Gainwell Technologies. The Medicare denial date submitted on the claim would represent the date the documentation was printed. Each year the provider must validate this list to ensure it continues to be valid documentation for future claims.

Claim Type/Payment	Manual Submission Information
Medicare Claim That Did Not Automatically Crossover	When a coinsurance and/or deductible claim does not automatically cross over electronically, it is necessary for the provider to submit a coinsurance and/or deductible claim to Gainwell Technologies. The provider can submit the claim electronically using a commercial vendor, Gainwell Technologies's Provider Electronic Solutions software (long term care claims only) or via the www.ctdssmap.com secure Provider Web portal. Alternatively, the claim may be submitted on *paper to the Connecticut Medical Assistance Program on the appropriate Medicare original (red) claim form. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.
*Paper Claim Submission Requirements	For Medicare Payments For coinsurance and/or deductible claims that are submitted on *paper, providers must submit one *paper claim attached to one EOMB and the claim must be submitted on an original (red) *paper claim form. Claims with multiple EOMBs attached to one claim or multiple claims attached to one EOMB will not be processed and will be returned to the provider. In addition, the information on the *paper claims must be the same information submitted to Medicare. The following information must be exactly the same on the *paper claim and on the EOMB: • Patient Name • Detail dates of service • Procedure codes and modifiers, if any • Units • Billed amounts (each line). The number of lines submitted on the claim must have corresponding lines on the EOMB. Columns that indicate Medicare billed amount, allowed amount, paid amount, coinsurance and deductible must appear on the EOMB. Only HIPAA values for Facility Type Code and procedure codes, including modifier(s) are accepted on *paper. All other claim submission requirements, such as Connecticut Medical Assistance

Claim Type/Payment	Manual Submission Information
	Program Client ID and NPI/Taxonomy or non-medical provider identifier(s), remain the same. For Medicare Denials For Medicare denials, the provider must indicate that Medicare was not applicable and indicate the date of the EOMB on the claim. A copy of the Medicare denial should NOT be attached to the claim. Field by field claim submission instructions for Medicare payments and denials can be found in Chapter 8 in the Provider Manual. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type. *As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.
Claim Payment	Pursuant to the provisions of Section 4714 of the Balanced Budget Act amending Section 1902 (n) of the Social Security Act Medicare crossover coinsurance and/or deductible claims will be paid at the lesser of either the coinsurance and/or deductible amount submitted or the Medicaid-allowed amount minus any Medicare payment. If a provider receives a third party payment equal to, or greater than, the Connecticut Medical Assistance Program maximum allowed amount for the same service, no further payment will be made by the Connecticut Medical Assistance Program. In this latter case, the provider may not collect the balance from the client, financially responsible relative, or representative of that client.
Medicare Health Maintenance Organization	It is the providers' responsibility to determine if the Explanation of Benefits (EOB) is a Medicare Health Maintenance Organization (HMO) or Third Party Liability (TPL) attachment. When it has been determined that the EOB is for a Medicare HMO, and the Medicare HMO has made a payment, any coinsurance, deductible, copayment, or member responsibility amount indicated on the EOB can be submitted to Gainwell Technologies for processing. The provider can submit the claim electronically using a commercial vendor, Gainwell Technologies's Provider Electronic Solutions

Claim Type/Payment	Manual Submission Information
	software (long term care claims only) or via the www.ctdssmap.com secure Provider Web portal. Alternatively, the claim may be submitted on *paper to the Connecticut Medical Assistance Program on the appropriate Medicare original (red) claim form. Please refer to Chapter 1 for information on where to submit those *paper claims. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the appropriate chapter based on claim type.

*As of October 1, 2016, DSS does NOT accept claims submitted on paper with exception to OOS providers and special handled claims.

5.8 Behavioral Health Services Claim Submission

Connecticut Behavioral Health Partnership (CT BHP)

Overview	Claims for services provided under the Connecticut Behavioral Health Partnership (CT BHP) for HUSKY A, HUSKY B, HUSKY C, HUSKY D, and DCF funded clients must be submitted to Gainwell Technologies for processing. Effective October 1, 2016, the Department of Social Services (DSS) no longer accepts paper claims. The only exceptions to this mandate are claims submitted on paper from Out of State (OOS) providers as well as the following special handled claims. Claims with Attachments to support Requests for Timely Filing Override, including Other Insurance: Gainwell Technologies P.O. Box 2971 Hartford, CT 06104 Any other claims submitted on paper that do not meet the exception criteria are shredded.
Connecticut Behavioral Health Partnership (CT BHP) Behavioral Health Services – (Cont'd)	HUSKY A, HUSKY B, HUSKY C, or HUSKY D benefit plan covered services and payment rates can be accessed through the Web site www.ctdssmap.com or the CT BHP Web site at www.ctbhp.com. From the Web page www.ctdssmap.com, go to “Provider”, then to “Provider Fee Schedule Download”. You will need to accept the end user license agreement by clicking on “I Accept” and then select “Behavioral Health Psychologist” or “Behavioral Health Clinician”. Please note that “Behavioral Health Clinician” includes LCSWs, LMFTs, LPCs, and LADCs. From the CT BHP Web site at www.ctbhp.com, go to “For Providers”, “Provider Resources” then to “Covered Services” and select “Covered Services/Fees” for the HUSKY Health Program, and select the applicable bulleted item.

5.9 Provider Remittance Advice and Electronic Funds Transfer (EFT)

Overview – Remittance Advice

All claims processed by Gainwell Technologies are reported to the provider on a bimonthly Remittance Advice (RA).

Availability

Providers receive RAs electronically via the secure Provider Web site at www.ctdssmap.com. RA's are available in either the ASC X12N 835 Payment/Advice standard transaction format or in the Portable Document Format (PDF) which provides the paper RA version.

The PDF RA via the secure Provider Web site will be available to providers on the check date indicated on the financial cycle schedule. The cycle schedule may be downloaded from the Web site portal under Provider > Provider Services. The provider will have access to their last ten (10) RAs.

The ASC X 12N 835 Payment/Advice via the Secure Provider Web site will be available the Wednesday following each claims processing cycle. The last ten (10) 835 Payment/Advices will be available.

Gainwell Technologies encourages providers to save a copy of their ASC X12N 835 Payment/Advice and/or their PDF RAs to their local computer system for future access, since **only the last ten (10) RAs are maintained on the Gainwell Technologies Web site**. RAs older than the last ten (10) will no longer be available.

Access to RAs

In order to access remittance advices providers will use an ID issued upon enrollment into the Medical Assistance Program. The provider can maintain clerk IDs through the secure Web site portal at www.ctdssmap.com > Provider > Secure Site. Passwords will be set by the provider on the secure portal on their first log in. Attempting to log in with six invalid passwords, or if 90 days lapsed since you last logged in, your password will become inactive. If this occurs, please contact the Provider Assistance Center at 1-800-842-8440 to have the password reset. Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information. The number is 1-866-604-3470.

To access the RA, go to our Web site www.ctdssmap.com and log onto the secure Web portal. Click Download Remittance Advice from the Quick Link box on the account home screen and this will give you the PDF format to download. Another way to access the PDF RA when on the secure Web portal is to locate "Trade Files" and choose "Download" from the drop down menu. Select "Remit. Advice (RA) - PDF" from the "Transaction Type" on the File Download Search screen. This will populate the current files available to download.

About RAs

For information about the ASC X12N 835 Payment/Advice, refer to Chapter 6, Electronic Data Interchange Options. PDF RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider's claim activity. The RA also contains information on processed financial transactions. It contains the following seven (7) sections:

- Banner Page
 - Claims Information (Paid, Denied, and Adjustments)
 - Financial Transactions Processed
 - Explanation of Benefits (EOB) Code Descriptions
 - Third Party Liability (TPL) Information
-

- Remittance Advice Summary
- Claims in Process

RAs are an important provider claim-tracking device. Tracking claim submissions to final resolution is a critical aspect of office management procedures. Claim transactions should be reconciled after receiving the RA statement.

The following pages contain an overview of the layout of the RA, including examples and descriptions of the seven sections listed above. Field numbers, field names, and field descriptions for the RA are listed.

Remittance Advice Layout Header and Banner Messages

Fields 1 through 10 are the Remittance Advice Layout Header which is provided at the top portion of all RA sections. The first page of the RA is the Banner Page. It is used to print messages to providers. Official notices from the Department of Social Services (DSS) or announcements from Gainwell Technologies appear here. Providers are advised to read these messages carefully.

REPORT: CRA-BANN-R	1	interchange MMIS	4	DATE: MM/DD/CCYY
RA#: 999999999	2	MEDICAID MANAGEMENT INFORMATION SYSTEM	5	PAGE: 9,999
		PROVIDER REMITTANCE ADVICE		
		3 BANNER MESSAGES		
Any Provider			7	PAYEE ID NPI XXXXXXXXXXXXXXXX
123 Main Street	6		8	ISSUE DATE MM/DD/CCYY
Anytown, CT 12345-1234			9	TAXONOMY XXXXXXXXXXXX
			10	P. AVRS ID 999999999
11 SUBJECT: Effective January 25, 2008 the Department of Social Service is implementing a new Web portal for provider self-service functions including claims submission, eligibility verification, claims adjustment and more. Attend a provider workshop to learn how to maximize the Web portal for your practice. Visit www.ctdssmap.com for Provider Workshop schedules.				

Number	Name	Description
1	Report	Gainwell Technologies internal report name.
2	RA #	This is the Remittance Advice Number which is a unique identifier assigned to the remittance advice.
3	Report Title	Title of the report.
4	Report Date	Date of the report.
5	Report Page	The page number of the Remittance Advice.
6	Address	The 'Pay To' Name and mailing address of the Payee.
7	Payee ID	This is the Provider identification number and type of number that uniquely identifies the provider in the MMIS interChange system. There are multiple types of IDs assigned to a provider; the most common will be the National Provider ID (NPI) and the Non-medical provider identifier (atypical) for those providers who do not have an NPI. The Provider identifier will be preceded by the type of provider ID being displayed on the RA in this field. NPI will appear for the National Provider Identifier and MCD will appear for a Non-medical provider identifier.
8	Issue Date	This is the date the payment was issued.
9	Taxonomy	The Primary Taxonomy code of the payee.
10	P. AVRS ID	The provider's Automated Voice Response System ID.
11	Subject	Banner heading with text message following.

**Claims Information and
Adjustments**

This section of the RA lists paid and denied claims and/or adjustments adjudicated within the payment cycle. The claims are sorted by claim type. Within claim type, claims are sorted by claim status (that is paid, denied, adjustments, and in process claims) and then by internal control number (ICN) within each claim status section.

The following pages are examples of Remittance Advices for the following types of providers:

- Providers who submit on a UB-04 claim form-Inpatient Claim
- Providers who submit on a CMS-1500 claim form
- Dental providers
- Long Term Care providers
- Pharmacy providers

NOTE: Rather than duplicate the Paid, Denied, and Adjustment Remittance Advice for each provider type; the examples provided are illustrated for UB-04 beginning on the following page.

The Remittance Advice - Inpatient Claims Paid report lists Inpatient claims that were paid. The report is separated by individual claims. Pertinent Explanation of Benefit (EOB) codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the acute inpatient provider a list of all inpatient claims that were paid along with explanations on any discrepancies between the billed and the paid amount.

[illegible]

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	Attending Prov	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
4	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
5	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
6	Days	This is the number of days the provider is billing for.
7	Admit Date	This is the date the client was admitted into the hospital or nursing home.
8	Billed Amt	This is the dollar amount billed by the provider for the claim.
9	Allowed Amt	This is the computed allowable dollar amount for the specified client.
10	Deduct Amount	This field will be blank.

Number	Name	Description
11	Co-ins Amount	This field will be blank.
12	Copay Amt	This is the dollar amount that is the client's responsibility and is deducted from the allowed amount to arrive at the paid amount.
13	TPL Amt	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the client's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.
14	Paid Amt	This is the dollar amount that is payable for the claim.
15	Pat Acct Num	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes.
16	Client Name	The first and last name of the client.
17	Client No.	The client's Connecticut Medical Assistance Program identification number.
18	DRG	The unique 3 digit APR DRG (Diagnosis Related Group) code and 1 digit Severity of Illness code assigned to the claim.
19	Header EOBS	These are the claim Header Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.
20	Rev Cd	These are the revenue center codes that pertain to the services being billed on the detail lines.
21	HCPCS/Rate	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue center codes on each of the detail lines being billed.
22	Srv Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the client.
23	Units	This shows the units of service rendered.
24	Billed Amt	This is the dollar amount billed by the provider at the detail level of the claim.
25	Alwd Amt	This is the computed allowable dollar amount at the detail.

Number	Name	Description
26	Detail EOBS	These are the Explanation of Benefit codes for the corresponding detail line.
27	Total Inpatient Claims Paid - Billed Amt	The total billed amount of all the Inpatient Claims.
28	Total Inpatient Claims Paid - Allowed Amt	The allowed amount total of all the Inpatient Claims.
29	Total Inpatient Claims Paid – Deduct Amt	This field will be blank.
30	Total Inpatient Claims Paid – Co-ins Amt	This field will be blank.
31	Total Inpatient Claims Paid - Copay Amt	The total of all co-pay amounts for the Inpatient Claims paid.
32	Total Inpatient Claims Paid - TPL Amt	The total of all TPL amounts for the Inpatient Claims paid.
33	Total Inpatient Claims Paid - Paid Amt	The total of all the Inpatient Claims paid.

The Remittance Advice - Inpatient Claims Denied report lists Inpatient claims that were denied. The report is separated by individual claims and displays header data only. Pertinent EOB codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the acute inpatient provider a list of all inpatient claims that were denied along with an explanation as to why they were denied.

[illegible]

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	ICN	This is a unique number used to identify and track a claim processed through the system.
2	Attending Prov	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
3	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
4	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
5	Days	This is the number of days the provider is billing for.
6	Admit Date	This is the date the client was admitted into the hospital or nursing home.
7	Billed Amount	This is the dollar amount billed by the provider for the claim.
8	Deduct Amount	This field will be blank.
9	Co-ins Amount	This field will be blank.
10	TPL Amount	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the client's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.
11	Patient Acct Num	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes.
12	Client Name	The first and last name of the client.
13	Client No.	The client's Connecticut Medical Assistance Program identification number.
14	DRG	The unique 3 digit APR DRG (Diagnosis Related Group) code and 1 digit Severity of Illness code assigned to the claim.
15	Header EOBS	These are the claim Header Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.

Number	Name	Description
16	Rev Cd	These are the revenue center codes that pertain to the services being billed on the detail lines.
17	HCPCS/Rate	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue center codes on each of the detail lines being billed.
18	Srv Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the client.
19	Units	This shows the units of service rendered.
20	Billed Amt	This is the dollar amount billed by the provider at the detail level of the claim.
21	Detail EOBS	These are the Explanation of Benefit codes for the corresponding detail line.
22	Total Inpatient Claims Denied - Billed Amt	The total billed amount of all the Inpatient Claims that denied.
23	Total Inpatient Claims Denied – Deduct Amt	This field will be blank.
24	Total Inpatient Claims Denied – Co-Ins Amt	This field will be blank.
25	Total Inpatient Claims Denied - TPL Amt	The total of all TPL amounts for the Inpatient Claims that denied.

Remittance Advice - Inpatient Claim Adjustments – UB-04

The Remittance Advice - Inpatient Claim Adjustments report lists Inpatient claims that were adjusted. The report is separated by individual claims. It displays header data for both the claim being adjusted (Original) and the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the acute inpatient provider a list of all inpatient claims that were adjusted along with explanations on why the claims were adjusted.

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REPORT:   CRA-IPAD-R
RA#:      999999999

                                interChange MMIS
                                MEDICAID MANAGEMENT INFORMATION SYSTEM
                                PROVIDER REMITTANCE ADVICE
                                INPATIENT CLAIM ADJUSTMENTS

                                DATE:   MM/DD/CCYY
                                PAGE:   9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX

1 2 3 4 5 6 7 8 9 10 11 12 13 14
FP --ICN-- ATTEND PROV SERVICE DATES DAYS ADMIT BILLED ALLOWED DEDUCT
15 --PATIENT NUMBER-- FROM THRU DATE DATE AMT AMT AMT AMOUNT
CO-INS CO-PAY TEL PAID
AMOUNT AMT AMT AMT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXXX DRG: XXXX
X RRYJJJBESSS XXX XXXXXXXXXX MMDDYY MMDDYY 999 MMDDYY (9,999,999.99) (9,999,999.99) (9,999.99) (9,999.99)
(9,999.99) (9,999,999.99) (9,999,999.99) (9,999,999.99)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X RRYJJJBESSS XXX XXXXXXXXXX MMDDYY MMDDYY 999 MMDDYY 9,999,999.99 9,999,999.99 99,999.99 99,999.99
9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99

19
HEADER EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
20
REV CD HCPCS RATE SRV DATE UNITS BILLED AMT ALWD AMT DETAIL EOB
21 22 23 24 25 26
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
TOTAL NO. ADJUSTMENTS 999,999 27
TOTAL INPATIENT ADJUSTMENT CLAIMS PAID: 99,999,999.99 99,999,999.99 9,999,999.99 9,999,999.99 99,999,999.99 99,999,999.99
28 29 30 31 32 33 34

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Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is the unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.
3	Attend Prov	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
4	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY) The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.
5	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY) The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.
6	Days	This is the number of days the provider is billing for.
7	Admit Date	This is the date the client was admitted into the hospital or nursing home.

Number	Name	Description
8	Billed Amt	This is the dollar amount billed by the provider for the claim. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
9	Allowed Amt	This is the computed allowable dollar amount for the specified client. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
10	Deduct Amount	This field will be blank.
11	Co-ins Amount	This field will be blank.
12	Copay Amt	This is the dollar amount that is the client's responsibility and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
13	TPL Amt	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the client's stay. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
14	Paid Amt	This is the dollar amount that is payable for the claim. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
15	Patient Number	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.
16	Client Name	The first and last name of the client.
17	Client No.	The client's Connecticut Medical Assistance Program identification number.
18	DRG	The unique 3 digit APR DRG (Diagnosis Related Group) code and 1 digit Severity of Illness code assigned to the claim.

Number	Name	Description
19	Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.
20	Rev Cd	These are the revenue center codes that pertain to the services being billed on the detail lines.
21	HCPCS/Rate	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue center codes on each of the detail lines being billed.
22	Srv Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the client.
23	Units	This shows the units of service rendered.
24	Billed Amt	This is the dollar amount billed by the provider at the detail level of the claim.
25	Allowed Amt	This is the computed allowable dollar amount for the detail of the claim.
26	Detail EOBS	These are the Explanation of Benefit codes for the corresponding detail line.
27	Total No. Adjustments	This is the total number of all claims adjusted for the current financial cycle.
28	Total Inpatient Claims Adjustments - Billed Amt	The total billed amount of all the Inpatient Claims.
29	Total Inpatient Claims Adjustments - Allowed Amt	The allowed amount total of all the Inpatient Claims.
30	Total Inpatient Claims Adjustments – Deduct Amt	This field will be blank.
31	Total Inpatient Claims Adjustments – Co-Ins Amt	This field will be blank.
32	Total Inpatient Claims Adjustments - Co-pay Amt	The total of all co-pay amounts for the Inpatient Claims.
33	Total Inpatient Claims Adjustments - TPL Amt	The total of all TPL amounts for the Inpatient Claims Adjustments.

Number	Name	Description
34	Total Inpatient Adjustment Claims Paid	The total paid amount of all the Inpatient Claims Adjustments.

The Remittance Advice – Home Health Claims Paid report lists Home Health claims that were paid. The report is separated by individual claims. Pertinent Explanation of Benefit (EOB) codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the home health provider a list of all claims that were paid along with explanations on any discrepancies between the billed and the paid amount.

REPORT: CRA-HHPD-R		interChange MMIS		MEDICAID MANAGEMENT INFORMATION SYSTEM		PROVIDER REMITTANCE ADVISE		HOME HEALTH CLAIMS PAID		DATE: MM/DD/CCYY	
RA#: 999999999										PAGE: 9,999	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX										PAYEE ID XXX XXXXXXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX										ISSUE DATE MM/DD/CCYY	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX										TAXONOMY XXXXXXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX										P. AVRS ID 999999999	
1	2	3	4	5	6	7	8	9	10	11	
FP	--ICN--	ATTEND PROV.	SERVICE	DATES	BILLED	ALLOWED	TPL	COPAY	PATIENT	PAID	
13	--PATIENT NUMBER--	12	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	LIABILITY	AMOUNT	
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX										CLIENT NO.: XXXXXXXXXXXXXXX	
X RRYVJJJBBBBSSS XXX XXXXXXXXXXXXXXXX MMDDYY MMDDYY										9,999,999.99 9,999,999.99 9,999,999.99 999,999.99 9,999,999.99 9,999,999.99	
15 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX											
HEADER EOB5: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999											
16	17	18	19	20	21	22	23				
REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	ALWD AMT	DETAIL EOB5				
999	XXXXXXX	MMDDYY	XX XX XX XX	999999.99	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999				
999	XXXXXXX	MMDDYY	XX XX XX XX	999999.99	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999				
999	XXXXXXX	MMDDYY	XX XX XX XX	999999.99	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999				
999	XXXXXXX	MMDDYY	XX XX XX XX	999999.99	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999				
999	XXXXXXX	MMDDYY	XX XX XX XX	999999.99	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999				
TOTAL HOME HEALTH CLAIMS PAID:										99,999,999.99 99,999,999.99 99,999,999.99 9,999,999.99 99,999,999.99 9,999,999.99	

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	Attend Prov	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
4	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
5	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
6	Billed Amt	This is the dollar amount billed by the provider for the claim.
7	Allowed Amt	This is the computed allowable dollar amount for the specified client.
8	TPL Amt	This is the dollar amount paid by third party sources other than the Connecticut Medical Assistance Program for the client's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.
9	Copay Amt	This is the dollar amount that is the client's responsibility and is deducted from the allowed amount to arrive at the paid amount.

Number	Name	Description
10	Patient Liability	This is the patient liability amount that the client is responsible for paying. This amount is obtained from the client's patient liability information and is subtracted from the allowed amount to arrive at the paid amount.
11	Paid Amt	This is the dollar amount that is payable for the claim.
12	Patient Number	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.
13	Client Name	The first and last name of the client.
14	Client No.	The client's Connecticut Medical Assistance Program identification number.
15	Header EOBS	These are the claim Header Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.
16	Rev Cd	These are the revenue center codes that pertain to the services being billed on the detail lines.
17	HCPCS/Rate	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue center codes on each of the detail lines being billed.
18	Srv Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the client.
19	Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.
20	Units	This shows the units of service rendered.
21	Billed Amt	This is the dollar amount billed by the provider at the detail level of the claim.
22	Alwd Amt	This is the computed allowable dollar amount at the detail.
23	Detail EOBS	These are the Explanation of Benefit codes for the corresponding detail line.
24	Total Home Health Claims Paid - Billed Amt	The total billed amount of all the Home Health Claims.

Number	Name	Description
25	Total Home Health Claims Paid - Allowed Amt	The allowed amount total of all the Home Health Claims.
26	Total Home Health Claims Paid - TPL Amt	The total of all TPL amounts for the Home Health Claims paid.
27	Total Home Health Claims Paid - Copay Amt	The total of all co-pay amounts for the Home Health Claims paid.
28	Total Home Health Claims Paid – Patient Liability Amt	The total of Patient Liability amounts for all the Home Health Claims paid.
29	Total Home Health Claims Paid - Paid Amt	The total of all the Home Health Claims paid.

Remittance Advice – CMS-1500 Claims Paid

This Remittance Advice – CMS 1500 Claims Paid report lists CMS-1500 claims that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes and EOB descriptions are also displayed on this report. The purpose of this report is to give professional providers a list of all CMS-1500 claims that were paid along with explanations on any differences between the billed and the paid amount.

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REPORT:   CRA-PHPD-R                               interChange MMIS
RA#:      999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM
                                                PROVIDER REMITTANCE ADVICE
                                                CMS 1500 CLAIMS PAID

DATE:     MM/DD/CCYY
PAGE:     9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX

1  2  3  4  5  6  7  8  9  10  11  12  13
FP --ICN-- SERVICE DATES BILLED ALLOWED DEDUCT CO-INS TPL CO-PAY APPLIED PAID CLIENT
14 15 16 17 18 19 20 21 22 23 24 25 26 27
--PATIENT NUMBER-- FROM THRU AMOUNT AMOUNT AMOUNT AMOUNT AMOUNT AMOUNT INCOME AMOUNT CONTR.
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999
X RRYJJJBBBBSSS MMDDYY MMDDYY 9,999,999.99 9,999,999.99 99,999.99 99,999.99 999,999.99 99,999.99 9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
17
HEADER EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

18 19 20 21 22 23 24 25 26 27
PL SERV PROC CD MODIFIERS UNITS SERVICE DATES RENDERING BILLED ALLOWED
XX XXXXXX XX XX XX XX 999999.99 MMDDYY MMDDYY XXXXXXXXXXXXXXXXXXXX 9,999,999.99 9,999,999.99
9999 9999 9999 9999 9999 9999 9999 9999 9999
XX XXXXXX XX XX XX XX 999999.99 MMDDYY MMDDYY XXXXXXXXXXXXXXXXXXXX 9,999,999.99 9,999,999.99
9999 9999 9999 9999 9999 9999 9999 9999 9999
XX XXXXXX XX XX XX XX 999999.99 MMDDYY MMDDYY XXXXXXXXXXXXXXXXXXXX 9,999,999.99 9,999,999.99
9999 9999 9999 9999 9999 9999 9999 9999 9999
XX XXXXXX XX XX XX XX 999999.99 MMDDYY MMDDYY XXXXXXXXXXXXXXXXXXXX 9,999,999.99 9,999,999.99
9999 9999 9999 9999 9999 9999 9999 9999 9999

28 29 30 31 32 33 34 35 36
TOTAL CMS 1500 CLAIMS PAID: 99,999,999.99 99,999,999.99 99,999,999.99 99,999,999.99 99,999,999.99
99,999,999.99 99,999,999.99 99,999,999.99 99,999,999.99

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Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
4	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
5	Billed Amount (Header)	This is the total dollar amount billed by the provider for all the detail lines.
6	Allowed Amount (Header)	This is the total computed allowable dollar amount for the specified client.
7	Deduct Amount	This field will be blank.
8	Co-ins Amount	This field will be blank.
9	TPL Amount	This is the total dollar amount paid by third party sources other than the Connecticut Medical Assistance Program. This amount is deducted from the allowed amount to arrive at the paid amount.
10	Co-pay Amount	This is the dollar amount that is the client's responsibility and is deducted from the allowed amount to arrive at the paid amount.
11	Applied Income	This is the applied income amount on the claim. This amount is subtracted from the allowed amount to arrive at the paid amount.

Number	Name	Description
12	Paid Amount	This is the dollar amount that is payable for the claim.
13	Client Contr.	This is the dollar amount a client who is state funded under a Case Managed, Self-Directed or Assisted Living Intermediate or Limited Waiver benefit plan and is not Fee For Service eligible for the date of service must contribute (15% of the net cost of their care plan).
14	Patient Number	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes.
15	Client Name	The first and last name of the client.
16	Client No.	The client's Connecticut Medical Assistance Program identification number.
17	Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.
18	PL Serv	This column shows the place of service code(s) indicating where the services were actually rendered.
19	Proc Cd	This column shows the HealthCare Common Procedure Codes (HCPCS) used to indicate what services were actually rendered to the client by the provider.
20	Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.
21	Units	This shows the units of service being billed on each detail line.
22	Svc Dates - From	This is the first date of service on the detail line (MMDDYY).
23	Svc Dates - Thru	This is the last date of service on the detail line (MMDDYY).
24	Rendering Provider	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
25	Billed Amount	This is the dollar amount billed by the provider for the service on the detail line.
26	Allowed Amount	This is the computed dollar amount allowable for the service rendered at the detail line.
27	Detail EOBS	These are the Explanation of Benefit codes for the corresponding detail line.

Number	Name	Description
28	Total CMS 1500 Claims Paid - Billed Amount	The total billed amount of all the CMS 1500 Claims Paid.
29	Total CMS 1500 Claims Paid – Allowed Amount	The allowed amount total of all the CMS 1500 Claims paid.
30	Total CMS 1500 Claims Paid – Deduct Amount	This field will be blank.
31	Total CMS 1500 Claims Paid – Co-ins Amount	This field will be blank.
32	Total CMS 1500 Claims Paid - TPL Amt	The total of all TPL amounts for the CMS 1500 Claims paid.
33	Total CMS 1500 Claims Paid – Co-pay Amt	The total of all co-pay amounts for the CMS 1500 Claims paid.
34	Total CMS 1500 Claims Paid - Applied Income	The total of applied income for all the CMS 1500 Claims paid.
35	Total CMS 1500 Claims Paid - Paid Amount	The total of all the CMS 1500 Claims paid.
36	Total CMS 1500 Claims Paid – Client Contr.	The total of client contributions for all of the CMS 1500 Claims paid.

The Remittance Advice - Dental Claims Paid report lists dental claims that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent EOB codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the dental provider a list of all dental claims that were paid along with explanations on any discrepancies between the billed and the paid amount.

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	Rendering Provider	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
4	Service Dates From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
5	Service Dates Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
6	Billed Amount (Header)	This is the total dollar amount billed by the provider for all the detail lines.
7	Allowed Amount (Header)	This is the total computed allowable dollar amount for the specified client.
8	TPL Amount	This is the dollar amount paid by third party sources other than the Medical Assistance Program. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.
9	Co-Pay Amount	This is the dollar amount that is the client's responsibility and is deducted from the allowed amount to arrive at the paid amount.
10	Paid Amount	This is the dollar amount that is payable for the claim.
11	Client Name	The first and last name of the client.

Number	Name	Description
12	Client No.	The client's Connecticut Medical Assistance Program identification number.
13	Header EOBS	These are the Header Explanation of Benefits (EOB) codes that apply to the header on the dental claim. There could be a maximum of twenty EOB codes per claim header.
14	PL Serv	This column shows the place of service code(s) indicating where the services were actually rendered.
15	Proc Cd	This column shows the American Dental Association (ADA) code used to indicate what services were actually rendered to the client by the provider.
16	Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.
17	Surface	This column shows the surface code pertaining to the part of the tooth that was worked on.
18	Date Svc Perf	This is the date the service was actually performed. (MMDDYY)
19	Billed Amount (Detail)	This is the dollar amount billed by the provider on each detail line.
20	Allowed Amount (Detail)	This is the computed allowable dollar amount at the detail.
21	Detail EOBS	These are the Detail Explanation of Benefits (EOB) codes that apply to the detail on the dental claim form.
22	Total Dental Claims Paid – Billed Amount	This is the total billed amount of all the dental claims paid.
23	Total Dental Claims Paid – Allowed Amount	This is the total allowed amount of all the dental claims paid.
24	Total Dental Claims Paid – TPL Amount	This is the total amount of TPL for all the dental claims paid.
25	Total Dental Claims Paid – Co-Pay Amount	This is the total of co-pay amounts for all the dental claims paid.
26	Total Dental Claims Paid – Paid Amount	This is the total of all the dental claims paid.

Remittance Advice - Long Term Care Claims Paid

The Remittance Advice - Long Term Care Claims Paid report lists Long Term Care claims that were paid. The report is separated by individual claims and displays header and detail data. Pertinent EOB codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the long term care provider a list of all long term care claims that were paid along with explanations on any discrepancies between the billed and the paid amount.

REPORT: CRA-LTPD-R		interchange MMIS		DATE: MM/DD/CCYY	
RA#: 999999999		MEDICAID MANAGEMENT INFORMATION SYSTEM		PAGE: 9,999	
		PROVIDER REMITTANCE ADVICE			
		LONG TERM CARE CLAIMS PAID			

Any Provider 123 Main Street Anytown, CT 12345-1234		PAYEE ID MCD XXXXXXXXXXXXXXXX	
		ISSUE DATE MM/DD/CCYY	
		TAXONOMY XXXXXXXXXXXX	
		P. AVRS ID 999999999	

1	2	3	4	5	6	7	8	9	10	11
FP	--ICN--	ATTEND PROV	SERVICE DATES	DAYS	BILLED	ALLOWED	TPL	PATIENT	PAID	
12	--PATIENT NUMBER--		FROM	THRU	AMOUNT	AMOUNT	AMOUNT	LIAB	AMOUNT	

CLIENT NAME: John Smith		13	14	CLIENT NO.: XXXXXXXXXXXXXXXX	
X	RRYYJJBBSSS	XXX XXXXXXXXXXXXXXXX	MMDDYY	MMDDYY	999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX					9,999,999.99
					9,999,999.99
					9,999,999.99

15	HEADER EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999									
16	17	18	19	20	21	22				
REV CD	HCPCS/RATE	SRV DATE	UNITS	BILLED AMT	ALWD AMT	DETAIL EOB				
999	XXXXXXXX	MMDDYY	999999.99	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999				
						9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999				

				23	24	25	26	27
TOTAL LONG TERM CARE FACILITY CLAIMS PAID:				99,999,999.99	99,999,999.99	99,999,999.99	99,999,999.99	99,999,999.99
					99,999,999.99		99,999,999.99	

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	Attending Prov	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
4	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
5	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
6	Days	This is the number of days the provider is billing for.
7	Billed Amount	This is the dollar amount billed by the provider for the claim.
8	Allowed Amount	This is the computed allowable dollar amount for the specified client.
9	TPL Amount	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the client's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.
10	Patient Liab	This is the patient liability amount that the client is responsible for paying. This amount is obtained from the client's patient liability information and is subtracted from the allowed amount to arrive at the paid amount.

Number	Name	Description
11	Paid Amount	This is the dollar amount that is payable for the claim.
12	Patient Number	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes.
13	Client Name	The first and last name of the client.
14	Client No.	The client's Connecticut Medical Assistance Program identification number.
15	Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.
16	Rev Cd	These are the revenue center codes that pertain to the services being billed on the detail lines.
17	HCPCS/Rate	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue center codes on each of the detail lines being billed.
18	Srv Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed.
19	Units	This is the number of units of service.
20	Billed Amt	This is the dollar amount billed by the provider at the detail level of the claim.
21	Alwd Amt	This is the computed allowable dollar amount at the detail.
22	Detail EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of twenty EOB codes per detail line.
23	Total Long Term Care Facility Claims Paid - Billed Amount	The total billed amount of the Long Term Care Claims.
24	Total Long Term Care Facility Claims Paid - Allowed Amount	The allowed amount total of all the Long Term Care Claims paid.
25	Total Long Term Care Facility Claims Paid - TPL Amount	The total of all TPL amounts for the Long Term Care Claims paid.
26	Total Long Term Care Facility Claims Paid - Patient Liab	The total of Patient Liability amounts for all the Long Term Care Claims paid.

Number	Name	Description
27	Total Long Term Care Facility Claims Paid - Paid Amount	The total of all the Long Term Care Claims paid.

Remittance Advice - Drug Claims Paid

The Remittance Advice - Drug Claims Paid report lists drug claims (except compound drugs) that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent EOB codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the pharmacy provider a list of all drug claims that were paid along with explanations on any discrepancies between the billed and the paid amount. Compound claim activity will be reported on the Remittance Advice – Compound Drug Claims Paid report.

REPORT: CRA-DRPD-R		interchange MMIS				DATE: MM/DD/CCYY					
RA#: 999999999		MEDICAID MANAGEMENT INFORMATION SYSTEM				PAGE: 9,999					
		PROVIDER REMITTANCE ADVICE									
		DRUG CLAIMS PAID									
Any Provider						PAYEE ID					
123 Main Street						ISSUE DATE					
Anytown, CT 12345-1234						MM/DD/CCYY					
						TAXONOMY					
						XXXXXXXXXXXX					
						P. AVRS ID					
						999999999					
1	2	3	4	5	6	7	8	9	10	11	12
FP	--ICN--	RX NO.	NDC	METRIC QTY	RENDERING PROVIDER	DISPENSE DATE	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
CLIENT NAME: John Smith 13											
X RRYJJJBESSS XXXXXX 9999999999 99999 XXXXXXXXXXXXXXXX MM/DD/CCYY 9,999,999.99 9,999,999.99 999,999.99											
15 EOBSS 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999											
TOTAL DRUG CLAIMS PAID:							16 99,999,999.99	17 99,999,999.99	18 99,999,999.99	19 9,999,999.99	20 9,999,999.99

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	RX No.	Indicates the prescription number on the prescription that was used to dispense the drug.
4	NDC	These are the National Drug Codes that pertain to the prescription dispensed.
5	Metric Qty	Quantity of the drug that was dispensed.
6	Rendering Provider	The NPI indicator and the National Provider Identifier identifying the provider that prescribed the drug.
7	Dispense Date	This is the date the drug was actually dispensed to the client. For drug claims, this serves as the service date.
8	Billed Amount	This is the dollar amount billed by the provider for the claim.
9	Allowed Amount	This is the computed dollar amount allowable for the dispensed drug.
10	TPL Amount	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the drug. This amount is subtracted from the allowed amount to arrive at the paid amount.

Number	Name	Description
11	Co-Pay Amount	This is the dollar amount that is the client's responsibility and is deducted from the allowed amount to arrive at the paid amount. The co-pay amount that is deducted depends on the type of drug that was dispensed.
12	Paid Amount	This is the dollar amount payable for the drug. This is arrived at by computing the allowable amount for the drug plus the dispensing fee and deducting the TPL amount and co-pay amount.
13	Client Name	The first and last name of the client.
14	Client No.	The client's Connecticut Medical Assistance Program identification number.
15	EOBS	These are the Explanation of Benefits (EOB) codes that apply to the drug claim. These codes are used to explain how the claim was processed. There could be a maximum of twenty EOB codes per claim.
16	Total Drug Claims Paid - Billed Amount	The total billed amount of all the Drug Claims.
17	Total Drug Claims Paid - Allowed Amount	The allowed amount total of all the Drug Claims paid.
18	Total Drug Claims Paid - TPL Amount	The total of all TPL amounts for the Drug Claims paid.
19	Total Drug Claims Paid - Co-Pay Amount	The total of co-pay amounts for all the Drug Claims paid.
20	Total Drug Claims Paid - Paid Amount	The total of all the Drug Claims paid.

Remittance Advice - Medicare Crossover Part A Claim Adjustments

The Remittance Advice - Medicare Crossover Part A Claim Adjustments report lists Medicare crossover part A claims that were adjusted. The report is separated by individual claims. It displays the header data for both the claims being adjusted (Original) and the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent EOB codes and EOB descriptions are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare crossover part A claims that were adjusted along with explanations on why they were adjusted.

REPORT: CRA-XAAD-R		interchange MMIS				DATE: MM/DD/CCYY			
RA#: 999999999		MEDICAID MANAGEMENT INFORMATION SYSTEM				PAGE: 9,999			
		PROVIDER REMITTANCE ADVICE							
		MEDICARE CROSSOVER PART A CLAIM ADJUSTMENTS							
Any Provider 123 Main Street Anytown, CT 12345-1234						PAYEE ID NPI XXXXXXXXXXXXXXXX ISSUE DATE MM/DD/CCYY TAXONOMY XXXXXXXXXXXXXXXX P. AVRS ID 999999999			
1	2	3	4	5	6	7	8	9	10
FP	--ICN--	SERVICE DATES		BILLED		ALLOWED			
	PATIENT NO.	FROM	THRU	DEDUCT	CO-INS	DEDUCT	CO-INS	TPL AMT	PAID AMT
CLIENT NAME: John Smith		11	12		CLIENT NO.: 999999999999				
X	RRYYJJJBSSSS	MMDDYY	MMDDYY	(999,999.99)	(9,999,999.99)	(999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX									
X	RRYYJJJBSSSS	MMDDYY	MMDDYY	999,999.99	9,999,999.99	999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX									
13	HEADER EOB								
14	15	16	17	18	19				
REV CD	PROCEDURE	MODIFIERS	SRV DATE	UNITS	DETAIL EOB				
999	XXXXXXXXXX	XX XX XX XX	MMDDYY	999999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999				
					9999 9999 9999 9999 9999 9999 9999 9999 9999				
999	XXXXXXXXXX	XX XX XX XX	MMDDYY	999999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999				
					9999 9999 9999 9999 9999 9999 9999 9999 9999				
				20	21	22	23	24	25
TOTAL MEDICARE CROSSOVER PART A ADJ CLAIMS:				999,999.99	9,999,999.99	999,999.99	9,999,999.99	9,999,999.99	9,999,999.99

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.
3	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY) The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.
4	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY) The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.
5	Billed Deduct	Indicates the dollar amount that Medicare reported as deductible for the claim. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
6	Billed Co-ins	This is the dollar amount that Medicare reported as co-insurance for the claim. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.

Number	Name	Description
7	Allowed Deduct	This is the computed allowable dollar amount for the deductible billed on the claim. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
8	Allowed Co-ins	This is the computed allowable dollar amount for the co-insurance billed on the claim. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
9	TPL Amt	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the client's stay. This amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
10	Paid Amt	This is the dollar amount that is payable for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.
11	Client Name	The first and last name of the client.
12	Client No.	The client's Connecticut Medical Assistance Program identification number.
13	Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the adjusted claim. These codes are used to explain why the claim was adjusted. There could be a maximum of twenty EOB codes.
14	Rev Cd	This shows the revenue code pertaining to the service billed on the detail line.
15	Procedure	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered.
16	Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.
17	Srv Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed.
18	Units	This is the number of units of service.
19	Detail EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of twenty EOB codes per detail line.

Number	Name	Description
20	Total Medicare Crossover Part A Adj Claims - Billed Deduct	The total of all billed deductible amounts for the Medicare Crossover Part A Claim Adjustments.
21	Total Medicare Crossover Part A Adj Claims - Billed Co-ins	The total of all billed co-insurance amounts for the Medicare Crossover Part A Claim Adjustments.
22	Total Medicare Crossover Part A Adj Claims - Allowed Deduct	The total of all deductible allowed amounts for the Medicare Crossover Part A Claim Adjustments.
23	Total Medicare Crossover Part A Adj Claims - Allowed Co-ins	The total of all co-insurance allowed amounts for the Medicare Crossover Part A Claim Adjustments.
24	Total Medicare Crossover Part A Adj Claims - TPL Amt	The total of all the Medicaid TPL amounts for Medicare Crossover Part A Claim Adjustments.
25	Total Medicare Crossover Part A Adj Claims - Paid Amt	The total of all the Medicaid Paid Amounts for Medicare Crossover Part A Claim Adjustments.

Financial Transactions

This section of the Provider's Remittance Advice details the provider's bi-monthly financial activity for both payouts and non-claim specific refunds received and applied during the current financial cycle. In addition, it lists all outstanding accounts receivables (AR) in AR number order. The purpose is to give the provider a full accounting of their bi-monthly financial activity. In addition, it informs the provider on a bi-monthly basis of all of their outstanding accounts receivables.

REPORT: CRA-TRAN-R
RA#: 999999999

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

DATE: MM/DD/CCYY
PAGE: 9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX

PAYEE ID NPI XXXXXXXXXXXXXXXXXXXX
ISSUE DATE MM/DD/CCYY
TAXONOMY XXXXXXXXXXXX
P. AVRS ID 999999999

1

-----NON-CLAIM SPECIFIC PAYOUTS-----

TRANSACTION NUMBER	--CCN--	PAYOUT AMOUNT	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
9999999999	9999999999	\$9,999,999.99	9999	999999999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY
9999999999	9999999999	\$9,999,999.99	9999	999999999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY

TOTAL PAYOUTS: \$99,999,999.99

2

-----REFUNDS FROM PROVIDERS-----

--CCN--	REFUND AMOUNT	REASON CODE
9999999999	\$9,999,999.99	9999
9999999999	\$9,999,999.99	9999

TOTAL REFUNDS: 99,999,999.99

3

-----ACCOUNTS RECEIVABLE-----

A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL RECOUPED	BALANCE	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
XXXXXXXXXXXXXX	MM/DD/CCYY	\$9,999,999.99	\$9,999,999.99	\$9,999,999.99	\$9,999,999.99	9999	999999999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY
XXXXXXXXXXXXXX	MM/DD/CCYY	\$9,999,999.99	\$9,999,999.99	\$9,999,999.99	\$9,999,999.99	9999	999999999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY

TOTAL BALANCE

99,999,999.99

4

-----1099 ADJUSTMENTS-----

TRANSACTION NUMBER	SETUP DATE	ADJUSTMENT AMOUNT	REASON CODE
XXXXXXXXXXXXXX	MM/DD/CCYY	\$9,999,999.99	9999
XXXXXXXXXXXXXX	MM/DD/CCYY	\$9,999,999.99	9999

TOTAL 1099 ADJUSTMENTS \$9,999,999.99

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	Non-Claim Specific Payouts	
	Transaction Number	This is the number assigned by the system to uniquely identify the payout transaction.
	CCN	This is the Cash Control Number assigned to the cash receipt. This will be used when a provider has refunded the Medical Assistance Program in error or has over refunded one or more of the Medical Assistance Programs. For expenditures, if an expenditure is tied to a cash receipt then this field will contain the corresponding CCN for the cash receipt otherwise it will remain blank.
	Payout Amount	The amount of the payout transaction.
	Reason Code	The reason code assigned to indicate why the payout/refund action was taken. This will also generate an associated Explanation of Benefits (EOB) message on the EOB Remittance Advice page which gives a brief explanation of why the payout was issued.
	Applicant/Client No.	The client number associated with a patient liability expenditure or the provider number of the applicant associated with a Connecticut Promoting Interoperability (PI), formally known as the Electronic Health Records (EHR), incentive payment. In some cases, the provider number of the applicant is different than the provider number of the payee. If the expenditure is not for patient liability or a Connecticut Medicaid PI Program payment, this field will be blank.
	Applicant/Client Name	The client name associated with a patient liability expenditure or the provider name of the applicant associated with a Connecticut Promoting Interoperability (PI), formally known as the Electronic Health Records (EHR) incentive payment is displayed under the Applicant Name field. If the expenditure is not for patient liability or a Connecticut PI Program payment, this field will be blank.
	Liab Date	The benefit month associated with a patient liability expenditure. If the expenditure is not for patient liability this field will be blank.
	Total Payouts	This is the sum of all payouts amounts reported.
2	Refunds from Providers	
	CCN	This is the Cash Control Number assigned to the cash receipt. This will be used when a provider has refunded the Medical Assistance Program in error or has over refunded one or more of the Medical Assistance Programs. For expenditures, if an expenditure is tied to a cash receipt then this field will contain the corresponding CCN for the cash receipt otherwise it will remain blank.

Number	Name	Description
	Refund Amount	The non-claim specific refund amount.
	Reason Code	The reason the non-claim specific refund transaction was performed. This will also generate an associated Explanation of Benefits (EOB) message on the EOB Remittance Advice page which gives a brief explanation of why the payout was issued.
	Total Refunds	This is the sum of all refund amounts reported.
3	Accounts Receivable	
	A/R Number/ICN	The unique identifying Accounts Receivable number assigned during processing.
	Setup Date	The date of the original AR setup.
	Recouped this Cycle	This is the dollar amount recouped this financial cycle.
	Original Amount	The amount of the original AR setup.
	Total Recouped	This is the total dollar amount recouped this cycle.
	Balance	The Account Receivable balance remaining after the current weekly financial cycle processes.
	Reason Code	The reason code which identifies the type and reason the AR was established. This will also generate an associated Explanation of Benefits (EOB) message on the EOB Remittance Advice page which gives a brief explanation of why the payout was issued.
	Applicant/Client No.	The client number associated with a patient liability AR. If the AR is not for patient liability this field will be blank. For a Connecticut Promoting Interoperability (PI), formally known as the Electronic Health Records (EHR), Incentive Program accounts receivable, the provider number of the applicant associated with the AR is displayed under the Applicant field.
	Applicant/Client Name	The client name associated with a patient liability AR. If the AR is not for patient liability this field will be blank. For a Connecticut Promoting Interoperability (PI), formally known as the Electronic Health Records (EHR), Incentive Program accounts receivable, the provider name of the applicant associated with the AR is displayed under the Applicant Name field.
	Liab Date	The benefit month associated with a patient liability AR. If the AR is not for patient liability this field will be blank.
	Total Balance	This is the sum of all balance amounts reported.
4	1099 Adjustments	

Number	Name	Description
	Transaction Number	This is the number assigned by the system to uniquely identify the 1099 Adjustment transaction. For a 1099 decrease the transaction number will be an AR number. For a 1099 increase it will be an expenditure number.
	Setup Date	The date the 1099 Adjustment was entered.
	Adjustment Amount	The amount of the 1099 adjustment transaction
	Reason Code	The reason code assigned to indicate why the 1099 adjustment action was taken. This will also generate an associated Explanation of Benefits (EOB) message on the EOB Remittance Advice page which gives a brief explanation of why the payout was issued.
	Total 1099 Adjustments	This is the sum of all 1099 Adjustments reported for the current financial cycle.

Explanation of Benefits (EOB) Code Descriptions

The Remittance Advice - EOB Code Descriptions report lists all the Explanation of Benefits (EOB) codes used in the preceding Remittance Advice (R/A) pages and displays their corresponding descriptions. The purpose of this report is to give the provider a better explanation of the reasons 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.

PAYEE ID	NPI	XXXXXXXXXXXXXXXXXX
ISSUE DATE		MM/DD/CCYY
TAXONOMY		XXXXXXXXXXXX
P. AVRS ID		999999999

1

2

[illegible]

FINANCIAL TRANSACTIONS REASON CODES

3

CASH RECEIPTS REASON CODES

[illegible]

4

ACCOUNT RECEIVABLES REASON CODES

[illegible]

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	EOB Code	These are the Explanation of Benefits (EOB) codes that were applied to the submitted claims - either on the header or detail lines. These codes are used to explain why the claim is in suspense. There could be a maximum of twenty EOB codes per claim header and twenty EOB codes per detail line.
2	EOB Code Description	These are the descriptions corresponding to the EOB codes that were used. These descriptions give the provider the reasons why submitted claims were suspended, denied or not paid in full.
3	Cash Receipts Reason Codes	
	Rsn Code	These are the financial transaction reason codes that explain why a financial transaction was processed.
	Reason Code Description	These are the descriptions corresponding to the financial reason codes that were used. These descriptions give the provider the reasons why a financial transaction was processed.
4	Account Receivables Reason Codes	
	Rsn Code	These are the account receivable reason codes that explain why an account receivable was created.
	Reason Code Description	These are the descriptions corresponding to the account receivable reason codes that were used. These descriptions give the provider the reasons why an accounts receivable is established.

TPL Information

The Remittance Advice - TPL Information report lists Third Party Liability (TPL) information pertinent to claims processed during the current financial cycle. The purpose of this report is to give the provider a listing of all TPL carriers pertinent to the clients to whom services were rendered. This report will provide information necessary for billing a third party carrier on claims denied for failing TPL edits.

REPORT: CRA-TPLM-R	interchange MMIS		DATE: MM/DD/CCYY
RA#: 999999999	MEDICAID MANAGEMENT INFORMATION SYSTEM		PAGE: 9,999
	PROVIDER REMITTANCE ADVICE		
	TPL INFORMATION		

Any Provider 123 Main Street Anytown, CT 12345-1234	PAYEE ID NPI XXXXXXXXXXXXXXXX ISSUE DATE MM/DD/CCYY TAXONOMY XXXXXXXXXXXX P. AVRS ID 999999999
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CLIENT NAME 1	3 CLIENT NO. --ICN-- 5	CARRIER/EMP ID 7	CARRIER/EMPLOYER NAME 9
POLICY HOLDER NAME 2	4 POLICY NUMBER / GROUP NUMBER 6	BILLING ADDRESS 8	

John Smith XXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999999 RRYJJJBESS XXXXXXXXXXXXXXXXXXXX/XXXXXXXXXXXX	XXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX, XX XXXX-XXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999999 RRYJJJBESS XXXXXXXXXXXXXXXXXXXX/XXXXXXXXXXXX	XXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX, XX XXXX-XXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999999 RRYJJJBESS XXXXXXXXXXXXXXXXXXXX/XXXXXXXXXXXX	XXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX, XX XXXX-XXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999999 RRYJJJBESS XXXXXXXXXXXXXXXXXXXX/XXXXXXXXXXXX	XXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX, XX XXXX-XXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999999 RRYJJJBESS XXXXXXXXXXXXXXXXXXXX/XXXXXXXXXXXX	XXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX, XX XXXX-XXXX	

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	Client Name	This field displays the first and last name of the client.
2	Policy Holder Name	The name of the owner of the insurance policy under which the client could be covered. This may or may not be the client.
3	Client No.	The client's Connecticut Medical Assistance Program identification number.
4	Policy Number	The individual identification number assigned to the policyholder by the private insurance carrier.
5	ICN	This is a unique number used to identify and track a claim processed through the system.
6	Group Number	This is the number assigned to the employer group insured under the other insurance carrier. The group number does not apply to non-employer based policies.
7	Carrier/Emp ID	Number assigned to the client's insurance carrier or employer, if the employer is self-insured.
8	Billing Address	The address where insurance claims are to be sent to bill the other insurance carrier. This includes the street address, city, state and nine-digit zip code.
9	Carrier/Employer Name	The name of the insurance carrier, or the name of the client's employer if the employer is self-insured.

Remittance Advice Summary

The Provider Remittance Advice Summary is generated each claims payment cycle. Its purpose is to summarize for the provider all claim and financial activity for each financial cycle and to report year-to-date totals of all claim and financial activity. In addition, it will supply the provider with information regarding lien payments which were made to lien holders by Gainwell Technologies during the current cycle, month and year-to-date.

REPORT: CRA-SUMM-R

RA#: 999999999

interChange MMIS

MEDICAID MANAGEMENT INFORMATION SYSTEM

PROVIDER REMITTANCE ADVICE

REMITTANCE ADVICE SUMMARY

DATE: MM/DD/CCYY

PAGE: 9,999

Any Provider

123 Main Street

Anytown, CT 12345-1234

PAYEE ID

NPI XXXXXXXXXXXXXXXX

ISSUE DATE

MM/DD/CCYY

TAXONOMY

XXXXXXXXXXXX

P. AVRS ID

999999999

1

-----CURRENT CYCLE TOTALS BY FUND PAYER-----

---NEW DAY CLAIMS---

---POSITIVE ADJUSTMENTS---

---TOTAL ALL CLAIMS---

FUND PAYER 1

FUND PAYER 2

FUND PAYER 3

FUND PAYER 4

FUND PAYER 5

2

-----CLAIMS DATA-----

CLAIMS PAID

POS. CLAIM ADJUSTMENTS

TOTAL CLAIMS PAYMENTS

CLAIMS DENIED

CLAIMS IN PROCESS

3

-----EARNINGS DATA-----

PAYMENTS:

CLAIMS PAYMENTS

PAYOUTS

ACCOUNTS RECEIVABLE:

CLAIM SPECIFIC:

CURRENT CYCLE

OUTSTANDING FROM PREVIOUS CYCLES

NON-CLAIM SPECIFIC

NET PAYMENT

1099 ADJUSTMENTS

REFUNDS:

CLAIM SPECIFIC ADJUSTMENT REFUNDS

NON-CLAIM SPECIFIC REFUNDS

OTHER FINANCIAL:

MANUAL PAYOUTS

CHECK VOIDS

NET EARNINGS

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	Current Cycle Totals By Fund Payer	The Fund Payer represents the program associated with the claim activity. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
	New Day Claims Number	The current RA's new day paid claim count for a fund payer.
	New Day Claims Paid Amount	The current RA's amount of new day claims paid for a fund payer.
	Positive Adjustments Number	The current RA's adjustment paid claim count for a fund payer.
	Positive Adjustments Paid Amount	The current RA's amount of adjustment claims paid for a fund payer.
	Total All Claims Number	The current RA's paid claim count for both new day and adjustment claims for a fund payer.
	Total All Claims Paid Amount	The current RA's paid claim amount for both new day and adjustment claims for a fund payer.
2	Claims Data – For Current, Month-To-Date, and Year-To-Date	
	Claims Paid	The total number of claims paid and their paid amount for each reporting period.
	Positive Claim Adjustments	The total number of claims and net dollar amount of all positive adjustments finalized for each reporting period. Negative adjustments which result in an AR are reported below in the Accounts Receivable section. Refund adjustments are reported in the Refunds section of the Remittance Advice.
	Total Claims Payments	The total number of claims paid and adjustments finalized and their paid amounts for each reporting period.

Number	Name	Description
	Claims Denied	The total number of claims denied for each reporting period.
	Claims in Process	The total number of claims in process for each reporting period.
3	Earnings Data – For Current, Month-To-Date, and Year-To-Date	
	Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized for each reporting period.
	Payouts	Payouts paid for each reporting period.
	Accounts Receivable - Claim Specific - Current Cycle	The total dollar amount of all claim specific Accounts Receivables established and satisfied during the current financial cycle will be reported in the Current period. The Month-To-Date period will report the sum of Accounts Receivables established and satisfied in the same financial cycle during the reporting month. The Year-To-Date total will equal the total Accounts Receivables established and satisfied in the same financial cycle during the reporting year.
	Accounts Receivable - Claim Specific - Outstanding from Previous Cycles	The total dollar amount of all claim specific Accounts Receivables established in previous cycles which have been satisfied in the current financial cycle will be reported in the Current period. The Month-To-Date period will report the sum of Accounts Receivables established in previous cycles and satisfied in the reporting month. The Year-To-Date total will equal the total Accounts Receivables established in previous cycles and satisfied in the reporting year.
	Accounts Receivable - Non-Claim Specific	The total dollar amount of all non-claim specific accounts receivables established during each reporting period.
	Net Payment	The sum of all claims payments less any Accounts Receivable for each reporting period.
	1099 Adjustments	The total dollar amount of 1099 Adjustments made during each reporting period.
	Refunds - Claim Specific Adjustment Refunds	Total of Claim Specific Refunds for each reporting period.
	Refunds - Non -Claim Specific Refunds	Total of Non-Claim Refunds for each reporting period.
	Other Financial - Manual Payouts	The total dollar amount of manual payouts made for each reporting period.
	Other Financial - Check Voids	The total dollar amount of voided checks processed in each reporting period.

Number	Name	Description
	Net Earnings	The calculation of the net earnings for each reporting period. The calculation is as follows: Payments and manual payouts less Accounts Receivable, refunds and voids.

Remittance Advice - Claims In Process

The Remittance Advice - Claims In Process report lists claims that are in suspense. The report is separated by individual claims. Pertinent EOB codes and EOB descriptions are also displayed on this report. The example below is an Inpatient provider.

```

REPORT:   CRA-IPSU-R
RA#:      999999999

interchange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
INPATIENT CLAIMS IN PROCESS

DATE:     MM/DD/CCYY
PAGE:     9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX

PAYEE ID   NPI XXXXXXXXXXXXXXXX
ISSUE DATE MM/DD/CCYY
TAXONOMY   XXXXXXXXXXXX
P. AVRS ID 999999999

1 2 3 4 5 6 7 8 9 10 11
FP --TEN-- ATTENDING SERVICE DATES DAYS ADMIT BILLED DEDUCT CO-INS TEL
12 PATIENT ACCT. NUM PROV. FROM THRU DATE AMOUNT AMOUNT AMOUNT
13
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X RRYJJJBSSS XXX XXXXXXXXXXXXXXXX MMDDYY MMDDYY 999 MMDDYY 9,999,999.99 99,999.99 99,999.99 9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

16
HEADER EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
17 18 19 20 21 22
REV CD HCPCS/RATE SRV DATE UNITS BILLED AMT DETAIL EOB
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
999 XXXXXXXX MMDDYY 999999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
23 24 25 26
TOTAL INPATIENT CLAIMS IN PROCESS: 99,999,999.99 9,999,999.99 9,999,999.99 99,999,999.99

```

Note: Refer to the Remittance Advice Layout Header for the fields contained in the top part of this report.

Number	Name	Description
1	FP	This is a one-character field to identify the Fund Payer (Program) associated with the claim. 1 – HUSKY A, C 3 – HUSKY B, 3 B – HUSKY B, 1 and 2 D – CADAP (for dates of service prior to November 1, 2018) F – Family Planning M – HUSKY D T - Tuberculosis X – Multiple Programs
2	ICN	This is a unique number used to identify and track a claim processed through the system.
3	Attending Provider	The NPI indicator and the National Provider Identifier identifying the provider that performed the service.
4	Service Dates - From	This is the earliest date of service on all the detail lines. (MM/DD/YY)
5	Service Dates - Thru	This is the latest date of service on all the detail lines. (MM/DD/YY)
6	Days	This is the number of days the provider is billing for.
7	Admit Date	This is the date the client was admitted into the hospital or nursing home.
8	Billed Amount	This is the dollar amount billed by the provider for the claim.
9	Deduct Amount	This field will be blank.
10	Co-ins Amount	This field will be blank.
11	TPL Amount	This is the dollar amount paid by third party sources other than the Medical Assistance Program for the client's stay.
12	Patient Acct Num	This is a unique patient account number assigned by the provider. This is usually used for filing or tracking purposes.

Number	Name	Description
13	Client Name	The first and last name of the client.
14	Client No.	The client's Connecticut Medical Assistance Program identification number.
15	DRG	The unique 3 digit APR DRG (Diagnosis Related Group) code and 1 digit Severity of Illness code assigned to the claim.
16	Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.
17	Rev Cd	These are the revenue center codes that pertain to the services being billed on the detail lines.
18	HCPCS/Rate	These are the HealthCare Common Procedure Codes (HCPCS) that correspond to the revenue center codes on each of the detail lines being billed.
19	Srv Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the client
20	Units	This shows the units of service rendered.
21	Billed Amt	This is the dollar amount billed by the provider at the claim detail level.
22	Detail EOBS	These are the Explanation of Benefit codes for the corresponding detail line.
23	Total Inpatient Claims In Process - Billed Amt	The total billed amount of all the Inpatient Claims in process.
24	Total Inpatient Claims In Process – Deduct Amount	This field will be blank.
25	Total Inpatient Claims In Process – Co-Ins Amount	This field will be blank.
26	Total Inpatient Claims In Process - TPL Amt	The total of all TPL amounts for the Inpatient Claims in process.

Remittance Advice – CSV (Comma Separated Value)

The Remittance Advice (RA) has been updated to offer an excel format for **some providers**. This allows providers to sort the file and search for specific claim approvals and denials. The same fields are available to all providers; just in a different format. To access the RA, go to our Web site at www.ctdssmap.com and log onto the secure Web portal. Under “Trade Files”, choose “Download” from the drop down menu. Select “CSV” from the “Transaction Type” on the File Download Search screen. This will populate the current files available to download.

The following provides an example of the data available in this excel format:

Provider ID	Client ID	Client Last Name	Client First Name	Client Acct Number	ICN	Paid Date (MMDDYY)	Detail Num	FDOS(MM DDYY)	TDOS(MM DDYY)	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Billed Amt	Paid Amt	EOB1	EOB2	EOB3	Medical Record Num	Adj Xref ICN
				FFS	591326000100	092313	1	082013	082013	A0100					18	8.5	9918	0	0	TC1FORANDIE	2013260600004
				FFS	591326000100	092313	2	082313	082313	A0200	AD				21	21	0	0	0	TC1FORANDIE	2013260600004
				FFS	591326000100	092313	3	082913	082913	A0100	RD				18	8.5	9918	0	0	TC1FORANDIE	2013260600004

A provider can sort by many variables such as Client ID, ICN, Paid Date, Procedure Code, EOB, Billed Amount, or Adjusted Claims.

Electronic Funds Transfer (EFT)

The Department of Social Services (DSS) requires providers to participate in electronic funds transfer (EFT). EFT provides for the direct deposit of your payment amount into a bank account of your choosing and is available to Connecticut Medical Assistance Program providers.

For providers that are required to enroll/re-enroll via the on-line Enrollment/Re-enrollment Wizard, EFT information is required as part of that application. Detailed EFT instructions, including field by field descriptions and procedures for changes to or cancellations of EFT enrollment information, can be found by selecting the link below. Providers may also refer to Chapter 10 of the provider manual to view the EFT panel in the on-line Enrollment/Re-enrollment Wizard.

[EFT Instructions](#)

For providers that must enroll/re-enroll using a paper application, an EFT form and detailed field by field descriptions and procedures for completion of that form is included as part of that application. These providers may also access the instructions above for more EFT information, including changes to or cancellations of EFT enrollment information.

5.10 Carrier Code List

Overview

Third party insurance carriers are identified by a three-digit carrier code. Providers may use the lists to identify other insurance when submitting claims, or to identify the carrier name when other insurance is indicated during eligibility verification.

Carrier Code Lists

There are two versions of the carrier code list. One shows carrier codes in numeric order and the other is alphabetic by carrier name. Carrier code lists can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com.

To access the Carrier Code lists from the Connecticut Medical Assistance Program Web site Home Page:

1. Click on Information.
 2. Click on Publications.
 3. Find the section titled Provider Manuals.
 4. Select Carrier listing under Additional Chapter 5 Information.
-

5.11 EPSDT Information

Overview

The State of Connecticut's Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program was established to provide early and periodic screening, diagnosis, and treatment for Medicaid-enrolled children under the age of 21. Services include periodic comprehensive health screenings, interperiodic encounters, vision services, dental services, hearing services, other diagnostic and treatment services and Special Services. The timetable for performing periodic comprehensive health screenings is found in the Periodicity Schedule. The timetable for childhood immunizations is found in the Immunization Schedule. Both schedules are described later in more detail, with links that allow providers to access the most current schedule.

CMS-1500 Claim Form Submissions

The federal government requires states to provide detailed information on childhood screenings. To comply with these requirements, DSS requests providers who submit claims on a CMS-1500 claim form to submit with procedure codes appropriate to the age of the client and to use the EPSDT modifier. The procedure codes for new and established patient screenings can be found on the EPSDT Billing Chart in this section.

Immunization Tracking Codes

Immunization tracking procedure code(s) are submitted according to each vaccine given during a periodic comprehensive health screening or interperiodic encounter. A chart of the immunization tracking codes is included in this section. The purpose of the immunization tracking codes is to reimburse providers who report to DSS the type and dose of pediatric vaccines given. In addition, this information assists DSS in targeting EPSDT outreach efforts to children who have not been immunized. A link to a list of vaccine procedure codes is also located in this section.

Procedures Codes for Interperiodic Encounters

Interperiodic encounters are submitted using the routine evaluation and management procedure codes. Refer to the appropriate Fee Schedule for the reimbursable procedure codes for these types of service.

UB-04 Claim Form Submissions

Hospital providers are asked to use the standard revenue center codes and condition code A1. A periodic comprehensive health screening revenue center code is submitted according to the outcome of the screening.

Interperiodic Encounters

Interperiodic encounters are submitted using the hospital's routine outpatient revenue center codes.

ADA-2012 Claim Form Submissions

Dental providers are asked to use the standard Current Dental Terminology (CDT) codes along with the EPSDT modifier.

Periodicity Schedule	The Omnibus Budget Reconciliation Act of 1989 requires states to establish distinct time intervals for health, vision, hearing, and dental screenings. The EPSDT Periodicity Schedule is based on the recommendation from the Academy of Pediatrics and in consultation with appropriate health care providers in Connecticut. It provides information about the procedures to be performed during the periodic comprehensive screening and the scheduled screenings based on the age of the child. A link to the EPSDT Periodicity Schedule is included below.
Immunization Schedule	The EPSDT Periodicity Schedule includes information on the administration of pediatric vaccines. The vaccines and the intervals for administration of the vaccines are found in the Recommended Childhood Immunization Schedule published by the State of Connecticut Immunization Program.
Well Child Care	Information on Well Child Care (EPSDT) exams can be found at http://brightfutures.aap.org/.
Anticipatory Guidance	Information on Anticipatory Guidance can also be found at http://brightfutures.aap.org/.
Women, Infants, and Children, (WIC)	The Department of Social Services is responsible for ensuring that Medicaid providers screen all potentially eligible women, infants, and children for the WIC program of Supplemental Nutrition for Women, Infants, and Children. In order to promote high quality coordinated health care, Medicaid providers are required to refer potentially eligible clients to the WIC program with a Certification Form. WIC certification time requirements were revised so they would coincide with the EPSDT periodicity schedule. Children who qualify for WIC are considered “at risk.” Therefore, completion of the WIC forms and the measurement of height and weight should be considered part of the EPSDT interperiodic screen. If you need Certification Forms or you have any questions regarding WIC, you can contact your local WIC office. To find the nearest WIC office, go to the Department of Public Health link at: http://www.ct.gov/dph/cwp/view.asp?a=3137&q=387772&dphNav_GID=1862&dphNav.
EPSDT Special Services	EPSDT special services are not ordinarily covered by DSS and require prior authorization. To be reimbursed for EPSDT special services, providers must meet the requirements for such services. These requirements are discussed in Chapter 7, Medical Services Policy Section.

EPSDT Billing Chart

	New Patient Screening* (Initial)	Established Patient Screening* (Periodic)
AGE	Procedure Code	Procedure Code
NEWBORN	99460 (in hospital) 99461 (not in hospital or birthroom setting)	N/A
0-12 Mos.	99381	99391
1	99382	99392
2	99382	99392
3	99382	99392
4	99382	99392
5	99383	99393
6 through 11	99383	99393
12 through 17	99384	99394
18 through 20	99385	99395

*Consult Chapter 7 for the EPSDT Policy service limitations regarding initial and periodic screenings.

Immunization Tracking Codes

The Immunization Tracking Code Billing Chart lists codes that allow the Department of Social Services to track the type of vaccine and its administration at recommended ages.

Code	Connecticut Medical Assistance Policy EPSDT Services
Immunization Administration Tracking Codes	
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component.
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections; 1 vaccine (single or combination vaccine/toxoid).
90472	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid).
90474	Each additional vaccine (single or combination vaccine/toxoid). (List separately in addition to code for primary procedure)

Vaccine Procedure Codes

A list of vaccine procedure codes can be found on the Department of Public Health's Web site at:

<http://www.ct.gov/dph/cwp/view.asp?a=3136&q=511138>

Once on this Web site, scroll down to the Eligibility Criteria and click the most current link to get up-to-date vaccine procedure code information.

Note: Providers must bill one of the vaccine procedure codes in conjunction with the immunization tracking code to be reimbursed an administration fee for patient's age 0-18 years. Due to limitations of third party vendor software as well as the www.ctdssmap.com Web portal, providers should submit a billed amount of \$.01 for the vaccine procedure code and their usual and customary charge for the Immunization Administration Tracking Code.

Providers billing for patients age 19-20 will not receive reimbursement for the Immunization Administration Tracking Codes. For patients 19-20, the administration fee is built into the fee for the vaccine procedure code. Providers should bill their usual and customary charge for the vaccine procedure codes.

Periodicity and Immunization Schedule

The most current periodicity tables and vaccines, including the catch up schedule, can be found at by accessing Bright Futures Web site at: <https://brightfutures.aap.org>. Once on the Web site, select Materials & Tools, and, under the section labeled **Bright Futures/AAP Periodicity Schedule**, select the hyperlink for the Bright Futures/AAP Periodicity Schedule. That link has also been included here for your convenience.

https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

<http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>

Well Care (EPSDT) Exams and Anticipatory Guidance

Information on well care exams as well as anticipatory guidance can be found at <http://brightfutures.aap.org/>. This Web site offers information about child development and age-appropriate well care for medical professionals, public health professionals, parents, and other interested community members.

Coding

The appropriate preventive screening procedure code(s), from the series 99381-99395 (see the EPSDT Billing Chart above) which should be used to obtain reimbursement for an EPSDT screen are located in the box in the upper right hand corner of each form.

Well Care Visit ICD-10-CM Codes

ICD-10 Code	Diagnosis
Z0000	Encounter for general adult medical examination without abnormal findings
Z0001	Encounter for general adult medical examination with abnormal findings
Z00121	Encounter for routine child health examination with abnormal findings
Z00129	Encounter for routine child health examination without abnormal findings
Z005	Encounter for examination of potential donor of organ and tissue
Z0070	Encounter for examination for period of delayed growth in childhood without abnormal findings
Z0071	Encounter for examination for period of delayed growth in childhood with abnormal findings
Z008	Encounter for other general examination
Z0282	Encounter for adoption services
Z0289	Encounter for other administrative examinations
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z002	Encounter for examination for period of rapid growth in childhood
Z003	Encounter for examination for adolescent development state

Federally Qualified Health Care (FQHC) Centers – T1015

The FQHC encounter code must be combined with either age-appropriate preventive code or E and M codes or combined with the appropriate well-care diagnosis.

NOTE: Use of these other codes instead of a preventive care procedure code enable a visit to count as a well-child visit when DSS determines how many well child visits each child has received per year. However, use of the new forms does not change DSS policy regarding reimbursement for specific codes.

5.12 Forms – Examination Request for Medical Eligibility Determination, W-513, W-300, W-300A, Presumptive Eligibility, W-538, and Newly Eligible Clients under the ACA

Overview – Examination Request for Medical Eligibility Determination

The Request for Medical Payment, W-513 is used to determine a client's eligibility for Medicaid. The form is initiated by the Department of Social Services' Regional Office.

The W-513 form is attached to the Medical Report, W-300 and the Medical Statement, W-300A when it is brought by the client to the physician for completion.

The Medical Report, W-300 and the Medical Statement, W-300A are to be completed by the examining physician on behalf of a client who indicates he/she may have medical and/or psychiatric disability that precludes employment for a period of six months or more. Copies of the W-300 form and the W-300A form are included in this section.

When the CMS-1500 claim form is completed for the physician's services, the words "Pending Medicaid" are entered in Field 1a. and the claim and the appropriate W-513 form are forwarded to the address below.

Reimbursement for the medical eligibility determination will be done through a financial payout transaction, located on the financial transaction summary section of the provider's remittance advice, not via a claim payment. The payout will appear with a reason code 8383, 'Medical Determination for Non-Eligible Client'.

Where to Send Completed
CMS-1500 and W-513
Forms

Submit the CMS-1500 claim form along with the attached Request for Medical Payment, W-513 to the following address:

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

Where to Send Completed
Medical Report, W-300 and
Medical Statement, W-300A

Submit the Medical Report, W-300 and Medical Statement, W-300A to the Regional Office indicated on the Request for Medical Payment form, W-513.

Form W-513



W-513
Rev. (11/17)

**State of Connecticut
Department of Social Services**

Request for Medical Payment

Thank you for providing medical information about the patient named below. The patient or the person caring for the patient asked the Department of Social Services (DSS) for help, and the information you provide will help us determine whether we can provide this help.

Because this patient is not currently receiving Medicaid, you will need to provide your name and address in the space below and then return this form, along with a CMS 1500 claim form, to the address listed in the billing instructions. DSS cannot pay you for your services if you do not submit these forms.

Patient Name	SSN	Date of Birth

Name of Medical Provider requesting payment for this patient:

Medical Provider's address:

If you have not already submitted the medical information associated with this request for payment, please do so within 14 days of making this request.

Billing Instructions:

DSS will provide payment for services only to active, enrolled Medicaid providers. The payment amount will be the fee established by DSS for conducting the examination necessary to complete the medical report provided to you by the patient.

You must submit this form with a CMS 1500 claim form. The claim will not be paid without it. Enter the words "**Pending Medicaid**" instead of the insured's I.D. number in box 1 a. of the CMS 1500. Submit this form and the CMS 1500 to:

DXC Technology

P.O. Box 2971

Hartford, CT 06104

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons who are blind or visually impaired, can contact DSS at 1-860-424-5040.

Instructions for Completing Request for Medical Payment Form W-513

Field No. & Name	Description
1. Medical Provider	Enter the name of the medical provider being asked to complete the Medical Report, W-300 and Medical Statement, W-300A.
2. Address	Enter the street address, city, state, and zip code of the provider.
3. Worker	Enter the name of the town or state worker requesting the completion of the Medical Report, W-300.
4. Address	Enter the town office address or the address of the DSS Regional Office where the request originated.
5. Phone	Enter the telephone number of the Town or DSS Regional Office.
6. Patient Name	Enter the name of the client to be examined.
7. Date of Birth:	Enter the client's date of birth in MM/DD/CCYY format.
8. SSN:	Enter the client's social security number.
9. Form W-300	Enter an 'X' in this field if the W-300 form is attached.
10. Other Information	Enter the description or form number, if applicable, if other information is included.

Form W-300



WV-300
(Rev. 11/08)

State of Connecticut
Department of Social Services

Medical Report
(For Medicaid Disability and SAGA Cash Benefits)

Dear Medical Provider:

The individual named on page three has applied for assistance with the Department of Social Services. He or she has acknowledged physical and/or mental health problems that prevent employment. Please complete this form so that we may verify eligibility for Medicaid disability or State Administered General Assistance (SAGA) unemployability benefits. To qualify, the individual must have a severe mental or physical impairment, or a combination of impairments that will preclude employment for at least six months (SAGA) or twelve months (Medicaid).

Instructions for completing the form:

- Complete Section A., General Information. Complete other sections only if they are relevant to the conditions for which you are providing treatment.

Medical providers, please take note. If this individual is applying for the Medicaid for the Employed Disabled (MED) program, he or she may be eligible even if he or she is employed as long as there is a significant impairment that would normally be considered disabling. You will need to complete the form in full for an MED applicant.

This individual is applying for MED. ☐ Yes ☐ No

- Please provide objective medical evidence, including copies of any diagnostic test results that substantiate the listed conditions. If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials.
- Please tell us how the patient's symptoms, including possible side effects of medication, affect his or her ability to perform activities of daily living and function in the workplace. Specifically, what can the patient no longer do as a result of his or her health problems?
- Please tell us about how the combined effect of multiple conditions impacts this patient's ability to work, if applicable.
- If this patient has chronic conditions that have deteriorated over time, please tell us how and over what period of time the condition has worsened. What is the prognosis for the future?
- If you know of other providers that are treating this patient, please let us know so that we may contact them.
- If you know of diagnostic tests that have been taken but you do not know the results, please let us know from whom the results may be obtained.
- Return the completed form to the DSS worker named on page 2 of this form. Please feel free to contact the worker if you have any questions.

Thank you for taking the time to provide information on behalf of your patient.

Medical Report

Patient Name _____

Page 2 of 10

Please return this form to:		CCC use only
DSS Worker:		Date Received:
Address:		Date Due:
Phone:	Fax:	Tracking Number:

Release of Information

Name of Doctor, Clinic or Hospital _____

I hereby authorize the medical professional named above to release or disclose to the state of Connecticut, Department of Social Services and/or Colonial Cooperative Care, Inc. the following information:

All medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition including: psychological and psychiatric impairments, drug and alcohol abuse, sickle cell anemia, AIDS, sexually transmitted diseases, tests for HIV, and how my health problems affect my activities of daily living and my ability to work.

I authorize a photocopy or fax of this release to be accepted with the same authenticity as the original. I understand that I may withdraw this authorization in writing at any time, except for action already taken. Unless I have cancelled it, this authorization will expire when a determination is made with regard to my eligibility for Medicaid disability and/or SAGA unemployability benefits.

Signature of Patient or Other Legal Representative_____
DateBilling and Payment Instructions

Please access the Automated Eligibility Verification System (AEVS) for confirmation of eligibility.

If SAGA eligibility is confirmed, you will need to be enrolled as a CHNCT provider in order to be paid. Please call CHNCT Provider Relations at (800) 440-5071 to enroll and for billing instructions.

Submit claims for all other eligibility categories to EDS, P.O. Box 2941, Hartford, Ct. 06104. Submit your claim on a CMS 1500 form.

Important: You must attach form W-513, "Request for Medical Payment" to the CMS 1500 in order to be paid.

Medical Report

Page 3 of 10

Patient Name: _____ DSS Client ID #: _____

Telephone #: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Section A. General Information

1. For what condition(s) are you treating this patient?

Diagnoses: 1. _____ 2. _____ 3. _____

☐ This is a new condition (Approximate date of onset: _____).

☐ This is a pre-existing condition (Approximate date of onset: _____).

2. Does this condition, or combination of conditions, prevent the patient from working at this time?

☐ Yes ☐ No

If **no**, go directly to the signature block on the last page of this form.

If yes, go on to the next question.

3. How long do you expect that the patient will be unable to work?

☐ Less than 2 months

☐ 2 months or more, but less than 6 months

☐ 6 months or more

☐ 12 months or more

If you checked either that the patient will be unable to work "Less than 2 months" or "2 months or more, but less than 6 months", **stop**. Proceed to page 10 and complete the signature section.

4. Please tell us how the patient's diagnosis, symptoms and prognosis impact his or her ability to work. Consider the effects of medications the patient may be taking for these conditions.

5. If this condition has recently deteriorated, please explain.

Medical Report

Patient Name _____

Page 4 of 10

Please note: If the patient has mental health or substance abuse issues only, with no significant physical involvement, skip to Section D., “Mental Status Information” on page 6.

Section B. Clinical Information

1. Date first seen: _____
2. Date last seen: _____
3. Height _____ Weight _____ Blood pressure _____
4. Are there indications of mental health issues or substance abuse? ☐ Yes ☐ No ☐ Unknown
5. Please provide objective clinical findings in the following table (or substitute office notes).

Diagnosis	Supporting Symptoms	Objective Findings	Supportive Test Results (enter test, date of test and results <u>or</u> attach actual test results)
Primary:			
Onset: / /			
Secondary:			
Onset: / /			
Secondary:			
Onset: / /			
Other:			
Onset: / /			

Section C. Physical Capacities Evaluations

1. In terms of the patient's ability to perform during an 8-hour workday with normal breaks, the patient can:

Activity	Never	1 Hour	2 Hours	3 Hours	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours
Sit									
Stand									
Walk									

Medical Report

Patient Name _____

Page 5 of 10

2. The patient can lift:

Weight patient can lift	Never	Occasionally (1-33% of time on job)	Frequently (34-66% of time on job)	Continuously (67-100% of time on job)
Up to 5 lbs.				
6-10 lbs.				
11-20 lbs.				
21-25 lbs.				

3. The patient can carry:

Weight patient can carry	Never	Occasionally (1-33% of time on job)	Frequently (34-66% of time on job)	Continuously (67-100% of time on job)
Up to 5 lbs.				
6-10 lbs.				
11-20 lbs.				
21-25 lbs.				

4. The patient can use hands for repetitive action such as: (check yes or no)

Hand	Simple Grasping?		Push and Pull Arm Controls?		Fine Manipulation?	
	Yes	No	Yes	No	Yes	No
Right						
Left						

5. The patient can use feet repetitively for pushing and pulling leg controls:

Foot	Yes	No	Comments
Right			
Left			

6. The patient is able to:

Activity	Never	Occasionally (1-33% of time on job)	Frequently (34-66% of time on job)	Continuously (67-100% of time on job)
Bend				
Squat				
Crawl				
Climb				
Reach				

Medical Report

Patient Name _____

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7. To what extent can the patient be involved in the following activities?

Activity	Never	Occasionally (1-33% of time on job)	Frequently (34-66% of time on job)	Continuously (67-100% of time on job)
Unprotected heights				
Being around moving machinery				
Exposure to marked changes in temperature and humidity				
Driving automotive equipment				
Exposure to dust and fumes				

8. Please list any assistive equipment (cane, walker, etc.) required to perform any activities listed in this section (Physical Capacities Evaluations) of the form.

Section D. Mental Status Information

Complete this section if this patient has mental health issues that affect his or her ability to work. These may range from situational anxiety or mild depression to clinical depression or chronic, severe mental illness, and/or substance abuse. Some individuals seek treatment for these conditions from their primary care physician or general practitioner rather than mental health clinicians. If you are not a mental health clinician, you may skip question 5 unless you have access to this information.

1. Does this patient have mental health or substance abuse issues that impact his or her ability to work? ☐ Yes ☐ No ☐ Unknown

If you checked "No" or "Unknown" go directly to section F. on page 9.

2. If you answered "Yes", please summarize the patient's diagnosis, symptoms and prognosis as they affect his or her ability to work. Consider the effects of medications that patient may be taking for this condition.

3. This disorder is: ☐ a single episode ☐ an exacerbation of a chronic illness

4. If it is a recurrence, is there a cyclical pattern? ☐ Yes ☐ No
If yes, how frequent? _____

5. Please provide all five axes of a DSM-IF diagnosis, if you know:

Axis I _____ Axis II _____ Axis III _____ Axis IV _____

Axis V GAF score: current _____ highest level in past year _____

Medical Report

Patient Name _____

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Section E. Mental Residual Functional Capacity Assessment

1. Understanding and Memory

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
Remember locations & work-like procedures				
Understand and remember very short, simple instructions				
Understand and remember detailed instructions				

2. Sustained Concentration and Persistence

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
Carry out very short, simple instructions				
Carry out detailed instructions				
Maintain attention and concentration for extended periods				
Perform activities within a schedule, maintain regular attendance, be punctual within customary tolerances				
Sustain an ordinary routine without special supervision				
Work in coordination with or proximity to Others without being distracted by them				
Make simple work-related decisions				
Complete a normal workday/workweek without interruptions from psychologically based symptoms. Perform at a consistent pace without an unreasonable number and length of rest periods				

Medical Report

Patient Name _____

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3. Social Interaction

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
Interact appropriately with the general public				
Ask simple questions or request assistance				
Accept instructions and respond appropriately to criticism from supervisors				
Get along with co-workers or peers without distracting them or exhibiting behavioral extremes				
Maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness				

4. Adaptation

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
Respond appropriately to changes in the work setting				
Be aware of normal hazards and take appropriate precautions				
Travel in unfamiliar places or use public transportation				
Set realistic goals or make plans independently of others				

Medical Report

Patient Name _____

Page 9 of 10

Section F. Hospitalizations and In-patient Treatment

Please list hospitalizations and other in-patient admissions within the last five (5) years. Please include both medical and mental health admissions.

Dates of Admission	Facility	Reason for Admission and Treatment Received

Section G. Outpatient Treatment

Please indicate outpatient treatments received within the last five (5) years. Please do not include routine office visits.

Treatment	Date(s)	Description/Comments
Rehabilitation (PT,OT, speech, etc.)		
Counseling		
Dialysis		
Chemotherapy		
Radiation		
Other:		
Other:		
Other:		

Medical Report

Patient Name _____

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Section H. Medications

Please list all prescribed drugs that alone, or in combination with other drugs, may affect the patient's ability to work.

Medication	Is patient compliant with medications?	Please note any effects of this medication that impact this patient's ability to work. For example, significantly high dosage, severe side effects, etc.
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	
	☐ Yes ☐ No ☐ Unknown	

Signature Instructions

Thank you for taking the time to complete this form on behalf of your patient who has applied for assistance. Please print (or stamp) your name and sign below. This form may be signed by a <u>licensed M.D., D.O., Psychologist, Optometrist</u>, or, for diseases or injuries of the foot, a Podiatrist. If you are another type of medical professional, for example, a nurse practitioner or a Physician's Assistant, you may complete this form but it must be co-signed by a licensed M.D., D.O., Psychologist, Optometrist or Podiatrist.		
Name of person completing this form (print)	Title	Signature
Name of person co-signer, if required (print)	Title	Signature
Provider type (specialty)	License Number	Date
Telephone Number	Fax Number	

Form W-300A



W-300A
(Rev. 11/08)

State of Connecticut
Department of Social Services

Medical Statement

The individual listed below has applied for help with the Department of Social Services. This person has told us that he or she has a medical or psychiatric condition that will not allow him or her to work for at least 30 days. Your answers to the questions on this form will help us to determine the individual's employability status and/or disability status for our programs. If the patient is currently under your care, the report may be prepared from your existing records.

Client Name: _____ Social Security Number: _____

Date of Birth: _____ Client ID Number: _____

Client's statement of his/her medical condition: _____

Please answer the following based on your records and knowledge of the patient.

1. Does the patient have a significant medical condition that prevents him or her from working?

☐ Yes ☐ No If yes, what is the diagnosis? _____

2. How much longer is this condition expected to last? (please check one)

☐ Less than 30 days ☐ More than 2 months but less than 6 months
☐ More than 30 days but less than 2 months ☐ 6 months or more

When do you think the patient will be able to return to work? _____

Date

3. Does the patient have a mental health or substance abuse problem?

☐ Yes ☐ No If yes, which one? _____

Signature Instructions

Thank you for taking the time to complete this form on behalf of your patient who has applied for assistance. Please print (or stamp) your name and sign below. This form may be signed by a licensed M.D., D.O., Psychologist, Optometrist, or, for diseases or injuries of the foot, a Podiatrist. If you are another type of medical professional, for example, a nurse practitioner or a Physician's Assistant, you may complete this form but it must be co-signed by a licensed M.D., D.O., Psychologist, Optometrist or Podiatrist.

Name of person completing this form (print)			Title			Signature		
Name of person co-signer, if required (print)			Title			Signature		
Provider type (specialty)			License Number			Date		
Telephone Number			Fax Number					

Important - See Reverse for Mailing and Billing Instructions

Please return this form to:

DSS Worker: _____

Address: _____

Telephone: _____ Fax No. _____

Release of Information

Name of Doctor, Clinic or Hospital _____

I hereby authorize the medical professional named above to release or disclose to the state of Connecticut, Department of Social Services, the following information:

All medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition including: psychological and psychiatric impairments, drug and alcohol abuse, sickle cell anemia, AIDS, sexually transmitted diseases, tests for HIV, and how my health problems affect my activities of daily living and my ability to work.

I authorize a photocopy or fax of this release to be accepted with the same authenticity as the original. I understand that I may withdraw this authorization in writing at any time, except for action already taken. Unless I have cancelled it, this authorization will expire when a determination is made with regard to my eligibility for Medicaid disability and/or SAGA unemployability benefits.

Signature

Date

Billing and Payment Instructions

Please access the Automated Eligibility Verification System (AEVS) for confirmation of eligibility.

If SAGA eligibility is confirmed, you will need to be enrolled as a CHNCT provider in order to be paid. Please call CHNCT Provider Relations at (800) 440-5071 to enroll and for billing instructions.

Submit claims for all other eligibility categories to EDS, P.O. Box 2941, Hartford, Ct. 06104. Submit your claim on a CMS 1500 form.

Important: If client is not currently active with DSS, you must attach form W-513, "Examination Request for Medical Eligibility Determination" to the CMS 1500 in order to be paid.

Overview – Presumptive Eligibility

The Presumptive Eligibility Certification and Guarantee of Payment Form, W-538 is used to guarantee payment for medical services for children under the age of nineteen, pregnant women, parents and caretakers, low income adults and women and individuals seeking family planning services, under the family planning eligibility group. These services include, but are not limited to, medical, dental, behavioral health, prescription, laboratory, and radiology. This form is used by HUSKY Health Certified Entities (HHCE) to grant presumptive eligibility and to notify the CT Department of Social Services Regional Processing Unit. This form is good only for a period of ten days from the date listed at the top of the form and is used when presumptive eligibility for HUSKY A, HUSKY B, HUSKY D, or Family Planning Services – Limited Benefit has been determined.

Before submitting a claim to Gainwell Technologies Services for processing, every effort should be made to identify if the child, pregnant woman, or individual has an eligible Medicaid/CHIP client ID number through one of the options provided by the Automated Eligibility Verification Systems (AEVS). To process eligibility verification without a client ID, providers should use the Identifying Information (Date of Birth and Social Security Number) found on the W-538. **If the client has an eligible Medicaid/CHIP client ID, the W-538 form should not be submitted and the claim should be submitted directly to Gainwell Technologies.**

If after 10 days, no client ID is available in AEVS, submit a paper claim with the W-538 to the following address:

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

Please note that only active Connecticut Medical Assistance Program Providers will be reimbursed at the fee established by the Department of Social Services for the service provided. HUSKY B providers may collect any applicable co-payment or co-insurance.

The W-538 is a guarantee of payment. Participating providers are encouraged to provide goods and services covered by HUSKY A, HUSKY B, HUSKY D and Family Planning Coverage – Limited Benefit when this form is presented.

*Please note the W-538 form also **guarantees payment for pharmacy providers**. If the individual does not have an eligible client ID number at the time the form is presented to the pharmacy, leave the Medicaid Identification section of the claim form blank and contact the Gainwell Technologies Provider Assistance Center at 1-800-842-8440 for information on how to submit claims for pharmacy services.*

Form W-538



W-538
(Rev. 09/14)

STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

MEDICAID/CHIP PRESUMPTIVE ELIGIBILITY CERTIFICATION AND GUARANTEE OF PAYMENT TO ALL HUSKY PROVIDERS

Date: _____

The individual(s) listed below have been determined to be presumptively eligible for Medicaid: HUSKY A & HUSKY D – Lowest Income Populations (HUSKY Health), HUSKY B -- the Children's Health Insurance Program -- CHIP, or the HUSKY Limited Benefit -- Family Planning (LI-FP) program. **For active Connecticut Medical Assistance providers**, the Department of Social Services (DSS) guarantees payment for medically necessary health care services provided to these individuals for a period of **10 days** from the date shown above. Payment is made in accordance with the DSS fee schedule for the services provided, based on the program for which the client is eligible. Health care services include, but are not limited to, medical, dental, behavioral health, prescription, laboratory and radiology. Please note, however, that the HUSKY Limited Benefit – Family Planning program covers family planning and family planning-related services only.

Eligible Participants				HUSKY Program Eligibility: A,B, D or LI-FP
Individual's Name	Gender	Date of Birth	Social Security Number	
	☐ Male ☐ Female	/ /		
	☐ Male ☐ Female	/ /		
	☐ Male ☐ Female	/ /		
	☐ Male ☐ Female	/ /		

Authorized By: _____
Worker name and Organization

Telephone Number: _____

Instructions to the Recipient, Parent and/or Caretaker

Use this form to secure health care services for the individual(s) approved to receive assistance. Remember that this form is valid **only for 10 days** from the date shown above. If you have not received an eligibility approval letter and your gray CONNECT card within ten days, please call the DSS Client Information Line and Benefits Center at 1-855-626-6632 if you are on HUSKY A, HUSKY D or the HUSKY Limited Benefit – Family Planning program. If your children are on HUSKY B, please call 1-800-656-6684.

Instrucciones para el Beneficiario, Padre(S) y/o Guardián

Use este formulario para asegurar servicios de salud para los beneficiarios elegible para recibir asistencia. Recuerde que este formulario es válido **por solo 10 días** desde la fecha listada arriba. Si no ha recibido una carta de aprobación de elegibilidad y la tarjeta gris de CONNECT en 10 días, por favor llame al Centro de Beneficios, al 1-855-626-6632, si participa en HUSKY A, HUSKY D o Beneficio Limitado HUSKY- Planificación Familiar. Si sus hijos participan en HUSKY B, llame a 1-800-656-6684.

The Department has a TDD/TTY hotline number for persons who are deaf or hearing impaired. If you have a TDD/TTY, you can call 1-800-842-4524. The Department also has auxiliary aids for the blind or visually impaired. Please call your local Department of Social Services for more information.

Copy 1: QE Site



W-538
(Rev. 09/14)

STATE OF CONNECTICUT – DEPARTMENT OF SOCIAL SERVICES

**MEDICAID/CHIP PRESUMPTIVE ELIGIBILITY CERTIFICATION AND
GUARANTEE OF PAYMENT TO ALL HUSKY PROVIDERS**

Instructions to Connecticut Medical Assistance providers

1. Please make every effort to verify the identity of the individual(s) determined to be presumptively eligible and determine whether there is already an active HUSKY client identification (ID) number for the individual by using the Automated Eligibility Verification System (AEVS) at 1-800-842-8440. You may also log on to www.ctdssmap.com to check on current eligibility.
2. The active HUSKY client ID will generally be available within 10 days from the date shown above. **If the client is granted eligibility, please put the client ID on the claim and submit it for processing as you would any other Connecticut Medical Assistance Program claim.** If the client has not been assigned an active client ID within 10 days, you must bill with a paper claim and you must submit this form along with the paper claim. **Do not submit this form with paper claims if the individual has an active HUSKY client ID number.**
3. When HUSKY B is checked above, providers may accept applicable co-payments or co-insurance for any individuals.
4. When this form is presented to you by an individual seeking medically necessary service, DSS guarantees payment for such services. We encourage you, therefore, to provide all medically necessary goods and services covered by HUSKY A, HUSKY B, HUSKY D and HUSKY Limited Benefit – Family Planning when this form is presented.

THIS AREA TO BE COMPLETED BY THE PRESUMPTIVE ELIGIBILITY SITE

Notice: Applications for on-going Medicaid may be submitted on-line at AccessHealthCT.com or by calling **1-855-805-4325**.

Reason why application was not submitted to AccessHealthCT? _____

Date of attempt to file application with AccessHealthCT: _____

Note: A copy of this voucher must be appended to the Presumptive Eligibility application submitted to the Department of Social Services

The Department has a TDD/TTY hotline number for persons who are deaf or hearing impaired. If you have a TDD/TTY, you can call 1-800-842-4524. The Department also has auxiliary aids for the blind or visually impaired. Please call your local Department of Social Services for more information.

Copy 1: QE Site

Overview – Newly Eligible Clients Under the Affordable Care Act (ACA)

Overview – HUSKY A, B and D Only

As of January 1, 2014, additional individuals are eligible for Medicaid as a result of the Patient Protection and Affordable Care Act (ACA). This eligibility is the result of an increase in the income limit for the HUSKY D eligibility group from its current level to 138% of the federal poverty level. The methodology for determining income eligibility is known as the Modified Adjusted Gross Income (MAGI). Individuals applying to Connecticut Medicaid for an effective date on or after January 1, 2014 will have their income eligibility calculated using the new MAGI rules. For current Connecticut Medicaid clients, the MAGI rules will be applied at the time of their annual redetermination.

Client Eligibility Verification

Eligible clients, including HUSKY D clients, continue to receive a standard gray State of Connecticut Connect Card. The Gainwell Technologies Automated Eligibility Verification System (AEVS) returns client information that identifies if a client is eligible for HUSKY A, B or D.

Eligibility Notices – Payment Guarantee

Effective January 1, 2014, the procedures for determining and granting eligibility for HUSKY A, B and D have changed. All applications for these eligibility groups will be processed by the eligibility system that the Department shares with Connecticut's State Based Marketplace, Access Health CT (AHCT). Access Health CT issues eligibility determinations for HUSKY A, B and D clients, in addition to clients seeking health plans through the Marketplace. These notices contain combined determinations of eligibility for HUSKY A, B and D and the qualified health plans offered through the Marketplace. The subject line for these notices is: "Eligibility Decision for Health Care Coverage".

These notices will guarantee providers payment for covered services including but not limited to hospital, medical, dental, behavioral health, prescription, laboratory, and radiology. The "Person ID" listed on the AHCT notice should **not** be used to submit claims to the Connecticut Medical Assistance Program (CMAP). Providers should perform an eligibility verification to obtain a valid client ID in order to submit claims to CMAP. Please refer to Chapter 4 for additional information on eligibility verification.

Temporary Client IDs

In the event that an individual presenting an AHCT "Eligibility Decision for Health Care Coverage" notice does not have an eligible client ID in the Automated Eligibility Verification System (AEVS) or the Secure Web portal, providers may contact Gainwell Technologies to have a temporary client ID issued. Please note that only HUSKY A and HUSKY D eligible individuals will be granted temporary identification numbers. This temporary client ID will allow a provider to submit pharmacy claims as well as claims for other services in limited circumstances to the Connecticut Medical Assistance Program (CMAP).

Providers can contact the Gainwell Technologies Provider Assistance Center at 1-800-842-8440 and select "Claim & Enrollment Assistance" from the main menu and then option #4 for Access Health CT Eligibility.

The call center agent will collect the following information from the provider in order to validate eligibility and issue a temporary client ID:

- Client Name
- Client DOB
- SSN (if available)
- Gender
- Person ID
- Application ID
- Benefit Plan
- Begin Date of Coverage

In order to activate the temporary client ID, providers will be asked to fax the client's AHCT Eligibility Notice to 1-877-413-4241. The fax cover sheet should contain the provider's contact information, including contact name and phone number, in case follow up is needed.

Providers should continue to verify a client's eligibility on the date of service, prior to performing the scheduled service, and discontinue the use of the temporary ID once a valid (permanent) 9 digit CMAP ID becomes available. When the CMAP client ID becomes available, Gainwell Technologies will 'link' the two IDs. Once the IDs are linked, eligibility verification responses will return the CMAP client ID (even if the request was submitted with the temporary ID). The temporary client ID which begins with the number "8" should be discontinued once it is replaced by a CMAP 9 digit ID which begins with a "00" number sequence. Once the IDs are linked claims will process using the CMAP ID by default.

Temporary IDs (9-digit client IDs that begin with a leading "8") are valid for a number of transactions. Eligibility verification may be performed using these ID's via the Secure Web portal at www.ctdssmap.com, the AEVS, e-Prescribing using SureScripts as well as vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.

Please note the following information regarding use of a temporary ID for claims and prior authorization requests:

Prior Authorization and
Claims Processing

- **Any claim for a service that does not require a Prior Authorization (PA)** may be submitted with the temporary ID.
- **Non pharmacy claims that require PA** - For services rendered that require PA, providers will need to obtain PA after the "permanent" 9 digit CMAP ID has been updated to reflect retro-active eligibility. Once PA has been given under the permanent 9 digit CMAP ID the provider can submit the claim to Gainwell Technologies.

- **Pharmacy claims that require PA** – Once the PA is approved, the pharmacy claim may be submitted with the temporary ID.

The Gainwell Technologies Pharmacy Prior Authorization Assistance Center will assist pharmacies in obtaining retroactive payment for medications dispensed to newly eligible individuals in good faith under the AHCT guarantee of payment notice. In the event that retroactive authorization is necessary to process a pharmacy or compound claim for such an individual, the pharmacy may contact the Gainwell Technologies Pharmacy Prior Authorization Assistance Center at 1-866-409-8386 or 1-860-269-2030.

For other services that require Prior Authorization, please contact the appropriate administrative services organization (ASO), as noted below:

- **Medical Services that require PA** – Contact Community Health Network of CT (CHNCT) for PA at CHNCT – 1- 800-859-9889. Claims may only be submitted with a valid 9-digit CMAP ID (starts with leading “0”). Claims will deny if submitted with a temporary ID.
- **Behavioral Health Services that require PA** – Contact Value Options (VO) for PA at 1-877-55-CTBHP or 1- 877-552-8247. Claims may only be submitted with a valid 9-digit CMAP ID (starts with a leading “0”). Claims will deny if submitted with a temporary ID.
- **Dental Services that require PA** – Contact BeneCare for PA at: 1-855-CT-DENTAL or 1-855-283-3682. Claims may only be submitted with a valid 9-digit CMAP ID (starts with leading “0”). Claims will deny if submitted with a temporary ID.

Client Reimbursement

As a reminder, clients may not be billed or charged for covered goods or services, except such cost sharing as is permitted under the HUSKY B program. If a client has paid for goods or services that are covered and subsequently becomes eligible for the date of service or the provider is able to subsequently confirm that the client was eligible on the date of services, payment made by the client (or by a representative on the clients behalf) shall be refunded by the provider. Only after the payment has been refunded to the client may the provider bill the Department for the goods or services. The provider must obtain proper documentation that the refund was made.

5.13 Forms – Hysterectomy, W613 and W-613A

Overview

The Hysterectomy Information Form, W-613 or the Physician Hysterectomy Certification Form Retroactive Eligibility, W-613A must be obtained and completed for any hysterectomy performed on a HUSKY A, HUSKY C or HUSKY D client. For specific policy requirements, refer to Chapter 7 in the Provider Manual under Hospital or Clinic provider types. Once in Chapter 7, continue to the headings titled Medical Services Policy and Family Planning, Abortions and Hysterectomies in subsection 173.

How to Order Forms

Providers may obtain the Hysterectomy Information Form, W-613 and Physician Hysterectomy Certification Form Retroactive Eligibility, W-613A at www.ctdssmap.com by selecting Information, then Publications, and locating the link to the form(s) under Other Forms.

The Hysterectomy Information Form, W-613 and Physician Hysterectomy Certification Form Retroactive Eligibility, W-613A can also be obtained from the following address:

Department of Social Services
Supervisor, Duplicating
55 Farmington Avenue
Hartford, CT 06105

Facsimile requests for forms may also be submitted to (860) 424-4954.

Providers may also duplicate blank W-613 and W-613A forms for future use.

The Hysterectomy Information Form, W-613 is available in the Spanish language at www.ctdssmap.com by selecting Information, then Publications, and locating the link to the form under Other Forms. It may also be obtained from DSS at the above address or facsimile number.

Where to Send the Completed Forms

Mail the completed consent form and, if available, the operative report to the following address:

Gainwell Technologies
P.O. Box 2971
Hartford, CT 06104

Additionally, completed forms may now be submitted via fax to (860) 986-7995.

Processing the Form

A consent form must be received before any claims associated with a hysterectomy procedure can be processed. Only one correctly completed consent form is required to process all the hysterectomy related claims submitted by multiple providers. Gainwell Technologies maintains a client file for this form. The file is accessed for each hysterectomy-related claim for that client. The form is matched to the claim to ensure that it meets the Department of Social Services (DSS) requirements for completion. If the form is correctly completed, the form and claims are processed by

Instructions for Completing
the Form

Gainwell Technologies. If it is not correctly completed the form will be returned to the provider for correction. DSS will accept a photocopy of a completed hysterectomy consent form.

The following pages provide detailed instructions for completing the Hysterectomy Information Form, W-613 and the Physician Hysterectomy Certification Form Retroactive Eligibility, W-613A.

Form W-613

(W-613)
(Rev. 8/95)

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Patient's Name _____ Medicaid I.D. _____
(please print)

HYSTERECTOMY INFORMATION FORM

A hysterectomy is an operation in which a woman's uterus (womb) is removed. A hysterectomy should be done only when there is a disease or injury of the uterus or some other medical problem that can be treated only by removing the uterus. Your doctor should explain to you the reason for performing a hysterectomy and the discomforts, risks, and benefits associated with a hysterectomy.

A HYSTERECTOMY OPERATION WILL MAKE IT IMPOSSIBLE FOR YOU TO BECOME PREGNANT OR BEAR CHILDREN. Since a hysterectomy is permanent and irreversible, you should consider this carefully before having the operation.

The Department of Social Services will not pay for a hysterectomy if the reason you are having it is to avoid bearing children. If this is the reason for your hysterectomy, you should consider other methods of sterilization. A hysterectomy is a much more serious operation than other methods of sterilization, like tubal ligation (having your tubes tied). A hysterectomy takes much longer to do, and you will be in the hospital longer. There are more discomforts and there is a greater chance of serious health problems.

SECTION A: (To be completed by the patient)

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Prior to my operation, I read the above information about the hysterectomy operation. I also received an oral explanation about hysterectomies. The discomforts, risks and benefits associated with a hysterectomy were explained to me. All of my questions were answered to my satisfaction.

I UNDERSTAND THAT THE HYSTERECTOMY OPERATION WILL MAKE IT IMPOSSIBLE FOR ME TO BECOME PREGNANT OR BEAR CHILDREN. I UNDERSTAND THAT A HYSTERECTOMY IS A PERMANENT OPERATION.

Signature of Patient: _____ Date: _____
or Authorized Representative Mo./Day/Yr.

Capacity of Authorized Representative: _____

SECTION B: (To be completed by the physician only)

The patient or her authorized representative was not required to sign the hysterectomy information acknowledgment (Section A) because the following condition(s) existed:

- ☐ a. The patient was already sterile at the time of the hysterectomy.
The cause of the sterility was _____
- ☐ b. The patient required a hysterectomy due to an emergency life-threatening situation in which prior acknowledgment was not possible. The nature of the emergency life-threatening situation was _____

Signature of Performing Physician Date: _____
Mo./Day/Yr.

INSTRUCTIONS FOR COMPLETING FORM W-613, HYSTERECTOMY INFORMATION FORM

1. Please print patient's name.

2. Insert the patient's Medicaid Identification Number.

Federal regulations (42 CFR 441.255) require that a Medicaid client undergoing a hysterectomy sign written acknowledgment of receipt of hysterectomy information unless one of the two conditions listed in Section B exist.

COMPLETE SECTION A OR SECTION B - DO NOT COMPLETE BOTH SECTIONS

SECTION A: *(To be completed by the patient)*

#3. Patient or her authorized representative must sign the form after being given an explanation orally and in writing that the operation will make her sterile.

#4. Patient or her authorized representative must enter the date on which the form was signed. The patient may sign the form before or after the surgery provided the written and oral explanations were given prior to surgery.

#5. If the patient's authorized representative signed on behalf of the patient, the capacity of the authorized representative (e.g., husband, daughter, etc.) must be entered in space. If the patient signed the form, leave this space blank.

SECTION B: *(To be completed by the performing physician when A is not applicable.)*

#6. If the patient was already sterile at the time the hysterectomy was performed, the physician must check Box a. and enter the cause of sterility on line #6.

#7. If the hysterectomy was performed under a life-threatening emergency situation, the physician must check Box b. and enter the nature of the situation on line #7.

#8. The performing physician must sign the form here. By signing this form, the physician is certifying that one (or both) of the two conditions had been met which would exempt the patient from the hysterectomy information requirement.

#9. The performing physician must enter the date on which the form is signed.

Instructions for Completing Hysterectomy Information Form, W-613

Field No. & Name	Description
1. Patient's Name	Print patient's name (first name, middle initial, last name).
2. Medicaid I.D.	Enter the HUSKY C/HUSKY D patient's 9-digit Connecticut Medical Assistance Program identification number as printed on the CONNECT Card.

Complete Section A or Section B – Do not complete both sections

Section A: (To be completed by the patient)

- | | | |
|----|---|--|
| 3. | Signature of Patient or Authorized Representative | <p>Have the patient or her authorized representative sign the form acknowledging receipt of verbal and written explanations that the operation will make her sterile.</p> <p>Federal regulations (42 CFR 441.255) require that a Connecticut Medical Assistance Program patient undergoing a hysterectomy sign written acknowledgment of receipt of hysterectomy information unless one of the two conditions listed in Section B exist.</p> |
| 4. | Date | <p>Have the patient or her authorized representative enter the date in MM/DD/YY format that the form was signed. The patient may sign the form before or after the surgery provided the written and verbal explanations were given prior to surgery.</p> |
| 5. | Capacity of Authorized Representative | <p>Indicate the capacity or relationship of the authorized representative to the patient. If the patient signed the form, leave this space blank.</p> |

Field No. & Name	Description
<u>Section B: (To be completed by the physician only)</u>	
6. (Unlabeled)	Check Box a. and indicate the cause of sterility if the patient was already sterile at the time of the hysterectomy.
7. (Unlabeled)	Check Box b. and indicate the nature of the situation if the hysterectomy was performed under a life-threatening emergency situation.
8. Signature of Performing Physician	Have the performing physician sign his/her full name. By signing this form, the physician is certifying that one (or both) of the two conditions had been met which would exempt the patient from the hysterectomy information acknowledgement requirement.
9. Date	Have the performing physician enter the date the form was signed. It should be in MM/DD/YY format.

Form W-613A

W-613A
(Rev. 8/95)

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Patient's Name _____ Medicaid I.D. No. _____
(please print)

PHYSICIAN HYSTERECTOMY CERTIFICATION FORM RETROACTIVE ELIGIBILITY

I hereby certify that I performed a hysterectomy on the above named patient on _____
under the following circumstances. Mo./Day/Yr.

- ☐ a. The patient was informed before the operation that the hysterectomy would make her permanently incapable of reproducing.
- ☐ b. The patient was already sterile at the time of the hysterectomy. The cause of sterility was _____
- ☐ c. The hysterectomy was performed under an emergency life-threatening situation in which I determined that prior acknowledgement was not possible. The nature of the emergency life-threatening situation was _____

Signature of Performing Physician _____ Date _____
Mo./Day/Yr.

FOR DEPARTMENT USE ONLY

Date eligibility was determined: _____

W-300
(Rev. 8/98)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

MEDICAL REPORT

Colonial Coop. Care Use Only

Date Received _____ / _____ / _____
Date Due _____ / _____ / _____
Tracking Number _____

THIS REPORT MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED BY A LICENSED PHYSICIAN, D.O. OR PH.D. IF YOU HAVE RECENTLY SUBMITTED A REPORT FOR A SOCIAL SECURITY OR SSI DISABILITY CLAIM, YOU MAY SUBMIT THAT REPORT IN PLACE OF THIS FORM.

INSTRUCTIONS FOR COMPLETING FORM W-613A
PHYSICIAN HYSTERECTOMY CERTIFICATION FORM – RETROACTIVE ELIGIBILITY

- #1. Please print patient's name.
- #2. Insert the patient's Medicaid identification number.
- #3. Insert the date of surgery.
- #4. **PLEASE NOTE:** *Check all boxes that apply. Only one box needs to be checked in order to satisfy the certification requirements.*
- Box a. Check if applicable.
- Box b. Check if applicable. If Box b. is checked, the physician must enter the cause of sterility in Space #4.
- Box c. Check if applicable. If Box c. is checked, the physician must enter the nature of the emergency life-threatening situation in Space #5. By "emergency life-threatening situation," the Department means that the patient was in imminent danger of loss of life; for example, the patient had to undergo a hysterectomy due to a perforated uterus or uteroplacental apoplexy.
- #5. The performing physician must sign the form.
- #6. The performing physician must enter the date on which the form was signed.

Instructions for Completing Physician Hysterectomy Certification Form Retroactive Eligibility, W-613A

Field No. & Name	Description
1. Patient's Name	Print patient's name (first name, middle initial, last name).
2. Medicaid I.D. No.	Enter the HUSKY Health Program patient's 9-digit Connecticut Medical Assistance Program ID number as printed on the CONNECT Card.
3. (Unlabeled)	Enter the date of surgery in MM/DD/YY format.
4.	NOTE: Check all boxes that apply. Only one box needs to be checked in order to satisfy the certification requirement.
(Unlabeled)	Check Box a., if applicable.
(Unlabeled)	Check Box b., if applicable. If Box b. is checked, the physician must enter the cause of sterility in Field 4.
(Unlabeled)	Check Box c, if applicable. If Box c. is checked, the physician must enter the nature of the emergency life-threatening situation in Field 5. By "emergency life-threatening situation", DSS means that the patient was in imminent danger of loss of life; i.e., the patient had to undergo a hysterectomy due to a perforated uterus or uteroplacental apoplexy.
5. Signature of Performing Physician	Have the performing physician sign his/her full name.
6. Date	Have the performing physician enter the date he/she signed the form. It should be in MM/DD/YY format.

5.14 Forms – Physician’s Certification for Abortion (Title XIX), W-484

Overview

The Physician's Certification for Abortion (Title XIX), W-484 is completed only in the instances where an abortion is performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest. This form is required for HUSKY Health Program clients meeting the above criteria. For specific policy requirements, refer to Chapter 7 in the Provider Manual under Hospital or Clinic provider types. Once in Chapter 7, continue to the headings titled Medical Services Policy and Family Planning, Abortions and Hysterectomies in subsection 173.

How to Obtain Physician's Certification for Abortion (Title XIX), W-484

Providers may obtain the Physician's Certification for Abortion (Title XIX), W-484 at www.ctdssmap.com by selecting Information, then Publications, and locating the link to the form under Other Forms.

Providers may also obtain copies of the Physician's Certification for Abortion (Title XIX), W-484 from the following address:

Department of Social Services
Supervisor, Duplicating
55 Farmington Avenue
Hartford, CT 06105

Facsimile requests for forms may also be submitted to (860) 424-4954.

Providers may duplicate blank W-484 forms for future use. Instructions for the completion of this form are included in this section.

Where to Send the Form

Mail the completed Physician's Certification for Abortion (Title XIX) with the physician's original signature to:

Gainwell Technologies
P.O. Box 2971
Hartford, CT 06104

Additionally, completed forms may now be submitted via fax to (860) 986-7995.

Instructions for Completing the Form

The following pages provide detailed instructions for completing the Physician's Certification for Abortion (Title XIX), W-484.

Form W-484

W-484
(Rev. 8/07)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

PHYSICIAN'S CERTIFICATION FOR ABORTION (TITLE XIX)

I hereby certify that _____
NAME OF PATIENT *CLIENT ID*

_____ has requested
ADDRESS

performance of an abortion. On the basis of my professional judgment, I certify that this abortion is necessary because:

- ☐ life of the mother would be endangered if the fetus were carried to term; or,
- ☐ pregnancy is due to rape; or,
- ☐ pregnancy is due to incest.

My reason for having made the above determination is based on _____

This abortion will be performed at _____
HOSPITAL OR LICENSED CLINIC

on _____
DATE

Signature of Attending Physician

Date

Instructions for Completing Physician's Certification for Abortion (Title XIX), W-484

Field Name	Description
NAME OF PATIENT	Print the patient's name (first name, middle initial, last name).
CLIENT ID	Enter the client's 9-digit Connecticut Medical Assistance Program ID number as printed on the CONNECT card.
ADDRESS	Enter the patient's street and city or town address.
(unlabeled)	Indicate the reason for the abortion by checking one box.
(unlabeled)	Enter the detailed explanation for performing the abortion.
HOSPITAL OR LICENSED CLINIC	Enter the address of the hospital, licensed clinic or freestanding surgical center where the abortion is to be performed.
DATE	Enter the date of surgery in MM/DD/CCYY format.
SIGNATURE OF ATTENDING PHYSICIAN	Have the attending physician sign his/her full name. NOTE: This must be an original signature.
DATE	Enter the date of the signature in MM/DD/CCYY format.

5.15 Forms – Consent to Sterilization, Federal Form OMB No. 0937-0166 (formerly DSS form W-612)

Overview

Only U.S. Center for Medicare and Medicaid Services (CMS)-approved Consent to Sterilization, Federal Form OMB No. 0937-0166 (formerly DSS form W-612) is accepted as valid for HUSKY Health Program clients. The Federal Form OMB No. 0937-0166 is also required for claims processing when a sterilization procedure is performed. Any other form of consent obtained by the provider is not considered valid and prevents the claim from being paid. For specific policy requirements, refer to Chapter 7 in the Provider Manual under Hospital or Clinic provider types. Once in Chapter 7, continue to the headings titled Medical Services Policy and Family Planning, Abortions and Hysterectomies in subsection 173.

A provider may have the client complete more than one Federal Form OMB No. 0937-0166 when obtaining consent. Each Federal Form OMB No. 0937-0166 must contain the signatures of the client, the interpreter (if applicable), the person obtaining consent, and the physician performing the procedure. Each completed Federal Form OMB No. 0937-0166 must be obtained at least 30 days prior to the date of service, and the dates corresponding to each signature must reflect that this occurred. The Department of Social Services (DSS) will accept a photocopy of a completed sterilization consent form.

How to Obtain the Consent to Sterilization Form, W-612

Providers may obtain the Consent to Sterilization, Federal Form OMB No. 0937-0166 at www.ctdssmap.com by selecting Information, then Publications, and locating the link to the form under Other Forms.

Providers can also obtain the Consent to Sterilization, Federal Form OMB No. 0937-0166 from the following address:

Department of Social Services
Supervisor, Duplicating
55 Farmington Avenue
Hartford, CT 06105

Providers may duplicate blank Federal Form OMB No. 0937-0166 for future use.

This form is available in the Spanish language and may be obtained at www.ctdssmap.com by selecting Information, then Publications, and locating the link to the form under Other Forms.

Where to Send Completed Form

Mail the completed form and, if available, the operative report to the following address:

Gainwell Technologies
P.O. Box 2971
Hartford, CT 06104

Form Processing

The consent form must be received before any claims associated with a sterilization procedure can be processed. Only one correctly completed consent form is required to process all the sterilization related claims

submitted by multiple providers. Gainwell Technologies maintains a client file for this form. The file is accessed for each sterilization-related claim for that client.

Instructions for Completing
the Form

The following pages provide detailed instructions for completing the Consent to Sterilization, Federal Form OMB No. 0937-0166.

Federal Form OMB No. 0937-0166

Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2018

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked _____
Doctor or Clinic
for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.
I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.
I understand that I will be sterilized by an operation known as a _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.
I am at least 21 years of age and was born on: _____ Date
I, _____, hereby consent of my own free will to be sterilized by _____
Doctor or Clinic
by a method called _____ . My
Specify Type of Operation
consent expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.
I have received a copy of this form.

Signature _____ *Date*
You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)
Ethnicity: ☐ Hispanic or Latino ☐ American Indian or Alaska Native
☐ Not Hispanic or Latino ☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____
language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter's Signature _____ *Date*
HHS-687 (10/12)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual
consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is
Specify Type of Operation
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent _____ *Date*

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____
Name of Individual _____ *Date of Sterilization*
I explained to him/her the nature of the sterilization operation _____, the fact that it is
Specify Type of Operation
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.
(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)
(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
☐ Premature delivery
Individual's expected date of delivery: _____
☐ Emergency abdominal surgery (describe circumstances): _____

Physician's Signature _____ *Date*

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

INSTRUCTIONS FOR COMPLETING CONSENT FOR STERILIZATION FORM (OMB No. 0937-0166)

Section 1 – Consent to Sterilization

1. Complete name of physician or facility.
2. Give complete medical terminology for procedure to be performed.
3. Patient's exact date of birth.
4. Patient's full name.
5. Complete name of physician or facility.
6. Give complete medical terminology for procedure to be performed.
7. Have patient sign full name.
8. Have patient enter the date on which the form was signed. This date must be at least 30 days before surgery is performed, but not more than 180 days.

Section 2 – Interpreter's Statement (If Appropriate)

9. Insert the language used.
10. Interpreter must sign full name.
11. Interpreter must enter the date on which the form was signed. This date must be the same as the date the patient signed.

Section 3 – Statement of Person Obtaining Consent

12. Insert the full name of the person to be sterilized.
13. Give complete medical terminology for the procedure to be performed.
14. Person obtaining initial consent must sign full name.
15. Person obtaining initial consent must enter the date on which the form was signed. This date must be the same as the date the patient signed.
16. Insert the name of the facility or office where consent was obtained.
17. Insert facility or office address.

Section 4 – Physician's Statement

18. Insert the full name of the person to be sterilized.
19. Insert the date the sterilization procedure is performed. This date must be at least 30 days after the date the patient signed the initial consent (number 7), but not more than 180 days.
20. Give complete medical terminology for the procedure to be performed.
21. This area must be completed, if appropriate. Follow the instructions on the form explicitly.
22. Physician performing the procedure must sign full name.
23. Physician must enter date on which the form was signed. It is essential that the second explanation be given by the physician shortly before surgery is performed (7 days or less), however, the physician must sign and date the statement after the surgery is performed. The physician may sign and date the form on the day surgery is performed, but the form must be signed and dated after the surgery has been completed.

General Conditions

1. The Consent for Sterilization Form (OMB No. 0937-0166) is the only acceptable consent form for sterilization procedures. Forms can be located at www.ctdssmap.com by selecting Information, then Publications, and locating the link to the form under Authorization/Certification Forms. Both English and Spanish forms are found at this link. Providers may fax the consent form into DXC Technology at 1-860-986-7995 or mail the completed form and, if applicable, the operative report to the following address:

DXC Technology, P.O. Box 2971, Hartford, CT 06104

2. Forms must be fully and accurately completed. Deviations from the above guidelines will result in denial of all claims associated with the sterilization procedure.
3. When two or more providers bill for services rendered in connection with the same sterilization, only one provider is required to submit the original completed consent form.
4. An original consent form must be received before any claims associated with a sterilization procedure will be paid.

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE 1-800-842-1508 or TDD/TTY 1-800-842-4524.

General Guidelines for Completing Consent to Sterilization, Federal Form OMB No. 0937-0166
(formerly DSS form W-612)

1. Federal guidelines require the following fields to be correctly completed at least 30 days prior to the date of surgery. All of these fields must be signed and dated on the same day.

Fields 7 and 8 – Client's signature and date

Fields 14 and 15 – Signature line for person obtaining consent and date of consent

Fields 10 and 11 – Interpreter and date (when applicable)

No alterations will be allowed to any signatures (Fields 7, 10 and 14)

If the consent form is submitted after the surgery with any of the required signature fields blank or incomplete, the claim will be denied.

2. If changes are to be made in fields other than the signature lines, cross out the incorrect information with one straight line, write the correct information and initial the change. Although a single line is the preferred method of correction, correction fluid is acceptable. All changes must be initialed by each party who has signed the form (i.e., the client, person obtaining consent and, if applicable, the interpreter). The only exception is a typed field that has been corrected in type; this may be initialed only by the person obtaining consent.
3. The only pre-typed fields which will be accepted are Fields 1, 2, 3, 5, 6, 9, 12, 13, 16, 17, 18, 19 and 20. Sign language for the hearing impaired is an acceptable language for Field 9. If Field 9 is completed, Fields 10 and 11 must be completed as well.
4. A change to the surgery date is acceptable if it matches the date of surgery on the claim and conforms to the above-mentioned requirements. If there are any doubts as to the actual date of surgery, please reference the operative report.

If the surgery date is incorrect, please correct and initial the date on the consent form. To substantiate this change, you must submit the operative report along with the consent form.

5. If there are blank or incomplete fields the consent form is returned to the provider for correction. The form will continue to be returned to the provider until it is correctly completed. If any of the required signature or date fields (Fields 7, 8, 14, 15, and when applicable, Fields 10 and 11) are blank or incomplete, the claim will deny (see Guideline 1, this page).
6. Forms must be fully and correctly completed. Deviations from the above requirements shall result in denial of all claims associated with the sterilization procedure.
7. If a valid consent form is submitted after the denial of the original claim, the denied claim may be resubmitted for processing by the provider. Providers can contact other providers who participated in the surgery to determine if a valid consent exists, or providers may contact the Gainwell Technologies Provider Assistance Center toll free at 1-800-842-8440. Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information. The number is 1-866-604-3470.

Instructions for Completing Consent to Sterilization, Federal Form OMB No. 0937-0166 (formerly DSS form W-612)

Field No. & Name	Description
------------------	-------------

CONSENT TO STERILIZATION

- | | | |
|----|--------------------|--|
| 1. | (Doctor or clinic) | Enter the name of the physician or facility. |
| 2. | (Unlabeled) | Enter the complete medical description for procedure to be performed. |
| 3. | Month Day Year | Enter the client's exact date of birth. |
| 4. | (Unlabeled) | Enter the client's full name. |
| 5. | (Doctor) | Enter the name of the physician, physician group or facility. |
| 6. | (Unlabeled) | Enter the complete medical description for procedure to be performed. |
| 7. | Signature | Have the client sign his/her full name. |
| 8. | Month Day Year | Have the client enter the date on which he/she signed the form. This date must be at least 30 days (but not more than 180 days) before surgery is performed. |
| 9. | Client ID | Enter the client's 9-digit Connecticut Medical Assistance Program ID number as printed on the CONNECT card. |

INTERPRETER'S STATEMENT

- | | | |
|-----|-------------|--|
| 10. | (Unlabeled) | Enter the language used. Sign language is acceptable for the hearing impaired. |
| 11. | Interpreter | Have the interpreter sign his/her full name. |
| 12. | Date | Have the interpreter enter the date on which he/she signed the form. This date must match the date of the client signature in Field 7. |

STATEMENT OF PERSON OBTAINING CONSENT

- | | | |
|-----|--------------------|---|
| 13. | Name of individual | Enter the full name of the person to be sterilized. |
|-----|--------------------|---|

Field No. & Name	Description
14. (Unlabeled)	Enter the complete medical description for the procedure to be performed.
15. Signature of person obtaining consent	Have the person obtaining initial consent sign his/her full name.
16. Date	Have the person obtaining initial consent enter the date on which he/she signed the form. This date must match the date of the client signature in Field 7.
17. Facility	Enter the name of the facility or office where consent was obtained.
18. Address	Enter the facility or office address.

PHYSICIAN'S STATEMENT

19. Name of individual to be sterilized	Enter the name of the individual to be sterilized.
20. Date of sterilization operation	Enter the date the sterilization procedure will be performed. This date <u>must</u> be at least 30 days (but not more than 180 days) after the date the client signed the initial consent (Fields 7 and 8).
21. Specify type of operation	Enter the complete medical description for the procedure to be performed.
22. (Unlabeled)	Complete this area, if appropriate, by checking the applicable box. If premature delivery occurred, give individual's expected date of delivery. If emergency abdominal surgery was performed, describe the circumstances.
23. Physician	Have the physician performing the procedure sign his/her full name.
24. Date	Have the physician enter the date on which the form was signed. The physician is required to give the patient a full explanation of the sterilization procedure no more than seven days before the sterilization is performed. The signing and dating of form can be done within the seven days prior to surgery, date of surgery or any time after surgery as long as the full explanation is given to the client within the seven days prior to the sterilization procedure.

5.16 Forms – Notification of Newborn, W-416

Overview

The newborn application process is handled by the Central Office of the Department of Social Services (DSS). All Notification of Newborn, W416 forms should be completed and faxed to DSS, Central Office, Central Processing Unit. Hospitals must notify DSS within 5 calendar days of the date of birth. DSS will add the newborn to the medical program, assign a Connecticut Medical Assistance Program client number to the W416 form and fax the annotated W416 form back to the hospital. DSS will also notify the mother, and the regional worker.

When transmitting Notification of Newborn Forms or inquiring as to the status of the application, providers should use the following Central Processing Unit information:

Fax number (860) 424-5678 or (860) 424-5679
Telephone (860) 424-5756

Providers should mail written inquiries to the following address:

Department of Social Services
Central Processing Division, Newborn Applications
55 Farmington Avenue
Hartford, CT 06105

How to Obtain the Notification of Newborn, W416 Forms

Providers may obtain copies of the Notification of Newborn, W416 form from the following address:

Department of Social Services
Supervisor, Duplicating
55 Farmington Avenue
Hartford, CT 06105

Providers may duplicate blank W416 forms for future use. The form is available in the Spanish language and may be obtained from DSS at the above address.

The Notification of Newborn, W416 form is on the following page.

Form W-416

W-416
(Rev. 6/09)

NOTIFICATION OF NEWBORN

TO: THE DEPARTMENT OF SOCIAL SERVICES

1. Mother's Information - To be completed by hospital official.

Name _____ Date of Birth _____
Address _____ SSN _____

Is this mother an active Medicaid recipient? ☐ Yes ☐ No If Yes, DSS Client ID # _____
Will the newborn be released to the mother? ☐ Yes ☐ No

2. Hospital Certification – To be completed and signed by hospital official.

PCP Name and Address _____

I certify that _____ (baby's name (first, middle initial, last)) (☐ boy, ☐ girl) was born at this hospital on _____ (date)
(check one)

I also certify that the mother ☐ has, ☐ has not (check one) applied for a Social Security Number for the newborn through the enumeration at birth process.

Signature of Hospital Official _____ Title _____ Date _____

Printed Name of Hospital Official _____ Telephone # _____ Hospital Fax #: _____

3. Mother's Certification - To be read and completed by mother.

Certificación de la Madre – Para ser leído y completado por la madre.

I declare under penalty of perjury that _____ was born to me at this hospital and is a United States citizen. _____
baby's name (first, middle initial, last)

Declaro bajo pena de perjurio que _____ me nació en este hospital y es un ciudadano de los Estados Unidos _____
nombre del bebé (nombre, inicial, apellido)

Signature of Mother _____ Printed Name of Mother _____ Date _____
Firma de la Madre Nombre de la Madre en Letra de Molde Fecha

4. Fax To: Department of Social Services, Central Processing Unit Fax Numbers: 860-424-5678 or 860-424-5679

THIS AREA TO BE COMPLETED BY THE DEPARTMENT OF SOCIAL SERVICES OR ACS

Newborn Client ID # _____ Newborn Client ID # _____ EMS ID _____
(HUSKY A) (HUSKY B)

TO HOSPITAL STAFF

In order to receive reimbursement, you **must** complete all items on this form and obtain the mother's signature in section 3 whenever possible.

For Section 2:

Hospital officials completing section 2 **should do so only** if he or she can certify the accuracy of the information he or she provides in section 2.

- The hospital official **must** attempt to obtain the newborn's PCP name and address if it is known.
- The hospital official signing the W-416 **must** attempt to obtain the mother's signature in section 3.
- The W-416 **must** be completed and signed in the hospital and submitted to DSS by a hospital official and **printed on hospital letterhead**.
- The hospital must submit the W-416 to DSS even if the mother does not sign the W-416.

TO MOTHER

When you sign this form, it serves as an application for medical assistance for your newborn. If you are already a recipient of Medicaid, HUSKY A coverage for your baby may be granted for a period of one year from date of birth providing your newborn lives with you and you continue to be eligible for medical assistance or you would be eligible if you were still pregnant. HUSKY A coverage for the child is automatically discontinued at the end of the year unless eligibility is established under another HUSKY category. If you are not a recipient of HUSKY A or another Medicaid category, you will have to provide additional documentation to the Department of Social Services. You may apply at any time for these and other benefits, including cash assistance and SNAP, at your local DSS Regional Office.

A LA MADRE

Cuando usted firme este formulario, esto sirve como una solicitud para asistencia médica para su recién nacido. Si usted ya es un beneficiario de Medicaid, puede ser que se le concede la cobertura de HUSKY A para su bebé por un período de un año desde la fecha de nacimiento siempre que su recién nacido viva con usted y usted continúe siendo elegible para la asistencia médica o usted sería elegible si estuviera todavía embarazada. La cobertura de HUSKY A para su hijo se discontinuará automáticamente al final del año a menos que se establezca la elegibilidad bajo otra categoría HUSKY. Si usted no es un beneficiario de HUSKY A u otra categoría de Medicaid, usted tendrá que ofrecer documentación adicional al Departamento de Servicios Sociales. Usted puede aplicar en cualquier momento a estos y otros beneficios, incluyendo ayuda monetaria y SNAP, en su Oficina Regional local del DSS.

5.17 e-Prescribing

Overview

e-Prescribing allows licensed authorized practitioners, clinics, hospitals and pharmacies to provide enhanced patient service and ensure medication safety by streamlining practice workflows through the efficiency of electronic medication orders, receiving pharmacy program benefits for the patient and obtaining patient medication history information.

Licensed Authorized Practitioner means any physician or other licensed practitioner who is authorized to prescribe drugs within the scope of his or her professional practice as defined and limited by Federal and State law.

As of October 2009, DSS is a certified payer in the Surescripts network. Through the Surescripts network, the e-Prescribing technology is securely linked to the Connecticut Medicaid Management Information System (MMIS). Surescripts electronically routes up-to-date patient eligibility, medication history, and information about how the different pharmacy programs cover specific medications at every point of care.

This allows providers who currently use an approved e-Prescribing system access to Connecticut Medical Assistance Program client's eligibility, formulary, and medication claim history for:

- HUSKY A,
- HUSKY B,
- HUSKY C,
- HUSKY D, and
- Connecticut Aids Drug Assistance Program (CADAP) for dates of service prior to November 1, 2018. For dates of service November 1, 2018 and forward, the CADAP program is administered by the Department of Public Health's pharmacy benefit manager, Magellan. For contact information, please reference Chapter 1.

How to Become Certified with Surescripts

Hospitals and clinics need to become certified directly with Surescripts so that the licensed authorized practitioners in your facilities may access the e-Prescribing information. Providers may contact Surescripts at 1-866-797-3239 or online at www.surescripts.com.

e-Prescribing Client Eligibility Information

Connecticut Medical Assistance Program licensed authorized practitioners, clinics and hospitals use their valid National Provider Identification number (NPI) to access real-time pharmacy eligibility information for CT Medical Assistance Program clients.

Patient and eligibility data are transmitted through Surescripts using the HIPAA compliant X12N 270/271 standard Health Care Eligibility Benefit Inquiry and Response transaction. Eligibility information is retrieved from Surescripts' Master Patient Index (MPI). The MPI is a directory of patients with minimal demographic information (name, date of birth, gender, and zip code). This demographic information is used by matching algorithms to identify data sources (such as insurance plans or Pharmacy Benefit Management (PBMs) that have medication history and formulary benefit information for the specific patient.

To access a CT Medical Assistance Program client's eligibility

information via Surescripts, **providers must include the client's identification number from their CONNECT card and the client's date of birth on the eligibility request.** Social Security Numbers are not a data element used in retrieving eligibility information in e-Prescribing. **Other key elements that are recommended for submission on the request are the client's first name, last name, zip code, and gender.**

In the event that a client is not found on Surescripts' MPI, the provider receives a response in the 271 transaction stating "Patient not found". Eligibility requests for future dates of service also return a rejected response in the 271 transaction stating "Future eligibility cannot be requested".

e-Prescribing Medication
History Information

Connecticut Medical Assistance Program licensed authorized practitioners, clinics and hospitals must use their valid NPI to access CT Medical Assistance Program clients' medication history. Providers have access to two (2) years of medication history. Medication history transactions will be processed using the NCPDP Script 8.1 HIPAA standard transaction.

As a reminder, medication history is classified as Protected Health Information (PHI) under [HIPAA](#). HIV/mental health information may be disclosed within this transaction and confidentiality of this information is protected by state law which prohibits re-disclosure without specific written consent of the client.

The Coordination of Benefits segment of the NCPDP transaction is used to communicate any starting and ending dates which the requestor of the medication history has asked to be applied in order to limit the time-frame of the history that is received. This segment is also where the provider confirms they have received the client's consent to access their medication history.

Field COO-090 – Date/Time Period Qualifier – These fields must be populated in the CCYYMMDD format to indicate the effective date and expiration date of the requested medication history. These fields are optional, but if used both dates must be present. If this element is not present on the request transaction, or if only one date is present, the most recent (up to 50) claims are returned in the corresponding response transaction. The MMIS limits its searches for medication history to the two years prior to the date on which the medication history request transaction is received.

Field COO-130 – <Consent> Condition/Response Coded - This field must always contain one of the following values to indicate that the client has given the prescriber authorization to access their medication history:

- **"Y" – Consent given** - The MMIS attempts to look up and return medication history for the patient when this value is used.

- **“N” - No Consent** – The MMIS does not attempt to return medication history when this value is used – an ERROR response is generated instead with a status type code of 900 (Transaction rejected) and an error code of 219 (COO Cannot process Medication History due to value of Condition/Response Code).
- **“X” - Parental/Guardian consent on behalf of a minor** - The MMIS attempts to look up and return medication history for the patient when this value is used.

Any value found in this field other than those listed above results in an error transaction with a status type code of 900 (Transaction rejected) and an error code of 124 (COO response code is invalid).

e-Prescribing Pharmacy Benefit Information

Connecticut Medical Assistance Program licensed authorized practitioners, clinics and hospitals use their valid NPI to access real-time pharmacy programs benefit information. Benefit information is at the prescriber's fingertips at the time of prescribing. This enables providers to:

- select medications that are on the formulary covered by the patient's pharmacy benefit,
- be informed of lower cost alternatives such as generic drugs and ultimately ensures that the staff in the pharmacy receives a “clean” script, and
- eliminate unnecessary phone calls from pharmacy staff to physician practices related to drug coverage.

Providers access prescription benefit information through the software of their e-Prescribing vendor. For providers who are not currently using an e-Prescribing vendor, a list of certified vendors is available at the following Web site:

<http://surescripts.com/network-connections/mns/prescriber-software>

Pharmacy program benefits information is updated weekly. Providers with an existing e-Prescribing system should contact their Point-of-Care software vendors to determine their frequency for downloading pharmacy program benefits from Surescripts in order to ensure access to the most reliable, up-to-date information on each CT Medical Assistance pharmacy program. The types of pharmacy program benefits information available through e-Prescribing is summarized below:

Prior Authorization

All current medications requiring prior authorization (PA) are identified for the provider at the time of prescribing.

Preferred Drug List (PDL) Alternatives

Providers have access to the PDL formulary real-time. Providers are able to identify which drugs are “non-preferred” and require PA. Preferred alternatives are identified by drug name (**not** strength or dosage form) and the provider is able to decide to either prescribe the preferred agent or to begin the prior authorization process in

order to obtain coverage for the non-preferred drug.

Resource Link

Web links are tied to specific drugs in each formulary. The Web link for Prior Authorization forms is provided for all drugs that currently require PA including Non-Preferred Drug (PDL), Optimal Dose, and Synagis, and Serostim for the CADAP program (for dates of service prior to November 1, 2018).

Coverage Text Message

Text messages are available to providers and allow specific messages to be conveyed about particular drugs. Examples include drugs that require diagnosis for coverage and drugs that are limited to once daily dosing.

Quantity Limits

Drugs that are limited by either quantity or days supply are visible real-time.

Age Limits

Drugs where age restrictions are applicable for coverage are visible real-time.

Gender Restrictions

Drugs where gender restrictions are applicable for coverage are visible real-time. Gender restrictions are determined through the use of First Data Bank's clinical drug modules.

Benefit Co-Pay

Co-pay information is identified for all State programs where co-pays are in effect. This includes the HUSKY B program. **Co-pay amounts identified are only an estimate of the client's liability.** Actual co-pay determination is finalized during claims submission from the pharmacy.

Submit the Prescription

Once prescribers receive and review all of the patient's information, a prescription can be submitted electronically via your software vendor to the patient's pharmacy of choice. Prescriptions may also be rendered in the traditional prescription pad format and provided to the patient or faxed to the pharmacy.

How to Obtain Additional Information

Providers looking for more information on e-Prescribing and its benefits can visit the Connecticut specific "Get Connected" Web site at <http://www.getrxconnected.com/CSMSIPA/site.aspx>.

5.18 Co-pays/Cost Shares

Overview

The following section provides information on co-pays and cost sharing for various provider types and client populations:

Provider Type(s)	Co-pay/Cost Share Requirements
Dentists, Dental Groups, Dental Hygienists, Dental Hygienist Groups, Dental Clinics and Federally Qualified Health Centers	As required by Public Act 10-3, all HUSKY B clients are required to pay for a portion of care provided for all endodontic, orthodontic, oral surgical, prosthodontic, restorative and adjunctive dental procedures. Providers may not charge HUSKY B clients more than the client's cost share indicated on the dental fee schedule. Fee schedules are available at www.ctdssmap.com by selecting Provider, then Provider Fee Schedule Download, and scrolling down to Dental. The cost share information is available on the PDF and CSV (Comma Separated Values) formats. The fee schedule lists the Connecticut Dental Health Partnership (CTDHP) fee and the client's cost share percentage. FQHC services are subject to these same cost-share requirements when T1015 is billed with a procedure code that is subject to cost-share. Dental providers who have questions about the cost share requirements should contact BeneCare's Provider Services Staff at 1-888-445-6665.
Psychiatric Residential Treatment Facilities, Freestanding Mental Health Clinics, Federally Qualified Health Centers (FQHC), School-Based Health Centers, Alcohol and Drug Centers, Methadone Clinics, Home Health Agencies, Psychiatrists, Advanced Practice Registered Nurses, Psychologists, Licensed Clinical Social Workers, License Marital and Family Therapists, Licensed Professional Counselors, and Licensed Alcohol and Drug Counselors	All HUSKY B clients are required to pay for a portion of care provided for all office-based outpatient behavioral health services. Providers may not charge HUSKY B clients more than the clients' cost-share for the same procedure. FQHC services are subject to these same cost-share requirements when T1015 is billed with a procedure code that is subject to cost-share. Effective September 1, 2018 and forward the Husky B co-payment requirement is being discontinued for behavioral health (BH) services. Cost-share requirements are posted to the CT Behavioral Health Partnership (CT BHP) Web site at: www.ctbhp.com select For Providers, then Covered Services on the left hand navigational menu, then click on the HUSKY B Client Cost-Share Services hyperlink.
Medical Services for HUSKY B	The Department of Social Services (DSS) and CHNCT have prepared benefit coverage grids that outline covered services and copay

information for clients in the HUSKY Health Program. Benefit information is broken down by provider type and the benefit plan. The contents provide a general summary of HUSKY Health benefits. Providers can access the benefit coverage grids from the Providers page of the CHNCT website under “Benefits and Authorization”. The link to the benefit coverage grids is listed below:

http://www.huskyhealthct.org/providers/benefits_authorizations.html.

Providers should review these grids to determine the services covered for a client’s benefit plan. The benefit coverage grids will be updated periodically.

Connecticut Home Care Cost Sharing

The Connecticut Home Care Program (CHCP) cost share amount is 7% of the total plan of care. Effective for dates of service July 1, 2013 and forward applied income and cost share is displayed but not deducted from the claim. Allied Community Resources is responsible for collecting this amount from the client. This change does not apply to Assisted Living providers.

Pharmacy

HUSKY B - Clients are subject to a tiered co-pay:

NDC Classification	Co-pay Amount
Generic	\$5.00
Brand	\$10.00
Family Planning	Claim will assign either the Brand or Generic co-pay amount based on the drug classification

Medicaid and Medicare Part D - All fee-for-service Medicaid clients who have Medicare Part A and/or Medicare Part B are considered **dually eligible clients**. These dually eligible clients are enrolled into a Medicare Part D Prescription Drug Plan (PDP) by the Federal government. Connecticut Medicaid pays for the Medicare Part D co-pays on behalf of the dually eligible client after the PDP is billed and a paid claim is returned to the pharmacy from the PDP. Claims that are submitted to Medicaid and exceed the co-pay amount for Medicare Part D covered claims will deny. If a claim is returned by the PDP with a co-pay greater than the annual designated co-pay amount the issue must be resolved with the PDP. Medicare Part D co-pays for the dually eligible are adjusted annually for inflation.

Dual eligible clients are financially responsible for the first fifteen dollars (\$15.00) of co-pays imposed by their Medicare Part D Prescription Drug Plan (PDP) every month. Once the client’s co pay amount exceeds fifteen dollars in a given month, any co-pays incurred thereafter will be paid by the Connecticut Medical Assistance Program for the remainder of the month. The cost of the Medicare Part D co-pay may be shared by the client and the Connecticut Medical Assistance Program if the full cost of the co-pay would cause the client to exceed their monthly co-

pay responsibility.

HUSKY D - HUSKY D individuals who have Medicare Part A and/or Medicare Part B are considered ***dually eligible clients***. These dually eligible clients must enroll into a Medicare Part D. Individuals with HUSKY D benefit coverage are financially responsible for the first fifteen dollars (\$15.00) of co-pays imposed by their Medicare Part D Prescription Drug Plan (PDP) every month. Once the client's co-pay amount exceeds fifteen dollars in a given month, any co-pays incurred thereafter will be paid by the Connecticut Medical Assistance Program for the remainder of the month. The cost of the Medicare Part D co-pay may be shared by the client and the Connecticut Medical Assistance Program if the full cost of the co-pay would cause the client to exceed their monthly co-pay responsibility.

5.19 Family Planning Services – Limited Benefit

Overview

The Department of Social Services has established a limited benefit coverage group for men and women seeking family planning and family planning - related services. The Family Planning – Limited Benefit provides confidential coverage for family planning and family planning - related services for individuals of childbearing age (including minors) who are **not** otherwise eligible for full Medicaid coverage. In order for services to be covered, therefore, they must be part of a visit relating to the individual's desire to prevent pregnancy, or regulate the number and spacing of children. The Department has identified ICD-10-CM diagnosis codes as related to family planning coverage, as long as they are provided as part of or as follow-up to a family planning visit.

Coverage includes family planning services as well as family planning - related services that are provided **as part of or as follow-up to a family planning visit**.

Family planning and family planning - related services include:

- Comprehensive physical examinations
- Screening and treatment services for sexually transmitted disease / illness
- Voluntary sterilizations in accordance with federal guidelines
- Contraceptive services and supplies
- Human papilloma virus vaccinations (including males)
- Family planning related surgical treatments (for example, perforated uterus as a result of an IUD)
- Pregnancy tests

Please note Family Planning Services - Limited Benefit does **not** cover:

- Infertility services and related treatment
- Hysterectomies
- Termination of pregnancy
- Pregnancy care
- Treatment for HIV/AIDS or hepatitis
- Treatment for cancer
- Any other service that is not provided as part of or as follow-up to a family planning visit.

Covered Services, including Diagnosis Code List

Physicians, Advanced Practice Registered Nurses (APRNs), Certified Nurse Midwives (CNMs), ambulatory surgical centers, clinics, independent labs, and outpatient hospitals may bill for family planning and family planning - related services that are on their applicable fee schedules.

Physicians, APRNs, CNMs, ambulatory surgical centers, clinics, and independent labs should refer to their applicable fee schedules for a definitive list of covered services. Each fee schedule will contain a header or footer that identifies the services covered or excluded from coverage under the new limited benefit family planning group.

Diagnosis codes identified by the Department of Social Services as family planning and related services and that are to be used when billing for services provided under the Limited Benefit - Family Planning

coverage group can be found in the Fee Schedule Instructions. Please note when billing for services under the Limited Benefit - Family Planning eligibility group, one of the diagnosis codes found within the fee schedule instructions must be submitted on the claim.

The fee schedule instructions can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com.

To access the instructions from the Connecticut Medical Assistance Program Web site Home Page:

1. Click on Provider
2. Click on Provider Fee Schedule Download
3. Review the End User License Agreements and select either:
 - I Accept
 - I Do Not Accept

In order to access the fee schedule, you must accept the end user license agreements.
4. Select the Fee Schedule Instructions quick link and scroll down to the Diagnosis Codes for Family Planning Services table:
 - Table 3b for ICD-10-CM diagnosis.

Pharmacy

Limited pharmacy coverage is included for the new family planning eligibility group. A select group of drugs that are relevant to the treatment of family planning and family planning - related services will be covered when an ICD-10 diagnosis related to family planning is present on the prescription and submitted on the pharmacy claim.

Covered pharmacy services include drugs in the following drug categories:

- Antibiotics
- Antibacterials
- Antimycotics
- Antiparasitics
- Analgesics
- Drugs Acting Principally on Joints
- Contraceptives-oral
- Contraceptives –topical
- Contraceptives-systemic-non oral

Transportation

Transportation to and from scheduled medical appointments for family planning and family planning - related services will be available for clients eligible under the family planning coverage group. Clients should contact LogistiCare at 1-888-248-9895 to coordinate transportation at least 2 business days prior to the scheduled medical appointment.

Presumptive Eligibility

A HUSKY HEALTH Certified Entity (HHCE) may grant confidential presumptive eligibility to qualified individuals, based on the Department's criteria, who apply for Family Planning Services - Limited Benefit. Only the Department of Social Services may grant a provider HHCE status. Please refer to Section 5.12 for more information regarding presumptive eligibility.

5.20 Tuberculosis Eligibility Waiver

Tuberculosis Eligibility Waiver

Overview

The Tuberculosis Eligibility Waiver provides coverage for TB-related services for those individuals with TB who are not otherwise eligible for Medicaid. Specific providers may bill for procedures on their individual fee schedules that are related to a TB diagnosis. The Department has identified ICD-10 diagnosis codes as TB related. Limited pharmacy coverage is included for the new TB eligibility group.

Any provider who identifies an individual not eligible for Medicaid who has active or latent TB is encouraged to refer the client to the Department of Social Services Adult Support Unit at (860) 424-5250 for eligibility determination. The Department will mail a paper application to the individual which must be completed and sent back to Adult Services, Department of Social Services, State of Connecticut, 55 Farmington Avenue, Hartford, CT 06105 or faxed to (860) 424-4957.

Physicians, advanced practice registered nurses, certified nurse midwives, clinics, independent labs, independent radiologists, and outpatient hospitals may bill for procedures on their individual fee schedules that are related to a TB diagnosis.

Home Health Agencies may only bill Direct Observation Therapy (DOT) codes G0493 - Skilled Services by a Licensed Nurse (LPN) and G0494 - Skilled Services by a Registered Nurse (RN) on the Home Health fee schedule related to a TB diagnosis.

Local Health Departments (LHDs) are an eligible provider type that can bill for TB-related services. A select group of procedure codes are listed on the Local Health Department's fee schedule under the rate type of "TB". LHD providers should refer to the Provider Manual Chapter 8 "Special Services" for claim submission instructions. Please refer to Table 12 in the Fee Schedule Instructions to identify the appropriate ICD-10 TB related diagnoses codes.

The fee schedule instructions can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com.

To access the instructions from the Connecticut Medical Assistance Program Web site Home Page:

1. Click on Provider
2. Click on Provider Fee Schedule Download
3. Review the End User License Agreements and select either:
 - I Accept
 - I Do Not Accept

In order to access the fee schedule, you must accept the end user license agreements.
4. Select the Fee Schedule Instructions quick link and scroll down to the TB Related Diagnosis Codes table.

Home Health	The home health agency fee schedule includes code G0163 - Skilled nursing services of a licensed nurse...in the delivery of observation and assessment of the patient's condition, also known as "Direct Observed Therapy" (DOT), G0493 - RN care ea 15 min dd/hospice and G0494 - LPN care ea 15 min hh/hospice. These codes may be used for current Medicaid clients as well as the new eligibility group. Home health agencies may bill these codes for clients receiving DOT when ordered by a physician. The primary diagnosis must be TB. No other codes on the home health fee schedule are payable for the TB coverage group. DOT may not be billed on the same date of service as a skilled nursing visit or a medication administration visit.
Pharmacy	Limited pharmacy coverage is included for the new TB eligibility group. A select group of drugs that are relevant to the treatment of TB will be covered when an ICD-10 diagnosis of TB is present on the prescription and submitted on the pharmacy claim. These drugs include select antibacterials, antimycobacterials, antimicrobials, and steroids/anti-inflammatory agents. A comprehensive list of payable drugs is available at www.ctdssmap.com . From the Home page, go to Pharmacy Information→Pharmacy Program Publications→TB Drug List. This list will be updated as needed.
Billing Instructions	Billing instructions for the TB Waiver can be found in Chapter 8 of the Provider Manual.