Connecticut interChange MMIS

Provider Manual

Chapter 8 – Hospice Claim Submission Instructions

October 1, 2020

Connecticut Department of Social Services (DSS)
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Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	12/02/2009	New document created for Hospice program.	All	All
1.1	12/17/2009	Added links to Spanish versions of forms and updated form number for Hospice Election form.	8.4	9
1.2	07/22/2010	Updated to replace EDS references/logo with HP references/logo, replaced references to OI/Medicare Billing Guide links with Chapter 11; added references to Medicaid LIA; revised fee schedule instructions.	8.1 8.3 8.5 8.6	2 7 19, 21 23
1.3	01/20/2011	Updated as a result of PPACA clarifications for children under the age of 21, added information on extension of services.	8.1 8.2 8.4 8.5	2 5 9 16
1.4	09/01/2011	Updated to reflect removal of SAGA program, updated with HIPAA 5010 changes, misc other updates.	8.1 8.3 8.4 8.5	2 7 9 21
1.5	04/13/2012	Updates made as a result of the ASO transition and implementation of online Hospice transactions.	8.1 8.2 8.3 8.4 8.5	2 5 7 9 12, 14-15
1.6	01/09/2013	Updates made to reflect current billing instructions.	8.1 8.5	3 17
1.7	10/02/2013	Updates made to reflect OPR edits.	8.5	22
1.8	12/30/2013	Updates made to reflect the shutdown of the Charter Oak Health Plan Program.	8.1 8.4 8.5	2 9 12

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Version	Version Date	Reason for Revision	Section	Page(s)
1.9	09/24/2015	Removed references to Charter Oak Program. Updated ICD-10 references. Replaced references to ICF/MR with ICF/IID. Updated instructions for Hospice Forms.	All	All
2.0	11/01/2015	Updated to replace HP references/logo with Hewlett Packard Enterprise references/logo.	8.5	12
2.1	02/01/2016	Updated as a result of Hospice Payment Changes: Service Intensity Add-On (SIA) and Routine Home Care (RHC) Per Diem Rates	8.1 8.5	4-6 18-21
2.2	08/10/2016	Updated as a result of elimination of paper claims.	8.1 8.5	2 14-15
2.3	11/14/2016	Additional updates made as a result of elimination of paper claims. Updated to remove references to ICD-9.	8.1 8.5	2 14, 15, 26
2.4	4/20/2017	Hewlett Packard Enterprise to DXC Technology	All	All
2.5	10/5/2017	Clarification of the faxing requirements for hospice forms.	8.4	11
2.6	10/01/2020	Updated to replace DXC Technology references/logo with Gainwell Technologies references/logo.	All	All

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Table of Contents

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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, claim submission instructions, and fee schedule information for Hospice providers participating in the Connecticut Medical Assistance Program.

The information in Chapter 8 is important for all providers performing hospice 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.

Hospice

Hospice Services are a covered service for all HUSKY Health Program (HUSKY A, HUSKY B, HUSKY C – previously referred to as Medicaid, and HUSKY D – previously referred to as Medicaid LIA) clients. The client's interChange eligibility file will indicate a hospice lock-in segment for all HUSKY Health Program clients who have elected a Hospice benefit.

Effective March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) amended the definition of "hospice" and provides that election of hospice by a child under the age of 21 shall not constitute a waiver of payment for treatment of the condition for which the terminal diagnosis has been made. This same change was made to the Children's Health Insurance Program and allows children to receive hospice services concurrently with treatment of the child's condition. Note that these changes apply only to children defined as those under the age of 21 for HUSKY A, HUSKY C, and HUSKY D clients, and under the age of 19 for HUSKY B clients.

Primary Diagnosis Coding Instructions

The Department of Social Services (DSS) has limited the diagnoses that are acceptable as primary diagnosis. In keeping with Medicare guidance outlined in MLN MM887, DSS has developed guidance regarding: Limiting primary diagnoses. For more details about the primary diagnosis instructions, please refer to MLN MM887 by clicking on the following Web link:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8877.pdf

Based on the ICD-10-CM coding guidelines and coding conventions, the following diagnoses codes should not be used as the primary diagnosis:

R53.81 (Other malaise)

R62.7 (adult failure to thrive)

Additional dementia diagnosis codes:

F02.80 (Dementia in diseases classified elsewhere without behavioral disturbance)

F02.81 (Dementia in diseases classified elsewhere with behavioral disturbance)

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Overview

Hospice care is compassionate end-of-life care that includes medical and supportive services intended to provide comfort to the individual who is terminally ill, i.e. has a life expectancy of six months or less if the illness runs its normal course. Hospice care aims to manage a client's illness and pain but does not treat the underlying terminal illness. The hospice benefit is available to client's whose physician certifies that they are terminally ill. When a client elects hospice, the Department of Social Services pays the hospice a per diem rate to cover all services related to the illness. If a hospice patient requires care from another healthcare provider, e.g. durable medical equipment, hospital care or physician services, for the treatment of the terminal illness or related condition, it is the responsibility of the hospice to coordinate and reimburse the healthcare provider for such services.

Hospice services will be provided at one of the following four levels of care:

(1) **Routine care** is the level of care provided to a client who is not in crisis. It may be provided either at home, in a nursing facility, hospital or in an ICF/IID. Effective with claim dates of service January 1, 2016, the Department has implemented a two-tiered payment system for routine care (RHC), which has replaced the current single RHC per diem payment. These changes are consistent with the Medicare Hospice Payment reforms, MLN Matters MM9201. Hospice claims with dates of service on or after January 1, 2016 will be paid one of two RHC rates if the following criteria are met:

- The day billed must be an RHC level of care.
- If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC "High" Rate.
- If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC "Low" Rate.
- For a hospice client who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice will receive payment at the high or low rate, upon hospice re-election.
- For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient's 60-day window, paid at the RHC "High" rate upon the new hospice election.

Note: Hospice elections that occurred prior to January 1, 2016, will pay with the current rate reflected on the hospice fee schedule through December 31, 2015. The "High" rate will apply to the first 60 days within each episode and the "Low" rate will apply to days 61 and after from the beginning date of each episode for dates of service January 1, 2016 and forward. This reimbursement will be paid according to the geographic region.

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Note: For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient's 60-day window. Claims will be paid at the RHC "High" rate upon the new hospice election.

(2) **Continuous home care** is furnished during brief periods of crisis as described in 42 CFR 418.204(a) in order to maintain a client at home. A minimum of eight hours of care, of which at least half is direct nursing care, shall be provided in a 24-hour period to qualify for continuous home care to be billed on an hourly basis. The care does not need to be provided in successive blocks of time so long as a need for an aggregate of eight hours is required in a 24-hour period. All direct service hours are provided by the Hospice agency shall be clearly documented by the Hospice agency. Services provided by other disciplines, such as social workers or counselors, are expected during periods of crisis but are not counted towards the total hours of continuous care. In addition, documentation of care, modification of the plan or care and supervision of home health aides by a nurse shall not qualify as direct client care. A minimum of 8 hours must be billed or the claim will deny and the hospice would have to resubmit for routine care.

(3) **Respite care** is furnished for each day the client is in a nursing facility or other location in order to give the caregiver a rest. It is available for a maximum of five days in each 60-day period.

(4) **General inpatient care** is furnished in a nursing facility or hospital when pain control or chronic symptom management cannot be managed in other settings. After a consecutive or non-consecutive 5 days in a hospital, a prior authorization is required from DSS.

Consistent with the Medicare Hospice Payment reforms, MLN Matters MM9201, the Department will be making changes to the hospice fee schedule to support reimbursement for service intensity add-on (SIA) for patients in the last seven (7) days of life during a hospice episode. Hospice services with dates of service on or after January 1, 2016 are eligible for an end of life (EOL) SIA payment in addition to the per diem rate for the RHC level of care when the following criteria is met:

- The day billed is an RHC level of care day.
- The service is provided by a registered nurse (RN) or social worker that day for at least 15 minutes (one unit), not exceeding 4 hours total (16 units).
- The service cannot be provided by a social worker via telephone.

The SIA payment will be paid at the continuous home care (CHC) hourly rate divided by four multiplied by the number of units. This reimbursement will be based on the CHC rate for the appropriate geographic region.

Hospice claims that qualify for the EOL SIA payment must be billed with occurrence code 55 and date of death and the following codes:

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RCC	HCPCS	Description
551	G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
561	G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes

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8.2 Prior Authorization

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For the most part, there are no prior authorization (PA) requirements for Hospice Services. The only services that require PA are general inpatient care beyond the fifth day for all clients and hospice services beyond twelve months for HUSKY Health Program clients. 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 Hospice Fee Schedule for specific procedure prior authorization requirements.

For **dually eligible** clients who have or will exceed their 12 month hospice benefit period, providers must submit an extension for hospice care online transaction. The original Hospice Election Form, W-406 should still be completed with a strike through of the original effective date, an indication of the new effective date, and the word “Extension” next to the new effective date, and should be retained in the client’s file. The form should not be faxed.

Hospice clients who reside in a nursing facility or ICF/IID must be authorized for the level of care of the institution in which they reside as described in Chapter 8 of the Provider Manual for Nursing Facilities and ICF/IIDs.

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8.3 Patient Liability

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The Hospice provider bills for the facility room and board charges for a hospice client in a nursing facility or ICF/IID. The nursing facility or ICF/IID may bill for hospital or home leave charges when the hospice client meets the criteria for billing as defined in Connecticut General Statutes 19a-537 and 17b-278. In either event, the Department of Social Services deducts patient liability from the first claim processed.

Patient liability or applied incomes are the terms used to describe the financial amount a client is obligated to pay toward the cost of his or her long term facility care starting with the month in which the 30th day of consecutive institutionalized care occurs. Consecutive institutionalized care includes a stay in a long term care facility and/or chronic disease hospital. Although Patient Liability amounts are routinely collected from the client or the client's authorized representative by the nursing facility or ICF/IID, hospice agencies may wish to negotiate collection of the Patient Liability amount with the nursing facility or ICF/IID when a client elects the hospice benefit.

Patient liability is taken from the first claim of the month that contains a facility room and board charge and is taken at the header of the claim, not at the detail. For example, in the case where patient liability exceeds the allowed amount on the Hospice claim for RCC 658, Hospice Room and Board in a Nursing Facility, patient liability continues to be taken from the remainder of the claim, regardless of the RCC billed. An Accounts Receivable Transaction is set up for any patient liability amount remaining in excess of the total allowed amount on the claim. To illustrate, the Hospice provider submits a claim with a combination of multiple RCC 658, RCC 651, and RCC 657 line details. The combined allowed amount for RCC 658 is $1,000, for RCC 651 is $500 and for RCC 657 is $100 for a total claim allowed amount of $1,600. Patient liability is $2,000. Based on above claims processing, as the patient liability amount exceeds the claim allowed amount, the Hospice provider receives a $0 payment amount for this claim and an accounts receivable transaction is set up for the remaining $400 on the provider's Remittance Advice.

As a result, Hospice and Nursing facility/ICFMR providers are required to arrange for the reconciliation of the patient liability taken. Additional information can be found in the Chapter 8, Section 8.7, Patient Liability and Section 8.9, Bed Reserve, of the Nursing Facility/ICF/IID Provider Manual. This provider manual may be accessed on the www.ctdssmap.com Web site by selecting Information, Publications, and then selecting the appropriate Chapter 8 from the drop down box.

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8.4 Hospice Forms

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Overview	All Hospice transactions must be submitted online via the Hospice provider's secure Web account. Claims will not pay until the online transactions have been submitted by the provider and entered by DSS. Providers should refer to and carefully review the online step by step instructions and online edit and resolution guide, entitled "Instructions for Submitting Hospice Transactions" available as a "quick link" directly above the online Hospice Request Form. In addition to completing the online transactions, providers must complete the paper version of the Hospice form(s). The form(s) must then be signed by the Medicaid client and/or Hospice employee. All of the completed Hospice forms must be retained at the provider's office.
How to Obtain the Form(s)	Providers may download a copy of these forms from the Web portal at www.ctdssmap.com, by selecting Information, then Publications, and locating the appropriate form(s) under the Other Forms section, or by using the links provided below. Providers should retain a copy of the completed Hospice forms as part of the Medicaid client's medical records, which should be available for review by DSS upon request. Completed hospice forms should not be faxed to DSS, except when the patient is being discharged for "just cause".
Where to Send the Hospice Discharge Form Submitted for Just Cause	When the reason for completing the Hospice Discharge form is "just cause", the completed form should be faxed to DSS within 24 hours of the discharge of a Medicaid client for review by DSS. A copy of this form, along with fax confirmation, should be retained by the Hospice Agency in the event they are requested by DSS for review.

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8.5 Hospice Claim Submission Instructions

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Electronic Claim Submission Requirements	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.
Medicare Covered Services	For clients who are eligible for Medicare, the only hospice services payable by DSS are: 1) room and board charges for a client who resides in a nursing facility or ICF/IID; and 2) co-insurance and deductible for respite level of care.
How to Obtain the Claim Form	Providers permitted to submit paper claims must use original red UB-04 claim forms, as these claims will be electronically scanned. Providers may obtain UB-04 forms through private printing vendors. For more information on how to obtain these forms refer to the www.ctdssmap.com Web site, click on Publications, Forms, Claim Forms, UB-04 Claim Forms and the link to the NUBC Web site.
Where to Send the Completed Form	Mail completed forms to: Gainwell Technologies Written Correspondence P.O. Box 2991 Hartford CT 06104

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Instructions for Completion of UB-04 Required Fields for Claim Submission	This section includes complete claim submission instructions for the UB-04 claim form for HUSKY Health Program clients. The instructions below are for paper claims only. In this section, there are directions for completion of each field on the UB-04 and fields not required are noted. Black ink only should be used when completing the claim form. Do not use highlighter on claims or attachments.

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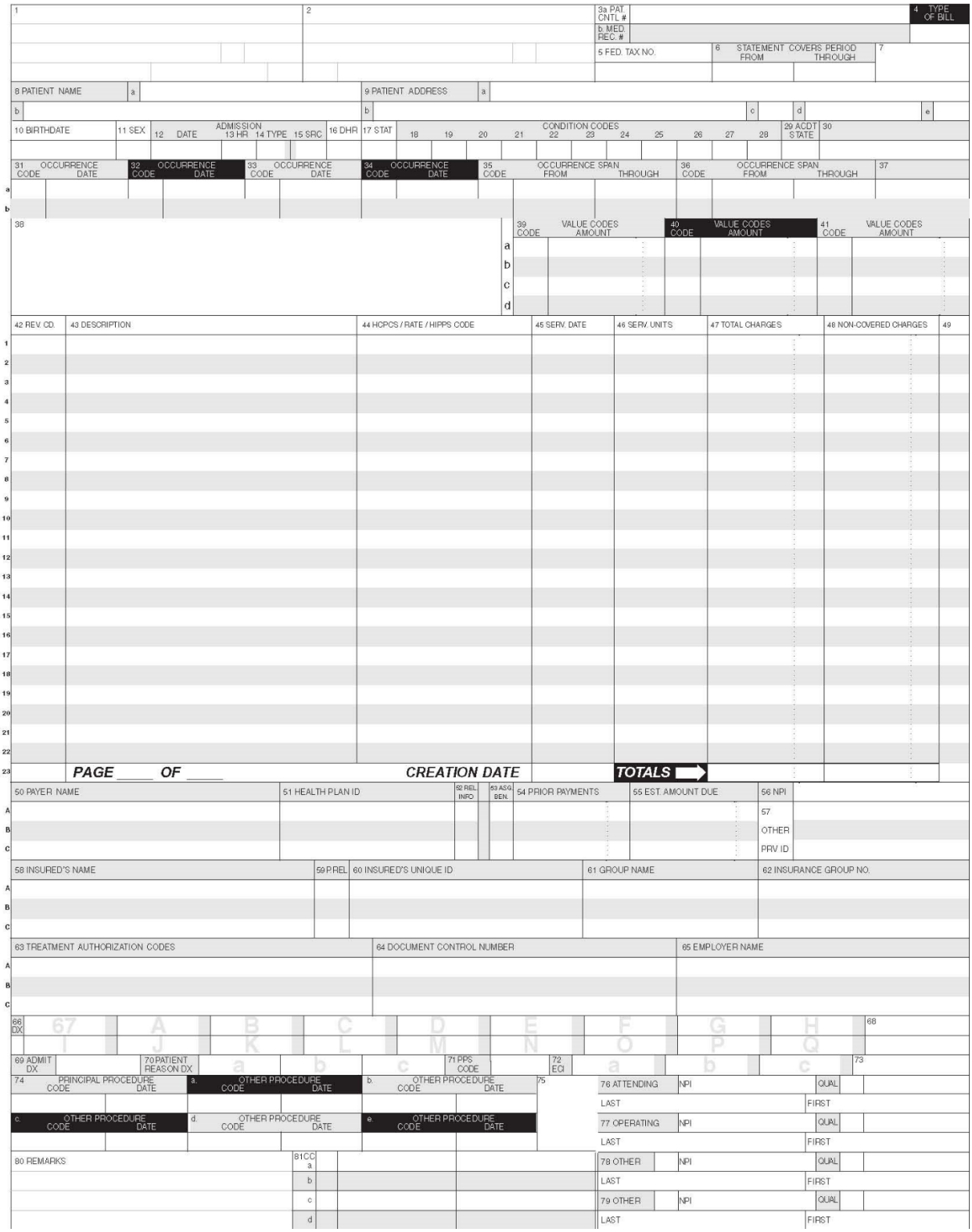

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UB-04 Required Fields for HUSKY Health Program

*Paper Claim Field No. and Name		Description
1.	UNLABELED FIELD	Enter the provider's 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 hospice services. First digit indicates claim classification. Code Description 8 Hospice Second digit indicates claim classification. Code Description 1 Non-hospital Based 2 Hospital Based Third digit indicates frequency. Code Description 1 Admit Through Discharge Date (one claim covers entire stay) 2 Interim-First Claim 3 Interim-Continuing Claim 4 Interim-Last Claim 7 Replacement of Prior Claim 8 Void/Cancel of Prior Claim
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.
7.	UNLABELED FIELD	Not required.

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*Paper Claim Field No. and Name		Description
8a.	PATIENT NAME - ID	Not required. The client's Connecticut Medical Assistance Program ID is required in field 60.
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	Not required.

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<table>
<tr><th colspan="2">*Paper Claim Field No. and Name</th><th>Description</th></tr>
<tr><td>31.-34.</td><td>OCCURRENCE CODE/DATE</td><td>Enter the applicable code and date, in MM/DD/YY format, for paper claims that contain another insurance denial or the date representing the date of death for SIA payments.

Code Description
24 Date Insurance Denied
55 Date of Death</td></tr>
<tr><td>35.-36.</td><td>OCCURRENCE SPAN CODE/ FROM/THROUGH</td><td>Not required.</td></tr>
<tr><td>37.</td><td>UNLABELED FIELD</td><td>Not required.</td></tr>
<tr><td>38.</td><td>UNLABELED FIELD</td><td>Not required.</td></tr>
<tr><td>39a.-41d.</td><td>VALUE CODES CODE /AMOUNT</td><td>Not required.</td></tr>
<tr><td>42.</td><td>REVENUE CODE</td><td>Enter the Revenue Center Code (RCC) applicable to the service performed.

DSS reimburses for hospice at one of four levels of care (routine, continuous, respite or general inpatient). If the client is in a nursing facility or ICF/IID, an additional payment is made to the hospice to cover room and board. The hospice reimburses the facility for the room and board according to a contract between the two entities. The table below shows which level of care may be billed for a client living in the community and a client living in a facility, and whether room and board and the SIA payment is payable in addition to the hospice per diem payment.

Table 8.1 – Hospice Reimbursement for Client in Community:

<table>
<tr><th rowspan="2">Location of Service</th><th colspan="2">Private Home</th><th></th></tr>
<tr><th>Hospice per Diem</th><th>Room and Board RCC 658</th><th>End of Life (EOL) Service Intensity Add-On (SIA)</th></tr>
<tr><td>Routine home RCC 651</td><td>Yes</td><td>No</td><td>Yes</td></tr>
<tr><td>Continuous home RCC 652</td><td>Yes</td><td>No</td><td>No</td></tr>
<tr><td>Respite RCC 655</td><td>Yes</td><td>No</td><td>No</td></tr>
<tr><td>General Inpatient RCC 656</td><td>Yes</td><td>No</td><td>No</td></tr>
</table>
</td></tr>
</table>

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*Paper Claim Field No. and Name		Description

Table 8.2 – Hospice Reimbursement for Client in Nursing Facility or ICF/IID:

Nursing Facility

Location of Service	Hospice per Diem	Room and Board RCC 658	End of Life (EOL) Service Intensity Add-On (SIA)
Routine home RCC 651	Yes	Yes	Yes
Continuous home RCC 652	No	No	No
Respite RCC 655	No	No	No
General Inpatient RCC 656	Yes	No	No
Nursing Home/ICF/IID bed hold 183, 185		Paid to nursing facility or ICF/IID	No

Table 8.3 – Other Services Billed by Hospice Agency:

Other Billable Codes	Description	Additional Comments
RCC 657 + HCPC	Physician/APRN services	May be billed in conjunction with any hospice RCC
RCC 658	Room and board in NF or ICF/IID	Payable to hospice when client has been authorized for admission to that facility
RCC 659 + HCPC S9381	Add-on code for escort service in accordance with §17b-262-845(b) of the Regulations of Connecticut State Agencies	Approved by DSS on a case by case basis for extraordinary costs associated with escort services
RCC 551 + HCPC G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting	Hospice services are eligible for an EOL SIA payment in addition to the RHC level of care when specific criteria are met. Reference Section 8.1.

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*Paper Claim Field No. and Name		Description			
		RCC 561 + HCPC G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes	Hospice services are eligible for an EOL SIA payment in addition to the RHC level of care when specific criteria are met. Reference Section 8.1.	
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 RCC 657 for physician or APRN Services or SIA payment. **NOTE**: Radiology services with HCPCs in the 7xxxx range must be billed with modifier 26. Enter S9381 if authorized by DSS in conjunction with RCC 659.			
45.	SERVICE DATE	Enter the single date of service in MM/DD/YY format. **NOTE:** Only one (1) date of service with corresponding RCC or RCC and HCPC is allowed per line item. **NOTE:** Claims can span only one month of service.			
	CREATION DATE	Enter date claim created.			
46.	SERVICE UNITS	Enter the number of units being billed for the revenue center code (RCC). **NOTE**: 1 unit = per diem rate - only 1 unit allowed for RCCs 651, 655, 656, 658 per day 1 unit = 1 hour where multiple units are allowed for RCC 652 1 unit = all physician and APRN services billed with corresponding HCPC(s) under RCC 657 1 unit = represents 15 minutes for each SIA unit allowed for RCC/HCPCS 551/G0299 or 561/G0155 up to four hours total per day			
47.	TOTALCHARGES	Enter the facility or servicing provider's usual and customary charge for the corresponding services indicated in Field 42.			
	Line 23 TOTALS	Enter the sum of all total charges in the designated "Totals" field at the bottom of the Total Charges column.			
48.	NON-COVERED CHARGES	Not required.			
	Line 23 TOTALS	Not required.			

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*Paper Claim Field No. and Name		Description
49.	UNLABELED FIELD	Not required.

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*Paper Claim Field No. and Name		Description
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 (Only applicable for Respite Care when submitting claims for co-insurance and deductible.)** 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). *Medicare Denial* 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 in field 50. 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), indicating a denial is not required to be attached to the paper claim. However, the EOMB must be retained in the event of an audit. *Medicare Payment* If a payment is received from Medicare, indicate Medicare Part A or Part B, MPA, MPB, or Medicare HMO in field 50. For deductible due amounts indicate A1 and deductible amount due, and A2 and coinsurance amount due in field 39 "Value Codes Amount" field. The Explanation of Medicare Benefits (EOMB), indicating a payment, is required to be attached to the paper claim. The patient's name, date of service and billed amount must match between the EOMB and the claim. In addition, the number of detail lines submitted on the claim must have a corresponding detail line on the EOMB. The EOMB must contain columns that indicate Medicare billed amount, allowed amount, paid amount in addition to coinsurance and deductible. 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. Only one EOMB per claim is allowed. 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** 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 > information > chapter 5 > carrier code listing. The 3-digit insurance code(s) may also be obtained through the AEVS.

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*Paper Claim Field No. and Name		Description
50.	PAYER NAME A, B, C (Cont'd)	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 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.

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*Paper Claim Field No. and Name		Description
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. **NOTE:** This is a new process where the system matches the services billed against authorizations data by using information related to the provider, client, dates of service and services rendered. The claims processing system does not edit against data entered in this field.
64.	DOCUMENT CONTROL NUMBER A, B, C	Not required.
65.	EMPLOYER NAME A, B, C	Not required.
66.	DX VERSION QUALIFIER	Enter 0 as the ICD indicator 0.
67.	PRINCIPAL DIAGNOSIS CODE	Enter the primary diagnosis code from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Manual.
67A. - 67Q.	OTHER DIAGNOSIS	Enter any additional ICD-10-CM diagnosis codes, if applicable.
68.	UNLABELED FIELD	Not required.

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*Paper Claim Field No. and Name		Description
69.	ADMIT DX	Not required.
70 a.-c.	PATIENT REASON DX	Not required.
71.	PPS CODE	Not required.
72 a.-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.
77.	OPERATING NPI/QUAL/LAST/ FIRST	A referring provider is only required when different than the attending provider.
78.	OTHER NPI/QUAL/LAST/ FIRST	Not required.
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 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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8.6 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:
   - I Accept
   - I Do Not Accept

   In order to access the fee schedule, you must accept the end user license agreements.
4. Locate the fee schedule applicable to your taxonomy/type/specialty.

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

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