Connecticut interChange MMIS

Provider Manual

Chapter 8 – Home Health Claim Submission Instructions

October 1, 2020

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

Gainwell Technologies
55 Hartland Street
East Hartford, CT 06108

Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	01/01/2008	Initial Release.	All	All
1.1	01/16/2009	Updates made to reflect the new Charter Oak Health Plan; updates made to clarify Medicare coinsurance and deductible billing instructions; updates made to prior authorization instructions; updates to field by field billing instructions to provide further clarification; updates to fee schedule instructions.	8.1 8.2 8.3 8.4	2 4 6, 8, 10-13 17-21
1.2	10/05/2009	Added Hospice claim submission instructions, updated other insurance/Medicare billing instructions, clarified instructions for service units, removed detailed fee schedule instructions.	8.1 8.2 8.3 8.4	2 4 6, 10-13, 16 18
1.3	10/26/2009	Updated Hospice effective date.	8.1	2
1.4	01/15/2010	Updated prior authorization section.	8.2	4
1.5	02/18/2010	Updated Medicare reconsideration requirements to include the ABN issue date, updated EDS references to HP.	8.2 8.3	4 9, 12
1.6	07/22/2010	Updated to reflect discontinuation of SAGA program and the implementation of the Medicaid Low Income Adults program; replaced references to OI/Medicare Billing Guide links with Chapter 11; revised fee schedule instructions.	8.1 8.3 8.4	2-3 7, 9, 14,17 19
1.7	09/01/2011	Updated as a result of CT BHP changes, as well as HIPAA 5010.	8.1 8.3 8.4	2 7, 17 19
1.8	03/27/2012	Updates made as a result of TB waiver and transition to ASO.	8.1 8.2 8.3 8.4	2 5 7-11 19

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Version	Version Date	Reason for Revision	Section	Page(s)
1.9	10/28/2013	Updates made as a result of the ordering, prescribing, referring provider requirements, CHC changes, and other misc updates.	8.1 8.2 8.3 8.4	2 5-6 8, 10, 16-18 20
2.0	03/04/2014	Updates made to reflect the shutdown of the Charter Oak Health Plan Program. Also updated as a result of the Med Box implementation.	8.1 8.2 8.3	6 10 12, 14-15, 17
2.1	05/07/2014	Updates made as a result of CHC changes and the ICD-10 implementation, as well as the implementation of the Early Childhood Autism Waiver.	8.2 8.3	9 16, 20-21
2.2	09/14/2015	Updates made to remove references to Charter Oak. Updates to ICD-10 references.	8.1 8.2 8.3	6-7 9 12, 14, 20-22
2.3	11/01/2015	Updated to replace HP references/logo with Hewlett Packard Enterprise references/logo.	8.1 8.2 8.3	6 9 12
2.4	02/23/2016	Updated to include PCA claim submission instructions, as well as updated link for the PCA Procedure Code/ Frequency crosswalk.	8.3	16
2.5	12/05/2016	Updated as a result of the elimination of paper claims. Removed references to ICD-9. Additional updates as a result of program changes.	8.1 8.3	12 14,16 18 22
2.6	4/20/2017	Hewlett Packard Enterprise to DXC Technology updates.	All	All
2.7	02/28/2018	Update to crosswalk links, added Autism Waiver information and updated the RCC and HCPCS claim fields with new codes and reference to list codes to Procedure code crosswalks.	8.1 8.2 8.3	3 6, 13-16,

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Version	Version Date	Reason for Revision	Section	Page(s)
			8.4	23
2.8	10/11/2019	Updated to include references to EVV Web page and billing guidance for modifiers	8.2 8.3	6, 13,15
2.9	10/01/2020	Updated to replace DXC Technology references/logo with Gainwell Technologies references/logo.	All	All

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

8.1 Overview

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

Chapter 8 contains claim information and procedures, specific claim submission instructions, and fee schedule information for home health providers participating in the Connecticut Medical Assistance Program. Home Health Services are a covered service for clients covered under the HUSKY Health Program (HUSKY A, HUSKY B, HUSKY C – previously referred to as Medicaid, HUSKY D – previously referred to as Medicaid LIA), clients receiving services through the Connecticut Behavioral Health Partnership (CT BHP) and clients covered under the State Funded Connecticut Home Care Program.

The information in Chapter 8 is important for all providers performing home health services. It is important to note, however, that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers.

Providers should refer to Chapter 6, Electronic Data Interchange Options for electronic claim submission information. Providers interested in submitting claims through the internet should refer to Chapter 10 for internet claim submission instructions. Claim Submission Help Text for the internet claim submission feature is also located on the claim submission panel by clicking on the Quick Links in the upper left corner of the Web page, and/or by clicking on HELP in the upper right corner of the Web page.

Connecticut Behavioral Health Partnership (CT BHP)

The Connecticut Behavioral Health Partnership (CT BHP), a joint initiative between the Department of Social Services, the Department of Children and Families (DCF), and the Department of Mental Health and Addiction Services (DMHAS), provides utilization management of behavioral health services for all HUSKY Health Program and DCF funded clients.

Home Health providers must submit behavioral health claims for services with a behavior health diagnosis code as the primary diagnosis code to Gainwell Technologies for processing. Providers must use an ICD-10-CM behavioral health diagnosis as the primary diagnosis code. To obtain the list of ICD-10 behavioral health diagnosis codes, refer to the Fee Schedule Instructions, Table 10.

To access the instructions from the Connecticut Medical Assistance Program Web site Home Page at www.ctdssmap.com:

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 page, you must accept the end user license agreements.
4. Select the Fee Schedule Instructions quick link and scroll down to Table 10 for ICD-10 Behavioral Health Diagnosis codes

Connecticut Home Care (CHC) Program

Home Health Services are covered services for clients under the Connecticut Home Care (CHC) Program. Home Health Services must be on the client's Care Plan, with a Prior Authorization number associated for all Home Health services to be rendered in order for the provider to be paid. Claims must be submitted with the appropriate ICD-10 diagnosis codes.

Home Health Agencies, who wish to provide non-medical services to Connecticut Home Care clients, must be credentialed with Allied Community Resources. Once credentialed, they must enroll as Connecticut Home Care (CHC) Service providers and should refer to the Waiver Provider Manual for CHC Program guidelines and claim submission instructions for non-medical CHC Services.

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Personal Care Assistance (PCA) Waiver

Effective for dates of service February 25, 2016 and forward, Home Health Services for clients covered under the Personal Care Assistance (PCA) Waiver Program, must be on the client's Care Plan. A Prior Authorization (PA) number must be associated for all Home Health services to be rendered in order for the provider to be paid. Claims must be submitted with the appropriate ICD-10 diagnosis codes.

Home Health Agencies, who wish to provide non-medical services to PCA Waiver clients, must be credentialed with Allied Community Resources. Once credentialed, they must enroll as Personal Care Assistance (PCA) Service providers and should refer to the Waiver Provider Manual for PCA Waiver Program guidelines and claim submission instructions for non-medical PCA Services.

Acquired Brain Injury (ABI) Waiver

Effective for dates of service September 1, 2016 and forward, Home Health Services for clients covered under the Acquired Brain Injury (ABI) Waiver Program, must be on the client's Care Plan. A Prior Authorization (PA) number must be associated for all Home Health services to be rendered in order for the provider to be paid. Claims must be submitted with the appropriate ICD-10 diagnosis codes.

Home Health Agencies, who wish to provide non-medical services to ABI Waiver clients, must be credentialed with Allied Community Resources. Once credentialed, they enroll as Acquired Brain Injury (ABI) Service providers and should refer to the Waiver Provider Manual for ABI Waiver Program guidelines and claim submission instructions for non-medical ABI Services.

Autism Waiver

Effective for dates of service January 1, 2018 and forward, Home Health Services for clients covered under the Autism Waiver Program, must be on the client's Care Plan. A Prior Authorization (PA) number must be associated for all Home Health services to be rendered in order for the provider to be paid. Claims must be submitted with the appropriate ICD-10 diagnosis codes.

Home Health Agencies, who wish to provide non-medical services to Autism Waiver clients, must be credentialed with Allied Community Resources. Once credentialed, they can enroll as Autism Waiver Service providers and should refer to the Waiver Provider Manual for Autism Waiver Program guidelines and claim submission instructions for non-medical Autism Waiver Services.

Hospice

A Hospice benefit is available for all HUSKY Health Program clients. For specific information about the Hospice benefit, providers can access the Chapter 8 Hospice Services Manual located at www.ctdssmap.com, by selecting Information, Publications and Hospice from the Chapter 8 drop down box.

For information on obtaining Hospice client eligibility information, refer to Chapter 4, also located at www.ctdssmap.com by selecting Information, Publications. Providers should review the client's eligibility information to determine under which Hospice Agency care is being provided. Please note that all Home Health services for hospice clients require prior authorization, if billed by the Home Health Agency.

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Tuberculosis (TB) Covered Services

Current HUSKY Health Plan clients and those with a "Tuberculosis Covered Services Only" benefit are eligible for Direct Observed Therapy (DOT). DOT services cannot be performed on the same day as other skilled nursing or medication administration visits and cannot be combined with other services on the same claim.

For the ICD-10 list of diagnosis codes related to TB services, refer to the Fee Schedule Instructions, Table 12.

To access the instructions from the Connecticut Medical Assistance Program Web site Home Page at www.ctdssmap.com:

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 page, you must accept the end user license agreements.
4. Select the Fee Schedule Instructions quick link and scroll down to Table 12 for ICD-10 Diagnosis codes for Tuberculosis Eligibility Waiver

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8.2 Prior Authorization

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There are prior authorization (PA) requirements for Home Health Services. All Home Health services for hospice clients require prior authorization, if billed by the Home Health Agency.

All Home Health Services for clients with a State Funded Connecticut Home Care (CHC), or HUSKY A or C benefit and an ABI,CHC or PCA waiver, must be uploaded or entered on the secure Web portal by the Case Management Agency (ABI Waiver) or Access Agency (CHC or PCA Waiver) managing the client's care and must appear on the client's Care Plan. Home Health Services for Autism Waiver clients are authorized by the DSS Community Options Autism Waiver Case Managers who create or link PAs directly to the client's care plan via a secure Web account. Providers can review services on the client's care plan via their secure Web account under the PA menu by selecting PA Inquiry, entering the client's ID and other search defining information. Home Health services entered on the care plan exceeding the maximum allowed will appear in an "In Process" status until the service is approved by DSS. Services that do not require PA will appear in an "Auto Approved" status.

In situations where HUSKY only client services are covered by another insurance carrier, the home health agency must seek PA from the Connecticut Medical Assistance Program. However, if the client has Medicare as their primary insurance, PA is not required, as per current policy. When the client has other insurance, authorization is not required prior to the service being rendered as in the instances of retroactive prior authorization and immediate service requests. PA for clients with an ABI, Autism, CHC or PCA benefit who have other insurance will continue to be added to the client care plan and auto approved or held in an "In Process" status until approved by DSS.

Please refer to Chapter 9 of the Provider Manual for full prior authorization requirements, contact information and related forms. Providers should also reference Chapter 7, Medical Policy and the Home Health Fee Schedule for specific procedure prior authorization requirements.

General Claim Submission	All Home Health services for clients with an ABI, Autism, PCA or CHC benefit plan with or without HUSKY A or C must be on the client's plan of care and submitted via the institutional claim format. Paper claims are no longer permitted unless otherwise directed if the claim must be special handled. Claims submitted for services that are not on the care plan will deny.
Electronic Visit Verification	Effective for dates of service beginning April 3, 2017 and forward, Electronic Visit Verification (EVV) is mandated for the time capture of all Home Health visits performed for clients with an ABI, CHC or PCA waiver benefit plan. Effective for dates of service beginning March 3, 2019 and forward, EVV is mandated for the time capture of all Home Health visits performed for clients with an Autism waiver benefit plan. Providers can choose to use the EVV system, the CMAP secure site, their own billing software or any combination of these 3 methods to export claims to Gainwell Technologies for dates of service beginning April 3, 2017. Providers servicing clients without an Autism, CHC, PCA or ABI waiver benefit plan that receive Home Health services are not required to utilize the EVV system at this time. For more information on the EVV program, including mandatory training documents, Interface Specifications and a Frequently Asked Questions (FAQ) document, providers should refer to the Electronic

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	Visit Verification Web page, available from the Home page of the www.ctdssmap.com Web site.
Third Party Liability and/or Medicare	Due to the Affordable Care Act (ACA), new claim submission requirements regarding Ordering, Prescribing and Referring (OPR) providers have been implemented. Providers should refer to the claim submission guidelines further in this chapter for OPR field requirements. As Medicaid is the payer of last resort, claims for HUSKY clients with or without an ABI, Autism, CHC or PCA waiver or those with a State Funded CHC benefit, must first be billed to all other insurance carrier(s). After the other insurance carrier(s) has processed the claim, the provider then submits the claim to Gainwell Technologies. If the client has an ABI, Autism, CHC or PCA Waiver or State Funded CHC benefit, the service billed must be on the care plan and the provider must indicate the other insurance carrier payment or denial information when submitting the claim to Gainwell Technologies. Providers should refer to Chapter 11 “Other Insurance and Medicare Billing Guides” for applicable TPL claim submission information. Claims for clients with a HUSKY, HUSKY with ABI, Autism, CHC or PCA Waiver or State Funded CHC benefit covered under Medicare, however, who do not meet the Medicare level of care for being homebound, can be submitted directly to Gainwell Technologies with an adjustment reason code of 150, 151 or 152 and the Advanced Beneficiary Notice (ABN) issue date for Medicare non-managed care clients, or the Managed Care Organization Notice of Medicare Non-Coverage (NOMNC) issue date for Medicare managed care clients, indicating that Medicare will not cover the claim. These claims are subject to a monthly Other Insurance Audit. If the claim is selected, the provider is required to send a copy of the ABN or NOMNC indicating that the client did not meet the Medicare level of care for the services provided, in addition to a copy of the other insurance EOB indicating payment or denial for each other insurance carrier indicated on the client’s eligibility file, active on the date of service.
Medicare Covered Services	Clients who are eligible for Medicare covered services **only** are eligible to have their coinsurance and deductible claims processed. The Connecticut Medical Assistance Program will pay the lower of 1) the coinsurance and/or deductible amount submitted or 2) the Connecticut Medical Assistance Program allowed amount minus any Medicare or other insurance payment. Charges that are denied or not covered by Medicare will not be considered for payment under the Connecticut Medical Assistance Program. **Medicare covered services are not payable under the CT BHP.**

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8.3 Home Health Claim Submission Instructions

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Electronic Claim Submission References	As a reminder, providers are required to submit claims electronically, unless the claims meet the exception criteria outlined below. Providers should use the following resources for electronic claim submission information: • Chapter 6, Electronic Data Interchange Options, for electronic claim submission options located at www.ctdssmap.com by selecting Information > Publications • Chapter 10, AVRS/Web Portal, for internet claim submission instructions located at www.ctdssmap.com by selecting Information > Publications • Implementation Guide found at www.wpc-edi.com • Companion Guide located at www.ctdssmap.com by clicking on the Trading Partner tab, then the EDI tab for format and code set information • Chapter 7 for Connecticut Medical Assistance Program for regulations and policy guidelines. Please note that, while the instructions below are intended to instruct providers on how to submit paper claims, this section can be reviewed by all providers to gain insight on claim requirements, such as permissible modifiers.
Paper Claims Exception Criteria	Paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. Please note that the only version of the form that is accepted is the UB-04 claim form.
How to Obtain UB-04 Claim Form	Providers must submit paper claims using original red UB-04 claim forms, as these claims will be electronically scanned. UB-04 forms are obtained from private printing vendors.
Where to Send Completed UB-04 Claim Forms	Mail completed UB-04 claim forms to: Gainwell Technologies P.O. Box 2971 Hartford, CT 06104
UB-04 Required Fields for HUSKY Health Program and Connecticut Behavioral Health Partnership (CT BHP)	This section includes complete claim submission instructions for the UB-04 claim form for both medical and Connecticut Behavioral Health Partnership (CT BHP) services provided to HUSKY Health Program clients. Black ink only should be used when completing the claim form. Do not use highlighter on claims or attachments.

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UB-04 Required Fields for the HUSKY Health Program and Connecticut Behavioral Health Partnership (CT BHP) Program Claim Submission

Field No.	Name	Description
1.	UNLABELED FIELD	Enter the providers name, address and zip + 4. This address must be the address provided upon enrollment in the Medical Assistance Program.
2.	UNLABELED FIELD	Not required.
3a.	PATIENT CONTROL NO.	Enter the patient's account number. Providers have the option of submitting up to 12 alphanumeric characters for their own accounting purposes.
3b.	MEDICAL RECORD NO.	Not required.
4.	TYPE OF BILL	Enter the 3 or 4-digit code to identify the type of bill for home health services. First digit indicates claim classification. Code Description 3 Home Health agency Second digit indicates claim classification. Code Description 3 Outpatient Third digit indicates frequency. Code Description 1 Admit Through Discharge Date (one claim covers entire stay)
5.	FEDERAL TAX ID NUMBER	Not required.
6.	STATEMENT COVERS PERIOD FROM/THROUGH	Enter the beginning and ending dates of service for the period covered on the claim in MM/DD/YY format for *paper claims. Note: Claims submitted for CT Home Care (CHC) clients with or without HUSKY A or C must have from and through dates of service within the same month, if Applied Income (AI) or Cost Share is applicable to the claim submitted.
7.	UNLABELED FIELD	Not required.
8a.	PATIENT NAME - ID	Not required. The client's Connecticut Medical Assistance Program ID is required in field 60.

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Field No.	Name	Description
8b.	PATIENT NAME	Enter the client's name (last name, first name, middle initial) **NOTE:** The client's name should be spelled as it is in the Automated Eligibility Verification System or as indicated on the client's Connect card.
9a.-9e.	PATIENT ADDRESS (Street, City, St, Zip Code, County)	Not required.
10.	PATIENT'S BIRTH DATE	Not required.
11.	PATIENT'S SEX	Not required.
12.	ADMISSION DATE	Not required.
13.	ADMISSION HOUR	Not required.
14.	ADMISSION TYPE	Not required.
15.	ADMISSION SOURCE	Not required.
16.	DISCHARGE HOUR	Not required.
17.	PATIENT STATUS	Not required.
18. - 28.	CONDITION CODES	Not required.
29.	ACCIDENT STATE	Not required.
30.	UNLABELED FIELD	Enter adjustment reason code 150, 151 or 152 corresponding to the reason an Advanced Beneficiary Notice or Managed Care Organization Notice of Medicare Non-Coverage was issued to a dually eligible client. Note: This applies to clients with a HUSKY and/or CHC benefit plan.
31.-34.	OCCURRENCE CODE/DATE	Enter the applicable code and date, in MM/DD/YY format for *paper claims that contain another insurance denial. Code — Description 24 — Date of Insurance Denial **NOTE:** Also use to indicate date ABN or NOMNC issued to client or client representative for dually eligible clients
35.-36.	OCCURRENCE SPAN CODE/ FROM/THROUGH	Not required.
37.	UNLABELED FIELD	Not required.
38.	UNLABELED FIELD	Not required.

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Field No.	Name	Description
39a.-41d.	VALUE CODES CODE /AMOUNT	Not required.
42.	REVENUE CODE	Enter the Revenue Center Code (RCC) applicable to the service performed. **Skilled Nursing Services** RCC 580 should be used when submitting skilled nursing services, including the sixty day care plan review of therapy service. **Home Health Aide Services** RCC 570 should be used when submitting Home Health Aide services. **Therapy Services** Effective January 1, 2018 RCC codes for the Evaluation of Start of Care (SOC) or Resumption of Care (ROC) for Physical Therapy(PT -RCC 424), Occupational Therapy (OT - RCC 434) and Speech Pathology Therapy (SPT - RCC 444), have been added to the ABI, Autism, CHC and PCA Waiver programs**.** **NOTE:** Refer to the Home Health Services Fee Schedule for applicable RCCs for routine therapy visits.
43.	DESCRIPTION	Not required.
	Line 23 PAGE __ OF __	Enter page number and total number of pages of claim.
44.	HCPCS/RATE/ HIPPS CODES	Enter the procedure code, if billing for Home Health Aide, Skilled Nursing, or Occupational Therapy, Physical Therapy or Speech & Language Pathology Evaluation services. **Skilled Nursing Services** Two (2) character modifiers may be used in conjunction with HCPCS S9123, T1002, S9124, T1003, T1502, T1503, H0033, and G0163 , for informational, auditing and/or pricing purposes. Valid values are TT – Subsequent patient (reduces the allowed amount by 50%) TG – Complex/high tech level of care TE – LPN/LVN TH – Obstetrical treatments/services, prenatal or postpartum TD – RN (effective April 1, 2017 no longer used in conjunction with T1001) U2 - One Time Only (effective April 1, 2014) The following Procedure Code/Modifier code lists may be authorized under an ABI, Autism, CHC or PCA Waiver or CT Home Care Benefit plan.

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Field No.	Name	Description
		Providers should refer to the specific Waiver Fee Schedule for effective dates of service. Providers should refer to the Procedure Code Crosswalk applicable to the client's waiver/CHC benefit plan for billable procedure code/modifier combinations. A link to these crosswalks can be found in this section and in section 8.4 of this chapter. SN – Skilled Nursing SS – Skilled Nursing – One Time Only MA – Medication Administration MM - Medication Administration – One Time Only 29 – Oral Medication associated to the code list authorized., Direct Observation effective March 1,2017 **Home Health Aide and CNA Services** Two (2) character modifiers may be used in conjunction with HCPCS T1004 or T1021 for services provided by a Home Health Aide or Certified Nurse Assistant (CNA). Valid values are: TT – Subsequent patient (reduces the allowed amount by 50% U2 - One Time Only The following Procedure Code/Modifier code lists may be authorized for Home Health Aide or CNA services under an ABI, Autism, CHC or PCA Waiver or CT Home Care Benefit plan. Providers should refer to the specific Waiver Fee Schedule for effective dates of service. Providers should refer to the Procedure Code Crosswalk applicable to the client's waiver/CHC benefit plan for billable procedure code/modifier combinations. A link to these crosswalks can be found in this section and in section 8.4 of this chapter. MT – Med Tech MU – Med Tech – One Time Only NA – Home Health Aide Services to Primary or Subsequent Client NN - Home Health Aide Service to Primary or Subsequent Client – One Time Only

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Field No.	Name	Description
		Therapy Services Evaluation for therapy services must be provided by a qualified therapist. Therapy Evaluations for physical therapy, occupational therapy and speech pathology services (RCC: 424, 434 and 444) have been added to the Autism, ABI, CHC and PCA Waiver care plans effective January 1, 2018. Two (2) character modifiers may be used in conjunction with HCPCS G0151, G0152 or G0153 for Physical, Occupational or Speech Pathology Valid values are: TT – Subsequent patient (reduces the allowed amount by 50%) U2- One Time Only NOTE: When submitting home health claims for a client with a **CHC** benefit plan, providers should refer to the current Procedure Code/Frequency Crosswalk for individual codes or billing combinations associated to a list code authorized on the care plan, applicable to the CHC Program. As a reminder, only procedure codes authorized on the care plan or those associated to a procedure code modifier list authorized on the care plan may be billed on the claim and reimbursed if units are available. NOTE: When submitting home health claims for a client with a **PCA** benefit plan, providers should refer to the current PCA Procedure Code /Frequency Crosswalk for individual codes or billing combinations associated to a list code authorized on the care plan, applicable to the PCA Program. As a reminder, only procedure codes authorized on the care plan or those associated to a procedure code modifier list authorized on the care plan may be billed on the claim and reimbursed if units are available. NOTE: When submitting home health claims for a client with a**n ABI** benefit plan, providers should refer to the current ABI Procedure Code Crosswalk for individual codes or billing combinations associated to a list code authorized on the care plan, applicable to the ABI Program. As a reminder, only procedure codes authorized on the care plan or those associated to a procedure code modifier list authorized on the care plan may be billed on the claim and reimbursed if units are available. NOTE: When submitting home health claims for a client with a**n Autism** benefit plan, providers should refer to the current Autism Procedure Code Crosswalk for individual codes or billing combinations associated to a list code authorized on the care plan, applicable to the ABI Program. As a reminder, only procedure codes authorized on the care plan or those associated to a procedure code modifier list authorized on the care plan may be billed on the claim and reimbursed if units are available

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Field No.	Name	Description
		NOTE: On *paper claims for Medicare coinsurance and/or deductible, the Medicare procedure codes and modifiers, if any, must be entered. Modifiers must match Medicare EOMB when they are primary payer. **NOTE:** Refer to the Home Health Services Fee Schedule for all possible codes. The Department of Social Services is responsible for identifying the RCCs and HCPCS each agency uses for claim submission. **NOTE:** Only Modifier **TT** is applicable for **CT BHP** services. When providing the same service to two clients in the same household covered under different programs, for example, Title 19 & CHC, the second client should be billed with modifier TT. **NOTE:** Only procedure code G0163, Direct Observed Therapy (DOT) is payable for those clients covered under the Tuberculosis (TB) Waiver. To bill for this service, the primary diagnosis must be TB and the service cannot be combined with any other service on the same claim.
45.	SERVICE DATE	Enter the single date of service in MM/DD/YY format. **NOTE:** Only one (1) date is allowed per line item.
	CREATION DATE	Enter date claim created.
46.	SERVICE UNITS	Enter the number of units of service provided. Note: Partial units cannot be billed. Instead, providers should follow these instructions: • Skilled nursing visits in excess of one hour should be billed using T1002 (RN) or T1003 (LPN) for each 15 minutes of service for a maximum of 4 units per visit. • Skilled nursing services in excess of two (2) continuous hours per day should be billed using modifier TG (complex level of care) and requires PA from the first visit. • Complex visits of at least one hour, in addition to a fraction of an hour, consisting of 29 minutes or less should be rounded down to the next full hour of service. • Complex visits of at least one hour, in addition to a fraction of an hour, consisting of 30 minutes or more should be rounded up to the next full hour of service.
47.	TOTAL CHARGES	Enter the home health agency's published charge for the corresponding services indicated in Field 42. Enter the total dollar amount on the last line in Field 47. (Line 23) Note: When submitting a monthly total charge for Automated Medication Dispensers where dispensing does not begin on the first day of the month, end on the last day of the month or a period of hospitalization occurs

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Field No.	Name	Description
		within the month, the total charge should be prorated for the number of days the dispenser was in service for the client. To prorate the charge, divide the allowed rate by the number of days in the month to obtain the per day charge. Multiply the per day charge by the number of days medication was dispensed to the client in the month billed. Current practice does not remove the Automated Medication Dispenser from the home during periods of admission as long as the client's discharge back to the home is expected within 90 days.
	Line 23 TOTALS	Enter the sum of all total charges at the bottom of the Total Charges column, designated for Total Charges.
48.	NON-COVERED CHARGES	Not required.
	Line 23 TOTALS	Not required.
49.	UNLABELED FIELD	Not required.
50.	PAYER NAME A, B, C	Enter the primary payer on line A and subsequent payers on lines B (secondary) and C (tertiary), as instructed below. Medicaid is always the payer of last resort. **Medicare Insurance** When Medicare is the primary payer, indicate the specific coverage (i.e., Medicare Part A (or MPA), Medicare Part B (or MPB), or Medicare HMO). If a denial is received from Medicare, indicate Medicare N/A, MPA N/A, MPB N/A, or Medicare HMO N/A and the date of Medicare's denial. (Note: An adjustment reason code of 150, 151 or 152 must be entered in field 30 if an ABN or NOMNC is issued, regardless if Medicare is billed for a denial. The date of the ABN or NOMNC should be included in field 50 along with the Medicare carrier code information.) Refer to Chapter 5, Section 3, Instructions and Forms for Third Party Liability for more information on third party liability requirements. The Explanation of Medicare Benefits (EOMB) should not be attached to the *paper claim. For coinsurance and/or deductible claims that are submitted on *paper, providers must submit one *paper claim attached to one EOMB. When submitting a *paper coinsurance and/or deductible claim for Connecticut Medical Assistance Program payment, providers must submit the claim information 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. **Non Medicare Other Insurance**

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Field No.	Name	Description
		Enter the 3-digit other insurance carrier code(s) if the client has other insurance coverage or Medicare. A response from each and every other insurance policy the client has must be indicated in this field. A complete listing of insurance carrier codes can be accessed/downloaded from the Web site www.ctdssmap.com, by selecting Information, then Publications. The 3-digit insurance code(s) may also be obtained through the AEVS. If the 3-digit code for a specific insurance carrier does not appear on the list, the provider should enter "999", along with the name of the insurance carrier in Field 50. Refer to Chapter 4, Section 3 for information on accessing the AEVS. If a payment is received, the amount paid by the other insurer must be indicated in Field 54 of the claim form. The other insurance paid date must be entered in Field 80. If a denial is received from the other insurance carrier, indicate “Not Applicable’ or “N/A” after the carrier code. The other insurance Explanation of Benefits (EOB) voucher, indicating a payment or denial, does not need to be attached to the claim, unless required to override timely filing. However, occurrence code 24 and the date of the other insurance(s) denial must be indicated in fields 31 – 34. Refer to Section 5.6 for additional information on timely filing. **NOTE:** Should you be unable to secure a response from a carrier as documented on the provider’s eligibility file, please refer to the subrogation procedures indicated in chapter 5, section 3 of the provider manual. A copy of the Third Party Billing Attempt Form is accepted in lieu of an EOB. 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 Institutional claim type.
51.	HEALTH PLAN ID A, B, C	Not required.
52.	RELEASE OF INFORMATION A, B, C	Not required.
53.	ASSIGNMENT OF BENEFITS A, B, C	Not required.
54.	PRIOR PAYMENTS A, B, C	Enter the amount paid by the corresponding insurance payer(s) as indicated in Field 50, if applicable. 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

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Field No.	Name	Description
		Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Institutional claim type.
55.	ESTIMATED AMOUNT DUE A, B, C	Not required.
56.	NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the 10 digit National Provider Identifier of the billing provider.
57 a.-c.	OTHER PROVIDER ID A, B, C	Not required.
58.	INSURED'S NAME A, B, C	Not required.
59.	PATIENT'S RELATIONSHIP A, B, C	Not required.
60.	INSURED'S UNIQUE ID FOR Payer A, B, C	Enter the client's 9-digit Connecticut Medical Assistance Program ID number exactly as it appears on the CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS).
61.	INSURANCE GROUP NAME A, B, C	Not required.
62.	INSURANCE GROUP NO. A, B, C	Not required.
63.	TREATMENT AUTHORIZATION CODES A, B, C	Not required.
64.	DOCUMENT CONTROL NUMBER A, B, C	Not required.
65.	EMPLOYER NAME A, B, C	Not required.
66.	DX	Enter 0 to indicate that ICD-10-CM code is being reported.
67.	PRINCIPAL DIAGNOSIS CODE	Enter the primary diagnosis code from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Manual.

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Field No.	Name	Description
		NOTE: For **CT BHP claims**, please refer to Fee Schedule Instructions, Table 10, on the www.ctdssmap.com Web site for the list of applicable diagnosis codes.
67A. - 67Q.	OTHER DIAGNOSIS	Enter any additional ICD-10-CM diagnosis codes, if applicable.
68.	UNLABELED FIELD	Not required.
69.	ADMIT DX	Not required.
70a. -c.	PATIENT REASON DX	Not required.
71.	PPS CODE	Not required.
72a. -c.	ECI	Not required.
73.	UNLABELED FIELD	Not required.
74.	PRINCIPAL PROCEDURE CODE/ DATE	Not required.
74 a.-e.	OTHER PROCEDURE CODE/DATE	Not required.
75.	UNLABELED FIELD	Not required.
76.	ATTENDING NP/QUAL/LAST/ FIRST	Enter the 10 digit NPI, qualifier, and the last and first name of the attending physician or the physician who had primary responsibility for the client's care and treatment. The attending provider is required on the claim. The attending provider must be an enrolled Connecticut Medical Assistance Program (CMAP) Provider.
77.	OPERATING NPI/QUAL/LAST/FIRST	Not required.
78.	OTHER NPI/QUAL/LAST/FIRST	Enter the 10 digit NPI, qualifier, and the last and first name of the referring physician, if applicable. The referring provider is required and must be an enrolled CMAP provider, if the referring provider is different than the attending provider.
79.	OTHER NPI/QUAL/LAST/FIRST	Not required.
80.	REMARKS	Enter the other insurance paid date if applicable. 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

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Field No.	Name	Description
		Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Institutional claim type.
81 a. – d.	CODE-CODE QUAL/CODE/ VALUE	Enter the NUBC qualifier B3 in the Qualifier field followed by the billing provider's taxonomy code. The taxonomy on the claim must be the correct taxonomy as submitted on the provider's enrollment application.

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8.4 Fee Schedule

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Overview

Fee schedules can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com.

To access your fee schedule 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:
    1. I Accept
    2. I Do Not Accept

    In order to access the fee schedule, you must accept the end user license agreements.
4. Locate the fee schedule by scrolling down to Home Health.

Select the Fee Schedule Instructions quick link for detailed instructions on accessing and using the fee schedule.

The Behavioral Health Partnership authorization schedule can also be accessed on the CT Behavioral Health Partnership Web Site www.ctbhp.com.

To access the authorization schedule from the CT Behavioral Health Partnership Web Site:

1. Click on For Provider.
2. Select Provider Resources.
3. Select Covered Services.
4. Locate Home Health Care Agencies provider specialty under the Authorization Schedule.

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8.5 Procedure Code List

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Overview	The following are links to the procedure code lists for CHC, PCA, ABI and Autism waiver benefit plans that are stored on the Provider Training page located on the ctdssmap.com Web site. These procedure codes are to be used only when submitting claims for Home Health services under the waiver programs noted below. Providers should review Chapter 7, Medical Services Policy, as applicable to the waiver program for complete information on reimbursement and payment limitations.

ABI Procedure Code Crosswalk

Autism Procedure Code Crosswalk

CHC Procedure Code Crosswalk

PCA Procedure Code Crosswalk

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