November 13, 2019

Waiver Provider Refresher Workshop

Presented by
The Department of Social Services
& DXC Technology

DXC.technology

Waiver Provider Refresher Workshop

Agenda

- ➢ **What's New in 2019**
- ✓Electronic Visit Verification Updates
- ✓Rate Increases
- ✓More 2019 Updates

- ➢ **Waiver Review**
- ✓Client Eligibility/Resolution

Waiver Provider Refresher Workshop

Agenda

- ➢ **Waiver Review cont.**
- ✓ Care Plan Review
- ✓ Claim Submission Guidelines
- ✓ Monthly Claims Reprocessing
- ✓ Claim Denials, Resolution and Resources
- ➢ **Program Resources**
- ➢ **Time for Questions**

What’s New in 2019 – A Review of Current Connecticut Medical Assistance Program Changes

Waiver Provider Refresher Workshop

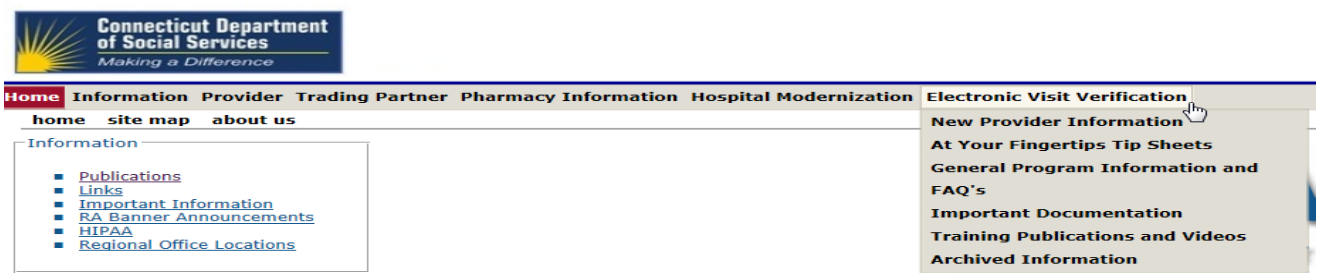
Program Updates – 2019

EVV Updates – Electronic Visit Verification Web page

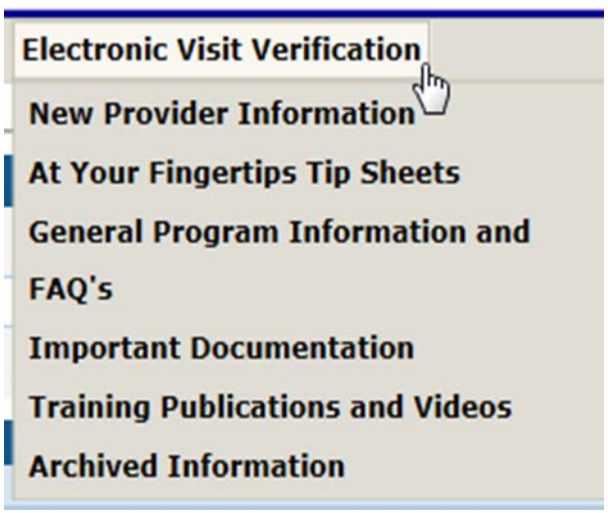
The Department of Social Services (DSS) announced effective May 8, 2019, an Electronic Visit Verification (EVV) Web page was added to the www.ctdssmap.com Web page. This EVV Web page allows providers to more easily locate and reference EVV resources to assist in using the EVV system to service clients with an EVV mandated waiver. All of the information that was previously housed on the Electronic Visit Verification Implementation Important Message, previously found on the www.ctdssmap.com Home Page, was relocated to the EVV Web page and categorized for easy navigation.

Program Updates – 2019

EVV Updates – How to Access the EVV Web page



To access the EVV Web page, navigate to www.ctdssmap.com and select Electronic Visit Verification in the header. From the EVV Overview Implementation Page, a user can navigate to the subpage of their choice. Once on the EVV Web page, user are able to navigate to one of the six(6) different pages for more specific information.



Program Updates – 2019

EVV Updates – Who Should Use the EVV Web page

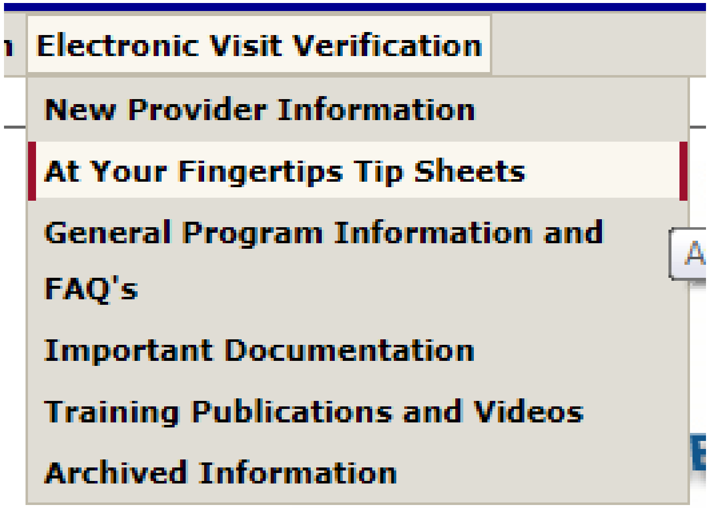
All agencies and their office staff that service clients with an EVV mandated waiver. The EVV Web page has information for new users, including newly enrolled agencies, and for persons who may just want a refresher on the EVV system and its functionality. All persons who use EVV, including schedulers, billers and office staff, are encouraged to familiarize themselves with the EVV Web page.

Program Updates – 2019

EVV Updates – What Information Can be Found on the EVV Web page?

The EVV Web page houses all the resources needed to successfully navigate the EVV program. Among the many resources on the Web page are training documentation and videos, instructions for new providers to obtain and use the EVV system, the list of EVV mandated and optional services, and information on the compliance requirement. The EVV Web page is divided up into six(6) sections:

New Provider Information, At Your Fingertips Tip Sheets, General Program Information and FAQ's, Important Documentation, Training Publication and Videos and Archived Information.



Program Updates – 2019

EVV Updates – What Information Can be Found on the EVV Web page cont.

New Provider Information Page will assist in familiarizing an agency with the EVV program. You will also find the EVV Service Code Listing, which identifies what service codes are EVV mandates and what ones are optional. The Finalized Reason Code List which identifies a list of approved reason codes to justify editing visit calls data in Santrax.

At Your Finger Tip Sheets page houses all of the published At You Fingertips tip sheets. At You Fingertips tip sheets are designed using questions that are submitted to Sandata Customer Care, the EVV mailbox ctevv@dxc.com or in communications with DSS for assistance. These are created to help providers navigate EVV by answering common questions and providing assistance resolving common issues encountered by providers in their use of the EVV system.

General Program Information and FAQ's page has information the all providers should be familiar with prior to using the EVV system. The Frequently Asked Questions document has over 200 questions about the EVV program and Santrax functionality and their answers.

Program Updates – 2019

EVV Updates – What Information Can be Found on the EVV Web page cont.

Important Documentation page has important messages and notifications published to assist in the use of the Santrax system. The information is categorized by purpose and/or functionality and includes a listing of EVV related provider bulletins and important messages, specifications to set up third-party interface and historical listing of Santrax App messages.

Training Publications and Videos page contains all the documents and videos that can be used to train new office staff and refresh current staff in using the EVV system. There are also links to instructions on how to enroll in the Web-based learning platform called Learning Management System (LMS) where new agencies must go and complete necessary training in order to receive their Welcome Kit.

Archived Information page is where you will find information that can be referenced for historical purposes and should not be used for the current EVV program.

Program Updates – 2019
Services

Mandated Home Health EVV Services

- **<u>All</u>** Home Health Services for Autism, ABI, CHC and PCA Waiver clients are mandated for EVV.

Non-Medical EVV Services

- Designated non-medical Autism, CHC, PCA and ABI Waiver services are mandated, optional or not applicable for EVV.
- EVV Mandated and Optional Services can be found on the Electronic Visit Verification Web page on the www.ctdssmap.com Web site.

<u>Self Directed Services</u>

- All claims for Community First Choice (CFC) or waiver self hire services, regardless of the EVV check-in/check-out election, will continue to be billed by Allied Community Resources, DSS's CFC Fiscal Intermediary.
- The EVV check-in/check-out process will be implemented for services rendered to clients who self direct their own care through the waiver or CFC starting September 2019 and continuing throughout 2020.

Program Updates – 2019

Compliance

COMPLIANCE:

DSS considers a provider to be compliant if 90% of the visits performed are ***validated by a check-in and a check-out documented by the caregiver via telephony, Mobile Visit Verification (MVV) or Fixed Visit Verification (FVV) device***. Providers who fail to reach this 90% threshold may be subject to audit, suspension of referrals or claim recoupments until the provider becomes compliant.

For more information regarding compliance, please see At Your Fingertip tip sheet #4 – Compliance, "Important EVV Compliance Clarifications" Important Message and Provider Bulletin 19-17 Electronic Visit Verification (EVV) – Compliance Requirement Update.

Program Updates – 2019
Issues

Client Eligibility

Client Eligibility <u>must</u> be verified prior to providing services to avoid claim denials because of ineligibility:

- ❑ A client present in the EVV system does not automatically mean they are eligible for the services provided.
- ❑ Prior Authorization does not guarantee that the client is eligible for the services to be provided.
- ❑ Eligibility can change at any time.

If a client is ineligible on their EVV mandated waiver benefit plan:

- ❑ A check-in/check-out can still occur.
- ❑ Using the temporary client feature the visit can be scheduled and, when completed, confirmed in Santrax
- ❑ The care manager at the access agency or DSS Case Manager responsible for the clients care plan should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible.
- ❑ The visit **CANNOT** be exported or uploaded to DXC for claim adjudication

Program Updates – 2019

Issues

Client Eligibility continued

Providers who identify an eligibility issue that has not been resolved after some time should **first contact the access agency in charge of the client's care plan for assistance**. The provider should check with the care manager to see if the **Medicaid redetermination and required financial verifications** have been submitted. If the redetermination and required documentation have been received and the access agency is unable to render assistance, the provider should send an encrypted email to Waiver.DSS@ct.gov.

The email should include:

- ❑ The client's name, client ID and the date service began or is scheduled to begin.
- ❑ Place the words "Autism, ABI, CHC or PCA Waiver Client Eligibility Issue" in the subject line of the email.

Program Updates – 2019
EVV Contacts

- ❑ If you are **missing a client** from your Santrax system and have verified that the client is active on their EVV mandated waiver *and* has an active PA on the CMAP portal, please send a **secure** email to ctevv@dxc.com. If you are unable to send encrypted emails, please just send a PA for that client to the ctevv@dxc.com mailbox.
- ❑ If a **prior authorization** (PA) is present on the DSS secure site but is not present in Santrax 48 hours after upload to the CMAP secure site, please send an email to ctevv@dxc.com and provide the PA number, as it is displayed on the CMAP secure site.
- ❑ If you are experiencing **issues with the Santrax system** and its functionality, please contact Sandata Customer Care. They can be reached at 1-855-399-8050 or by email at ctcustomercare@sandata.com.

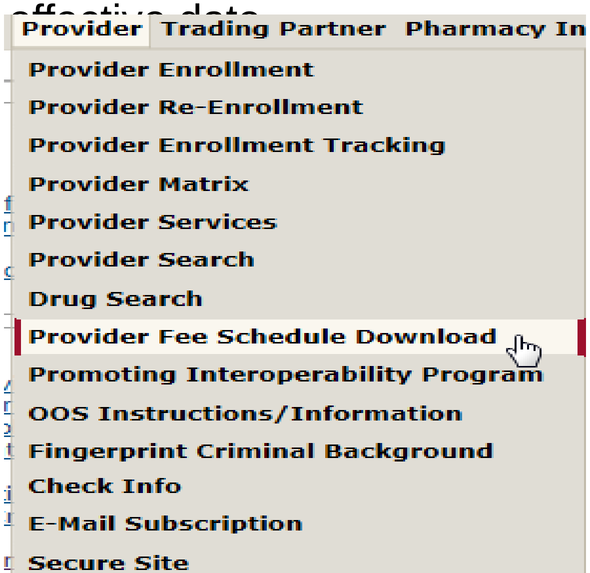
If you are unsure who to contact for assistance, please send an e-mail to ctevv@dxc.com. You are also encouraged to send an e-mail to the ctevv@dxc.com mailbox if you feel you need additional support resolving your issue.

Important: Do not email client identifying data unless you encrypt your e-mail.

Program Updates – 2019

Rate Increases

Effective for dates of service beginning October 1, 2019, the Department of Social Services (DSS) increased rates in response to the increase in the minimum wage by 1% for Connecticut Home Care Program for Elders (CHCPE), Acquired Brain Injury (ABI), Personal Care Assistance (PCA), Mental Health and Autism Waiver Service providers. You can reference this information in PB19-61. The updated fee schedules can be found on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com. Once on the CMAP website choose Provider>Provider Fee Schedule Download. Once you have the Waiver fee schedule opened refer to the rate line detail of the procedure code with an Oct 1, 2019 effective date.



ABI, AUTISM Waiver, PCA, and CHCPE Waiver Service providers who submit Electronic Visit Verification (EVV) for mandated and optional services, to DXC Technology for claim adjudication via the Santrax EVV System **must** update their usual and customary rates in the Santrax system **prior to billing claims for dates of service October 1, 2019 and forward.**

Program Updates – 2019

Meals on Wheels Rate Increase

Effective for dates of service July 1, 2019 and forward, the rate for Meals on Wheels singe, double and kosher meals increased by 10%. See PB 19-43 for more information.

For CHC, MHW and CFC Procedure Codes:

Code	Description	Rate
1218Z	Meal Service - Single Hot Meal	**$5.43**
1220Z	Double Meal (One Hot-One Cold)	**$9.93**
1221Z	Kosher Meals, Double	**$9.93**

ABI Procedure Codes:

Code	Description	Rate
1550P	Home Delivered Meals-Single Meals	**$5.43**
1551P	Home Delivered Meals-Double Meals	**$9.93**

Program Updates – 2019

Issues Prior Authorization

Access agencies (CHC and PCA Waiver clients) and Case Management agencies (Autism and ABI Waiver clients):

- Effective April 1, 2019 and forward Beacon Health Options is no longer submitting authorizations for clients under the Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC), and Personal Care Assistance (PCA) Waivers with a behavioral health primary diagnosis. Instead the Department of Social Services (DSS) Community Options Unit (COU) is now responsible for these authorizations. The Access Agency or DSS Autism Care Manager will be uploading the authorizations via the secure Web portal to DXC.
- Services provided to ABI, Autism, CHC and PCA Waiver clients with primary diagnosis codes requiring Behavioral Health Services can be located on the www.ctdssmap.com Web site.
- All Beacon Health Options authorizations with a “U” prefix for ABI, Autism, CHC and PCA Waiver were ended effective March 31,2019. New ones were created with “B” prefix by either the Access agency or DSS Autism Care Manager with effective date of April 1, 2019through the end date of the services authorized by Beacon Health Options.

Note: Prior authorizations must be able to be viewed in the DSS secure site in order to be able be viewed in Santrax. If you cannot view a PA in the DSS secure site, the PA has not been uploaded. Please contact the Access Agency or DSS Autism Case Manager responsible for the client’s care plan for assistance.

Program Updates – 2019 Issues

Missing Client/ Prior Authorization

If you are missing a client or prior authorization (PA) in the Santrax system:

- ❑ Confirm the client is eligible on an EVV mandated waiver by researching the client's eligibility on the DSS Web portal (www.ctdssmap.com)

and

- ❑ Confirm the client has an approved PA assigned to your agency by viewing the prior authorization on the DSS Web portal (www.ctdssmap.com)

If, after you confirm the client is eligible on their waiver benefit plan and has a PA assigned to your agency, the client is not present in your Santrax system, please send an email to the EVV mailbox, ctevv@dxc.com, and provide the **PA number (as displayed on the DSS secure site www.ctdssmap.com) and the eligibility verification number**. Someone will research the issue and provide any next steps.

Please note: if the client does not have a PA number on the CMAP portal, please follow up with the Access Agency or DSS Autism Case Manager responsible for the client's care plan.

Program Updates – 2019
Personal Care Assistant Waiver Enrollment

The following three new services were added to the Personal Care Services Waiver: Agency- based Personal Care Assistance services, Mental Health Counseling and Adult Day Health. As a result, Provider agencies who employ Personal Care Assistants, Masters Level Licensed Clinical Social Workers or Masters Level Licensed Professional Counselors (LCSW or LPC) or are Adult Day Health providers are now able to enroll as Personal Care Assistance PCA Waiver service providers.

Providers must enroll online via the Enrollment Wizard on www.ctdssmap.com. Allied Community Resources is responsible for credentialing services providers. Refer to PB 2019-62 for more information

Personal Care Services

1021Z - Personal Care Services; Per 15 Minutes

Mental Health Counseling

1247Z - Mental Health Counseling – Individual - (Provided In Client's Home)

1256Z - Mental Health Counseling – Individual

(45 - 50 Min) Out of Home/Mental Health Counseling-Individual (45-50 Min) - Out Of Home

Adult Day Health

1200Z - Adult Day Health - Full Day (Non-Medical Model Provider)

1201Z - Adult Day Health - Full Day (Approved Medical Model Provider)

1202Z - Adult Day Health - Half Day (Less Than or Equal To 4 Hrs)

Program Updates – 2019
eDelivery

Effective March 27, 2019, DSS implemented the electronic delivery of some provider's letters. As a result, many paper letters that providers previously received through the United States Postal Service (USPS) are now posted to the provider's Secure Web portal account.

What to Know

- The letter will be systematically posted to a user's Secure Web portal account for retrieval with a retention period of six to 12 months.
- An email notification will be sent notifying the user that a letter has been posted.
- Primary Account holders have been automatically set up to receive eDelivery notifications.

A clerk can access e-delivered letters if assigned that permission by their primary account holder.

Program Updates – 2019
eDelivery- Notification

- Email notification will be sent to the email address associated with the primary account holder and the clerk's Secure Web portal account.
- Emails are sent daily for letters posted the day prior.
- Only one email is generated, even if multiple letters were posted the previous day.
  - If a clerk is associated to multiple master users, the email will indicate the master user(s) to which the posted letters apply.

- **Sample Email text:**
- From: ctdssmap@dxc.com
- Subject: CMAP E-Delivery Alert – Letter(s) Available

Program Updates – 2019
eDelivery- Letters

- **As of March 27, 2019 the following letters are being delivered electronically:**
  - ➢ Letters to Organizations Confirming Changes Made via Secure Web Portal Maintain Organization Members Panel
  - ➢ Electronic Funds Transfer (EFT) Letters
  - ➢ Non-Pharmacy Prior Authorization (PA) letters
  - ➢ Trauma letters
  - ➢ Trading Partner New Transaction Approval letters
  - ➢ Trading Partner Update letters

- **Effective May 1, 2019 the following letters are being delivered electronically:**
  - ➢ Provider re-enrollment/add alternate service location address notification, reminder, approval, and denial letters
  - ➢ Letters to performing providers when joining/separated from organization
  - ➢ HUSKY Health Primary Care Payment Program approval, denial and update letters
  - ➢ Out of State Provider license verification request and deactivation letters
  - ➢ Vehicle registration expiration letters
  - ➢ Provider fingerprint background check related follow-up letters (note: the initial fingerprint letter will be mailed)

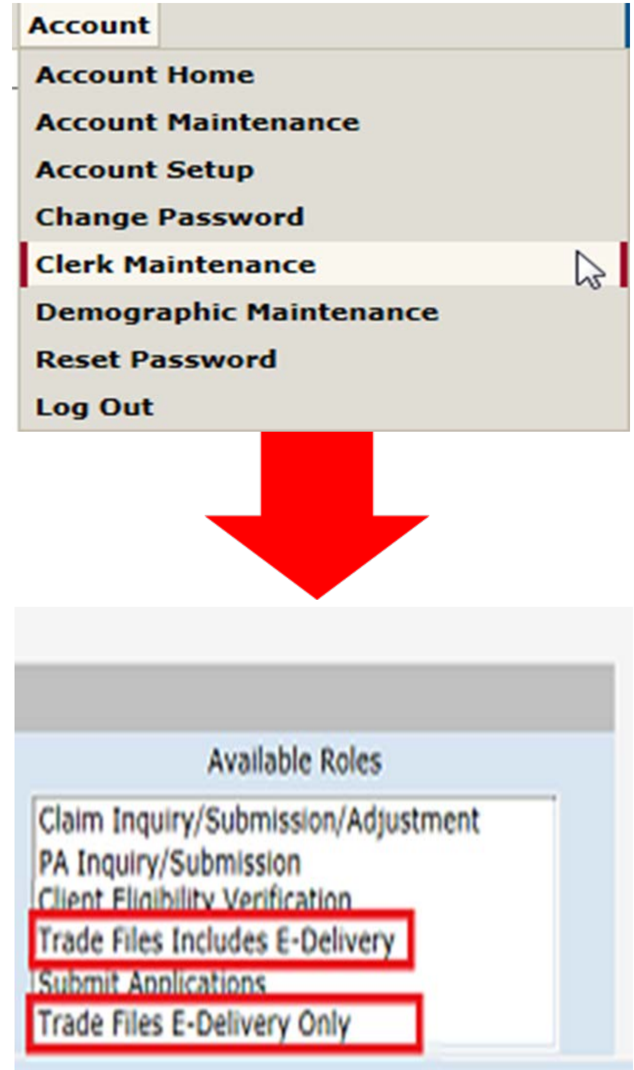
- **Effective June 3, 2019 the following letters are being delivered electronically:**
  - ➢ Third party liability notices

Program Updates – 2019
eDelivery-

Clerk Maintenance

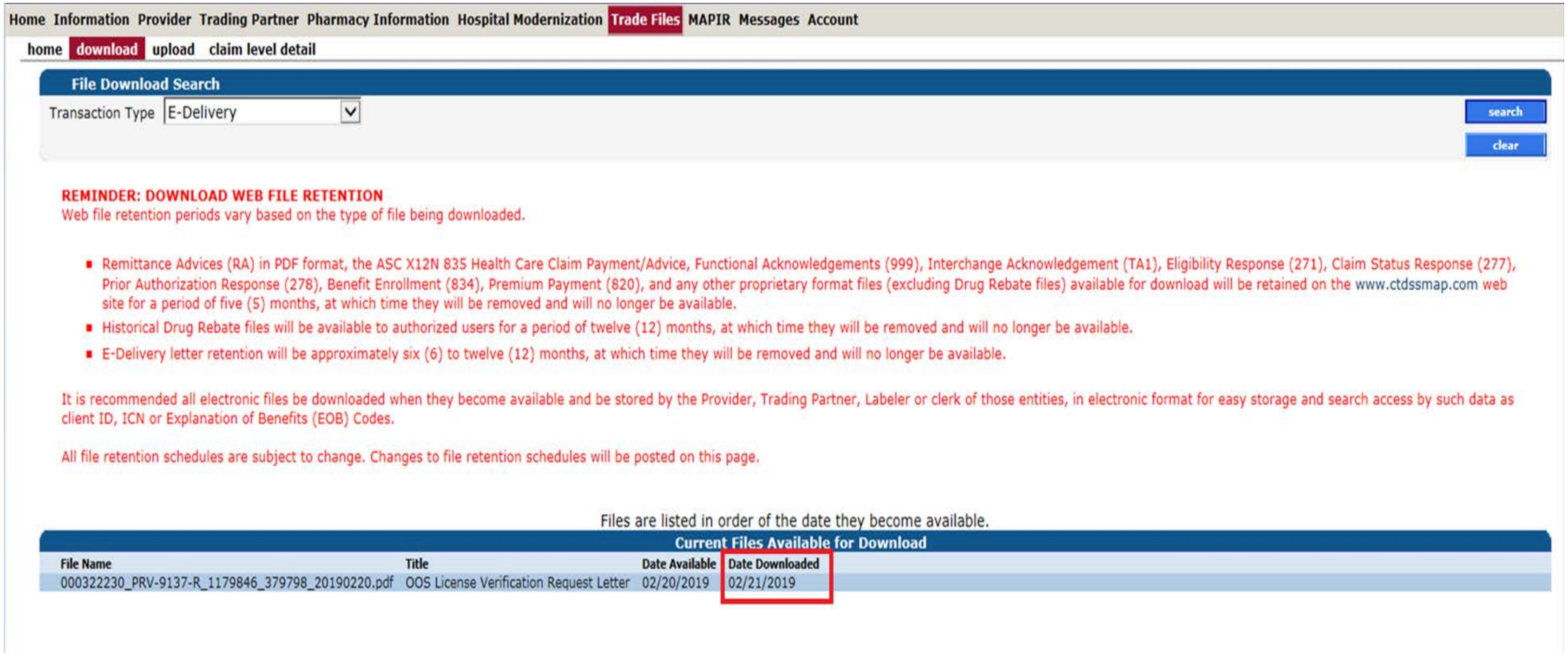
A clerk can access e-delivered letters if assigned that permission by their primary account holder. This can be done through two roles:

- Trade Files Includes E-Delivery (formerly Trade Files) – allows access to download all files
- Trade Files E-Delivery Only – allows access to eDelivery letters only



Program Updates – 2019
eDelivery-

- A user can download their letters by selecting Trade Files, Download and then selecting E-Delivery from the Transaction Type field.
- Letters can be sorted by title, date available and date downloaded.



Program Updates – 2019
Claim Rejections- Who do I Contact?

Beginning August 1, 2019 rejections for Medicaid Waiver eligibility issues must be directed to Waiver.DSS@ct.gov . Issues submitted to this mailbox should be limited to one client per email. The email MUST include client's first and last name, Medicaid ID and dates of service that were rejected.

Eligibility issues regarding recipients with a benefit plan of **CBCMS, Connecticut Home Care Community-Based Care Managed State Funded, CBCMD, CT Home Care Case Managed Disabled and Self-Directed State-Funded, SDIRS,** should be directed to:

ACUFinancial.DSS@ct.gov.

Please note as per Provider Bulletin PB 2019-50:

- **HomeandCommunityBasedServices.dss@ct.gov – mailbox was closed 8/1/19.**
- **Alternatecare.dss@ct.gov – mailbox was closed 8/1/19.**

For all other Provider enrollment; claim submission and claim adjudication questions:

ctdssmap-ProviderEmail@dxc.com

Program Updates – 2019

Claim Rejections- Who do I Contact?- Cont.

• **ctevv@dxc.com – Electronic Visit Verification (EVV) related questions.**
• **ctcustomercare@sandata.com - Issues related to the Santrax system and its functionality.**

The following denials MUST be resolved with the Access Agency that is responsible for the clients' care plan:

1. **3003** - Prior Authorization is required for payment of this service
2. **3015** - Care plan required
3. **3016** - Service not covered under care plan
4. **5151** - Units billed were cutback or denied as they exceed the frequency of service allowed on the care plan

Re-enrollment

Waiver Provider Workshop

Re-enrollment

Notification and Process

Providers will receive a reminder letter when they are due for re-enrollment 6 months prior to the end of their previous 2 year contract.

The reminder letter will include an **Application Tracking Number (ATN).**

To re-enroll providers should:

- Access the www.ctdssmap.com Web site
- From the Home Page click Provider > **Provider Re-enrollment**
- Enter the **ATN** received in the re-enrollment reminder letter
- Enter **NPI** or Non medical provider identifier (**AVRS ID**)

Re-enrollment
Notification and Process

Prior to Re-enrolling:

CT Home Care, PCA and ABI service providers must be credentialed/re-credentialed by Allied.

Autism providers must be credentialed/re-credentialed by Beacon Health Options, the Department of Social Services, (DSS).

- The **credentialing entity will issue a letter to the provider** confirming their credentials to continue to provide Autism Waiver services.
- **Providers must submit the credentialing letter as a follow on document (FOD) to DXC Technology**. **The Application tracking number should be pre-printed in the upper right hand corner of the (FOD) to** ensure the association of the FOD to the provider's re-enrollment application.

Re-enrollment

Notification and Process

Providers should successfully complete the re-enrollment application as quickly as possible upon receipt of their notice.

<u>Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP). As a result:</u>

- **<u>Case Managers may not be able to enter new PAs for future services.</u>**
- **<u>Providers will not be able to bill and be paid for services performed after their re-enrollment due date.</u>**
- ***<u>DSS Quality Assurance will not expedite the process for late re-enrollments.</u>***

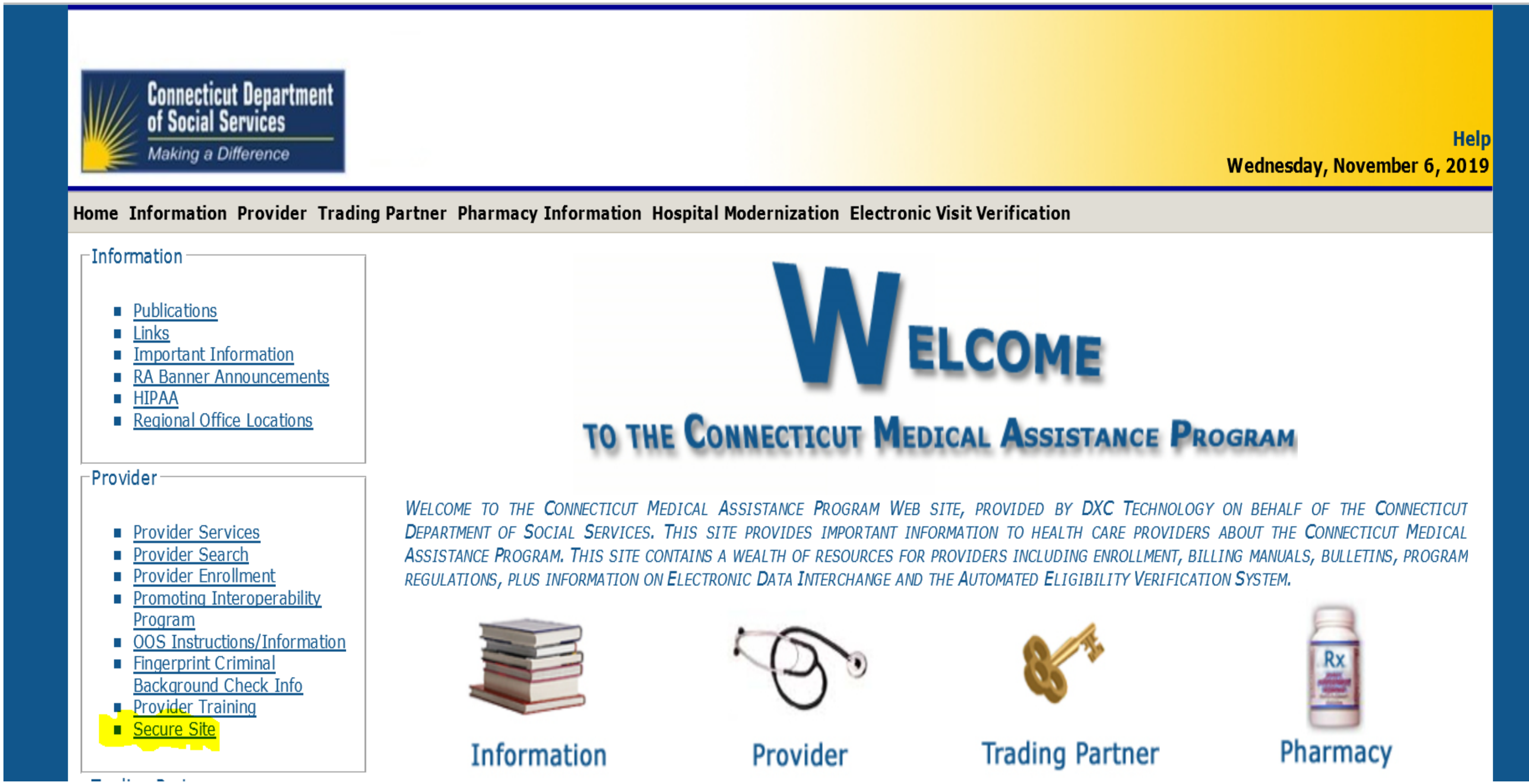
A Provider Enrollment contract will not be reinstated until the application is finalized.

- Reinstatement of contracts w/out a finalized application violates Affordable Care Act (ACA) policies.

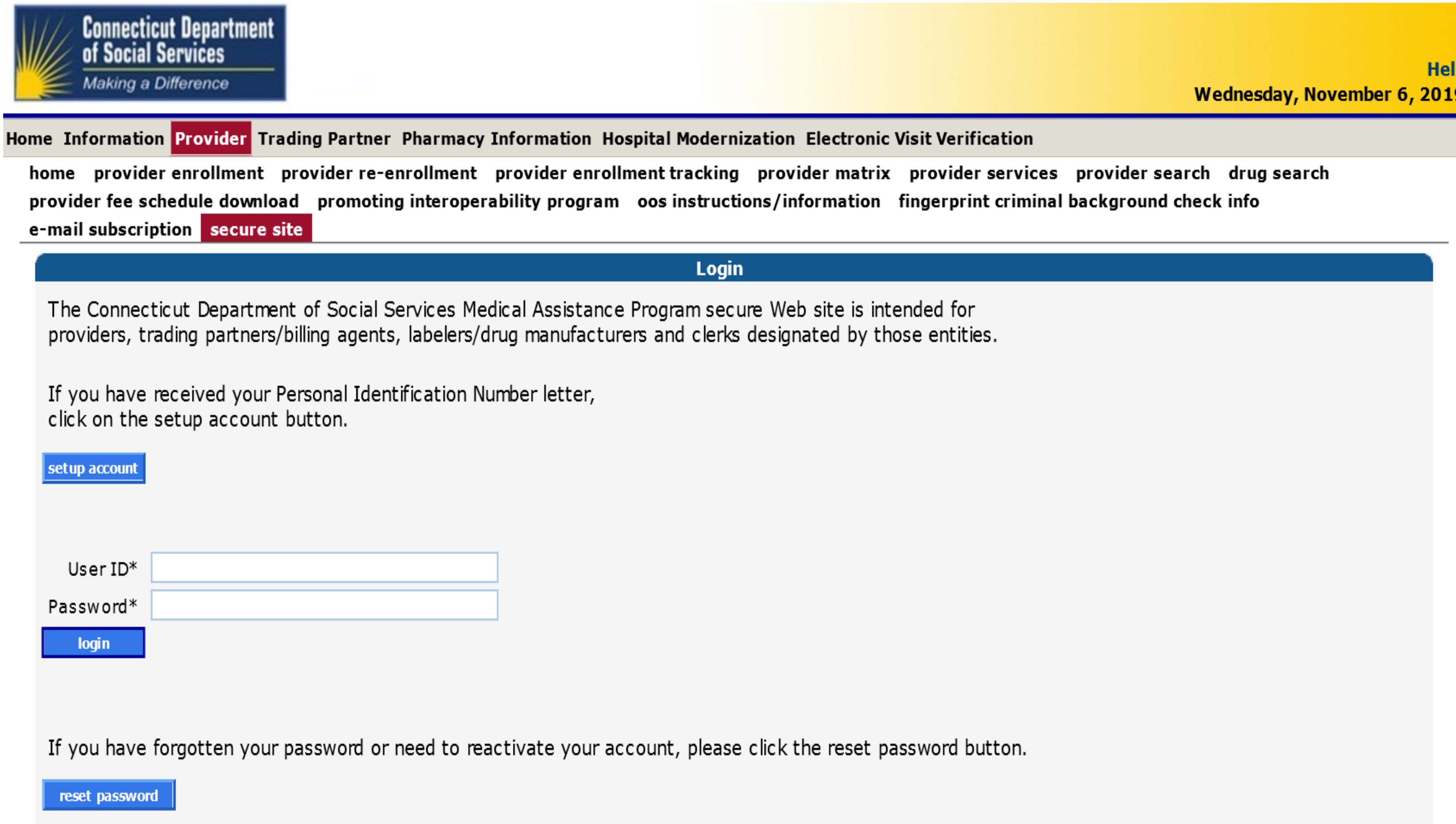
Determining and Resolving Eligibility Issues

Waiver Service Provider Workshop

Access to Secure Web Account



Access to Secure Web Account



Web Access

Eligibility Verification

To verify a CMAP client's eligibility through the secure site – click on the *Eligibility* tab on the main menu

Home Information Provider Trading Partner ConnPACE Pharmacy Information Claims **Eligibility** Prior Authorization Trade Files MAPIR Messages Account

Enter enough data to satisfy at least one of the *valid search combinations;* click *search*

Valid Search Combinations

- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID		last name	DOE	From DOS*	09/01/2014
SSN	666-55-4444	First Name, MI	JOHN	To DOS*	09/30/2014
Birth Date					
Service Type Code 1		Service Type Code 2			
Service Type Code 3		Service Type Code 4			search
Service Type Code 5					clear

*****When entering a full name as part of your search, a middle initial is required if present in their CMAP profile*****

Determining and Resolving Eligibility Issues

Client Eligibility cont.

✓ Resources:

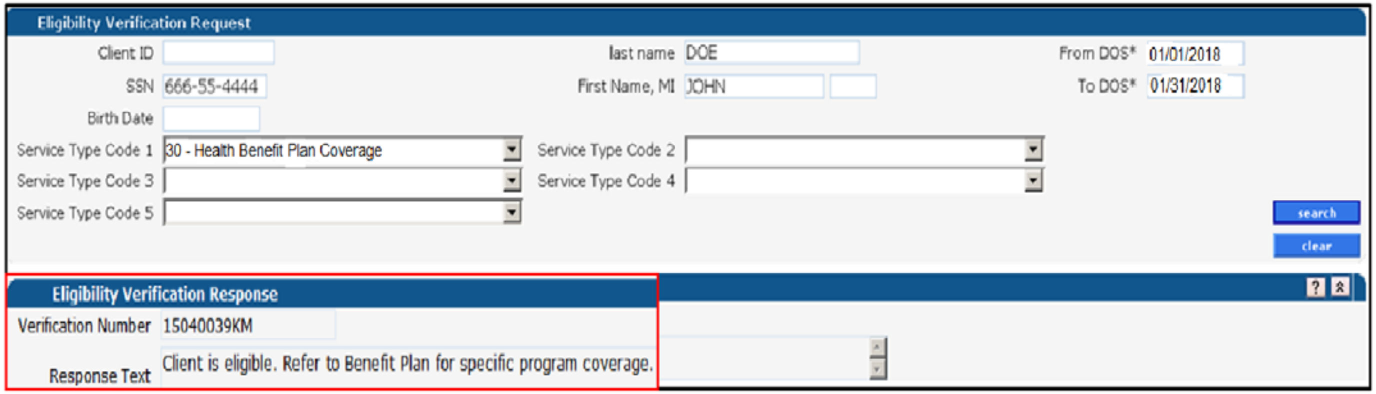
- Community Options at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to Waiver.DSS@ct.gov.
- The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

  - Providers who identify an eligibility issue upon claim denial should contact the DSS Community Options Unit as noted above. To avoid further claim denial, check eligibility before resubmitting claim.
  - The purpose of the Waiver.DSS@ct.gov. mailbox is to identify and refer the issue to the appropriate staff. Eligibility issues often must be referred to a DSS Regional Office. Community Options does not direct the work flow in these offices. Medicaid redeterminations not sent in on time may create lengthy periods of ineligibility. **Providers should contact the client's care manager for assistance.**

Determining and Resolving Eligibility Issues

Client Eligibility cont.

Is the client eligible? **Yes!**



Eligibility Verification Request

Client ID | last name DOE | From DOS* 01/01/2018

SSN 666-55-4444 | First Name, MI JOHN | To DOS* 01/31/2018

Birth Date

Service Type Code 1: 30 - Health Benefit Plan Coverage | Service Type Code 2

Service Type Code 3 | Service Type Code 4

Service Type Code 5

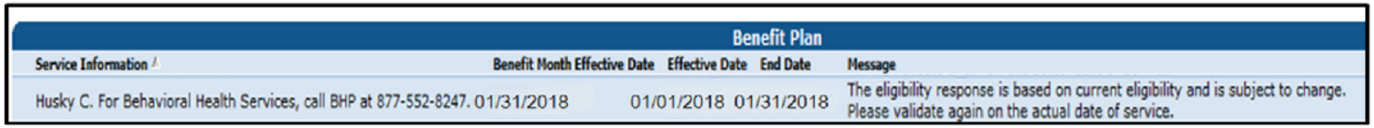
search

clear

Eligibility Verification Response

Verification Number 15040039KM

Response Text: Client is eligible. Refer to Benefit Plan for specific program coverage.



Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	01/31/2018	01/01/2018	01/31/2018	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

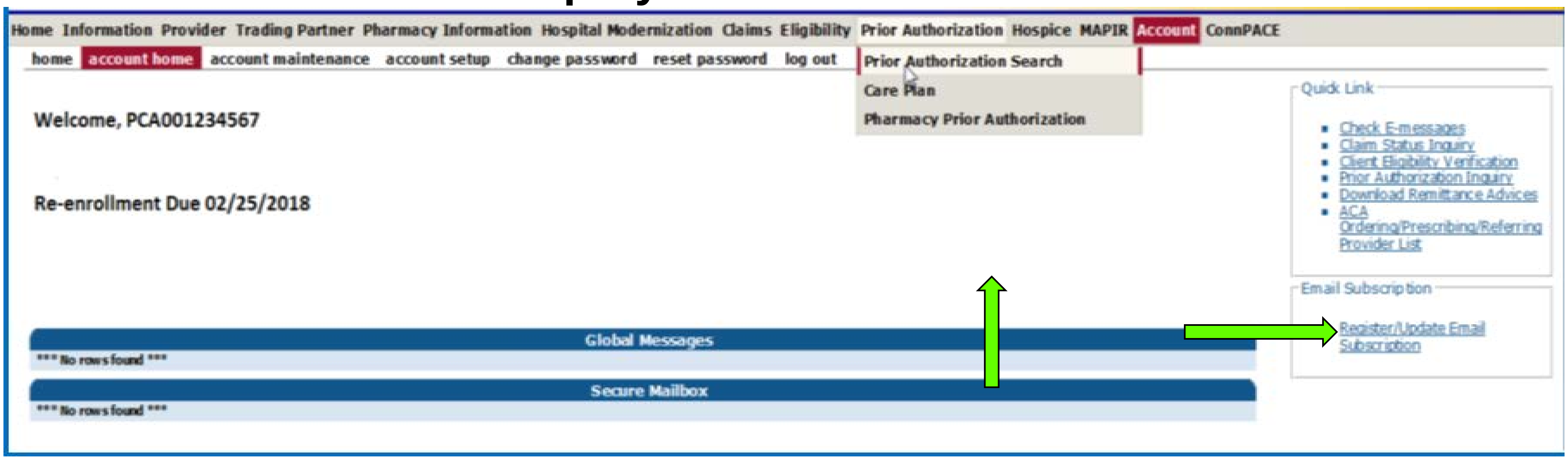
Does the client have waiver coverage? **NO!**

Viewing and Understanding the Care Plan

Waiver Service Provider Workshop

Viewing and Understanding the Care Plan

Prior Authorization Inquiry



Does the client have prior authorization? **Yes!**

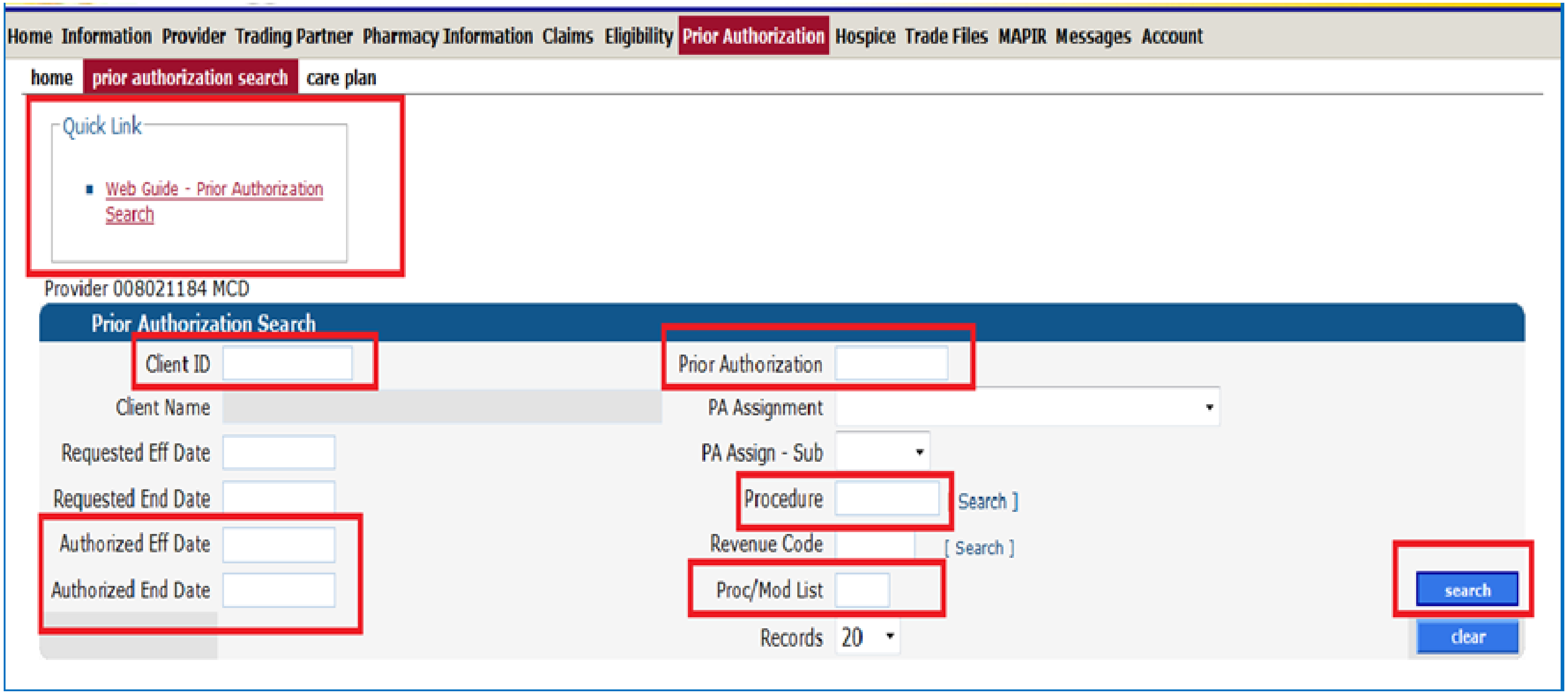
Search Results

Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedur	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2017275003	01	01012018	02282018	12	$0.00	Approved		AUTISM		1223Z									1 Per Calendar Month
2017256001	01	01012018	01312018	10	$0.00	Approved		AUTISM		1302Z									2 Per Calendar Week
2017256001	02	01012018	02282018	8	$0.00	Approved	09/13/2017	AUTISM		1404Z									4 Per Calendar Month

Viewing and Understanding the Care Plan

Prior Authorization Inquiry

PA Search Panel



Viewing and Understanding the Care Plan

Prior Authorization Inquiry

The search results by client shows multiple Prior Authorizations (PAs) and services authorized.

Note: **Search results can include PAs authorized by procedure code, procedure code with modifier, procedure code lists and proc/mod lists.** For ease in viewing, data can be sorted by clicking on the desired sort field, until a triangle appears. Click on the triangle to sort in ascending or descending order.

» Search Results

PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub	Billing Provider ID		Prescribing/Ordering Provider ID	Service Code	Service Code Thru	Proc/Mod List	Frequency
0770801156	02	08/16/2016	10/22/2016	08/25/2016	06:00:10	Home Care Progra	Initial	008060343	MCD		1214Z			18 Per Calendar Week
0770801156	01	08/16/2016	10/22/2016	08/25/2016	06:00:10	Home Care Progra	Initial	008060343	MCD		1210Z			24 Per Calendar Week
0770900674	01	10/06/2016	10/06/2016	11/30/2016	20:03:49	Home Care Progra	Initial	008060343	MCD		1210Z			20 Per Calendar Week
0770862683	02	10/23/2016	03/02/2017	10/26/2016	06:00:11	Home Care Progra	Initial	008060343	MCD		1214Z			18 Per Calendar Week
0770862683	01	10/23/2016	03/02/2017	10/26/2016	06:00:11	Home Care Progra	Initial	008060343	MCD		1210Z			24 Per Calendar Week
0770862683	03	04/13/2017	04/19/2017	04/21/2017	06:00:11	Home Care Progra	Initial	008060343	MCD		1021Z			252 Per Calendar Week
0770862683	04	04/20/2017	08/13/2017	04/21/2017	01:46:43	Home Care Progra	Initial	008060343	MCD		1021Z			224 Per Calendar Week
0771155364	01	08/14/2017	08/15/2017	09/22/2017	06:00:13	Home Care Progra	Initial	008060343	MCD		1021Z			224 Per Calendar Week
0771155364	02	08/16/2017	10/12/2017	09/22/2017	06:00:13	Home Care Progra	Initial	008060343	MCD		1210Z			126 Per Calendar Week
0771155364	03	08/16/2017	10/12/2017	09/22/2017	06:00:13	Home Care Progra	Initial	008060343	MCD		1214Z			42 Per Calendar Week
0771155364	04	10/13/2017	08/31/2018	10/16/2017	20:00:08	Home Care Progra	Initial	008060343	MCD		1021Z			252 Per Calendar Week

Viewing and Understanding the Care Plan

➢**Non-Medical Waiver Services may be authorized by:**

✓Procedure Code – code authorized must be billed on the claim

✓Procedure Code with modifier(s) – code and all modifiers authorized must be billed on the claim

✓Procedure Code(s) List – any combination of the codes on the list may be billed up to the number of units authorized

✓Procedure Code/Modifier(s) List – any combination of the codes with associated modifier(s) on the list may be billed up to the number of units authorized

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (CHC)

Authorized services are for a companion one time only service to a subsequent client with billing codes 1210Z U2 TT for 12 units = 3 hours of authorized service with an effective/end date of 4/4/2014.

Line Item

Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	NDC	Revenue Code	Revenue Code List
01	12.000	$0.00	12.000	$0.00	Auto Approved for Care Plan	1210Z	U2	TT							

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code 1210Z [Search] COMPANION SERVICE - AGENCY

Mod 1 U2 [Search]

Mod 2 TT [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List

Procedure Code List

Requested Eff./End Dates* 04/04/2014 04/04/2014

Requested Units/Dollars* 12.000 $0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

NDC [Search]

Status Auto Approved for Care

Authorized Units/Dollars 12.000 $0.00

Authorized Eff./End Dates 04/04/2014 04/04/2014

Used Units/Dollars 0 $0.00

Available Units/Dollars 12 $0.00

Frequency 12 Per Calendar Week

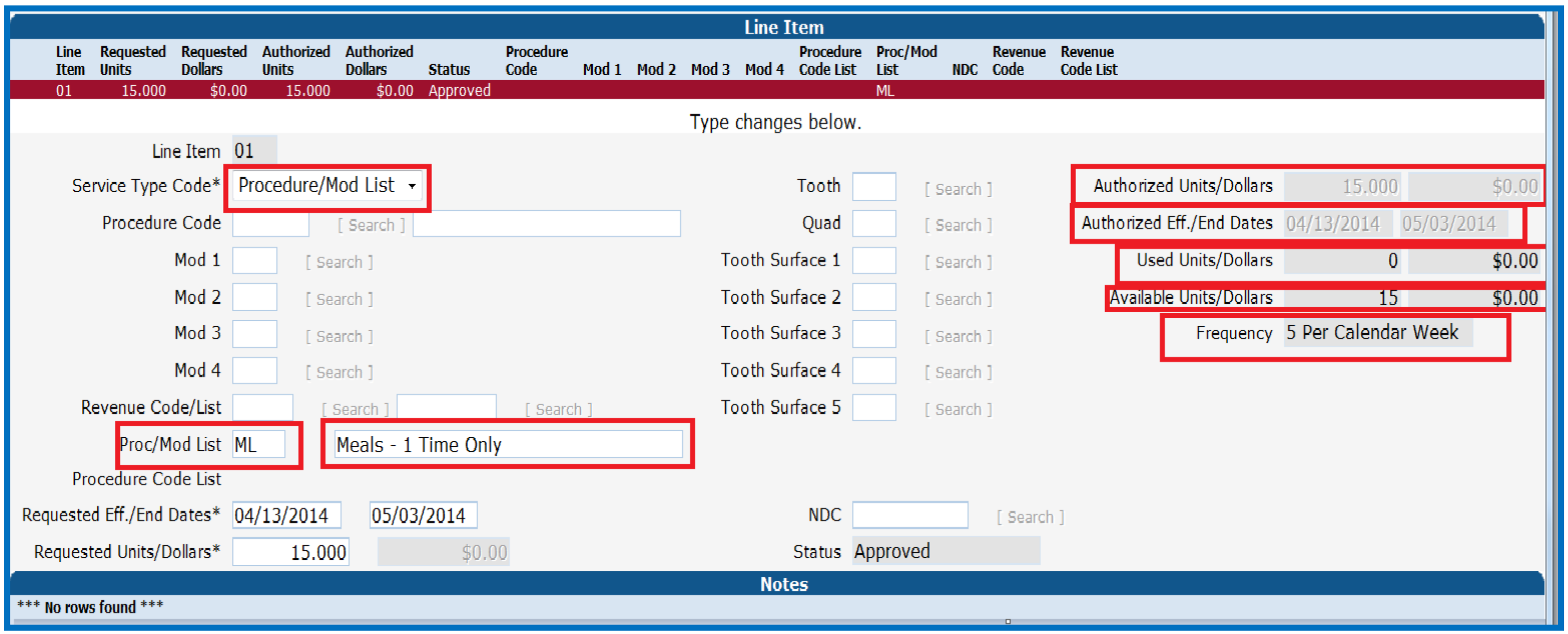
Notes

*** No rows found ***

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (CHC)

This PA for meal one time only services is authorized with a <u>Procedure Code/Modifier list ML</u>. The <u>Proc/Mod list ML</u> includes the same procedure codes as in <u>list code 970</u> with an added U2 modifier designating the service as one time only. The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.



Viewing and Understanding the Care Plan

Prior Authorization Inquiry (CHC)

A "list code," when authorized will appear on the PA. However, providers must bill the procedure code or procedure code/modifier for the service provided. Providers may not change services in the list code without authorization. Doing so will result in an audit finding.

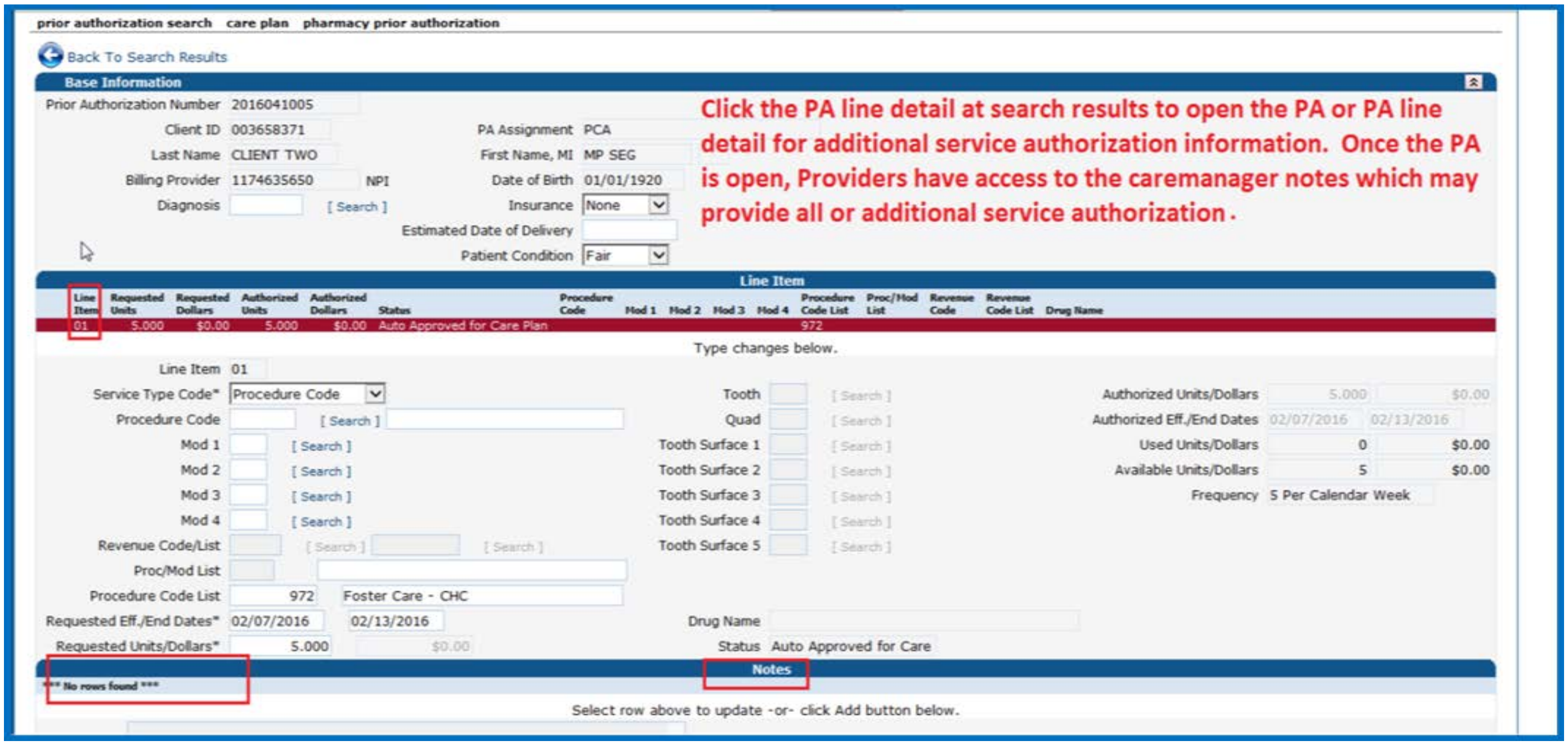
Reminder: Contact the care manager, if reimbursement for the service to be

Meals	**List Code = 970** (on care plan)
Description of Service	**Procedure Code** (on claim)
Single Meal	1218Z
Double Meal	1220Z
Kosher Meal	1221Z
Meals - One Time Only	**List Code = ML** (on care plan)
Description of Service	**Procedure Code/Modifier** (on claim)
Single Meal - One Time Only	1218Z U2
Double Meal – One Time Only	1220Z U2
Kosher Meal – One Time Only	1221Z U2

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (PCA)

This PA for Foster Care is authorized with Procedure Code list 972 which includes billing procedure codes S5140, 5140X, 5140Y, 5140Z. The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.



Viewing and Understanding the Care Plan

Prior Authorization Inquiry (PCA)

Meals	List Code = 972 (on care plan)
Description of Service	**Procedure Code (on claim)**
Foster Care, Adult, Per Diem 1	S5140
Foster Care, Adult, Per Diem 2	5140X
Foster Care, Adult, Per Diem 3	5140Y
Foster Care, Adult, Per Diem 4	5140Z
Foster Care – One Time Only	**List Code = FF**
Description of Service	**Procedure Code/Modifier (on claim)**
Foster Care, Adult, Per Diem 1 – One Time Only	S5140 U2
Foster Care, Adult, Per Diem 2 – One Time Only	5140X U2
Foster Care, Adult, Per Diem 3 – One Time Only	5140Y U2
Foster Care, Adult, Per Diem 4 – One Time Only	5140Z U2

Viewing and Understanding the Care Plan

➢**Modifiers used in the Waiver programs include:**

✓Modifier **U2 - One Time Only Services** can be used to authorize:

- Additional units needed on a day service is provided
- Another day of service in an existing care plan
- An additional frequency to an existing service

- The **U2** Modifier can be authorized for all **non-medical services** except:
  - Highly Skilled Chore
  - PERS Service Installation
  - Assistive Technologies
  - Minor Home Modifications
  - Two-way PERS-ongoing service
  - Care Management

Viewing and Understanding the Care Plan

➢ **Modifiers used in the Waiver program cont.**

✓ Modifier **<u>TT - Subsequent Client</u>** can be used to authorize:

- Service for an additional client residing in the home of a client already receiving the same service.
- No procedure code restrictions
- If authorized:
  - The **<u>TT</u>** modifier must be associated to the procedure code on the care plan/PA

Viewing and Understanding the Care Plan

Points to remember when viewing the client's Service Order/Prior Authorization on your secure Web Account:

➢The procedure code, modifiers, from and through dates of service, units and frequency should match:

- ✓ the paper service order or
- ✓ the service order noted in the notes section of the PA on your secure Web account (Access Agency Upload of Service Orders)
- ✓ information in Santrax should match with your secure account

Note: Discrepancies should be reported to the Access Agency or DSS Autism Case Manager

Viewing and Understanding the Care Plan

- **Codes Authorized on the care plan are not always the codes to be billed on the claim. Providers should refer to the procedure code crosswalk for billing codes associated to codes authorized on the (PA).**
  - **If a Procedure Code or Procedure Code Modifier List is authorized, providers should:**
  - ✓ Refer to the Procedure Code Crosswalk applicable to the client's waiver program for billing codes and unit increments associated to the Procedure Code List or Procedure Code Modifier List authorized.
    - Codes associated to the list can be billed interchangeably, based on the service provided, up to the units authorized within the frequency, unless otherwise indicated by the care manager as documented on the service order.
    - If the procedure code on the service order is of a lessor reimbursement value than the service being provided from the code list, the provider must contact the care manager unless otherwise indicated in the external notes on the PA.
- **Providers should also refer to the procedure code crosswalk for unit increments which should match back to the number of hours the service was authorized.**

Viewing and Understanding the Care Plan

➢**Procedure Code Crosswalk – A list of non-medical procedure codes, and procedure code modifier lists with associated procedure codes/modifiers that can be authorized under the Autism, CHC, ABI, or PCA waiver.**

➢**Providers should access the Procedure Code Crosswalks for the following information:**

- A list of procedure codes and procedure code/modifier combinations authorized under a procedure code/modifier list
- Service descriptions
- Unit increments
- Provider who can be authorized to bill the service
- If service can be spanned when consecutive dates of service are performed (N/A for home health services)
- Frequency of service
- Care Plan limitations (When PA is required by DSS or Beacon Health Options)
- Funding Source that covers the service
- If a service is EVV Mandated, Optional, or N/A
- For ABI Providers: Which ABI Benefit plan (1, 2, or both) the procedure code is applicable to

Viewing and Understanding the Care Plan

Claim Submission Points to Remember

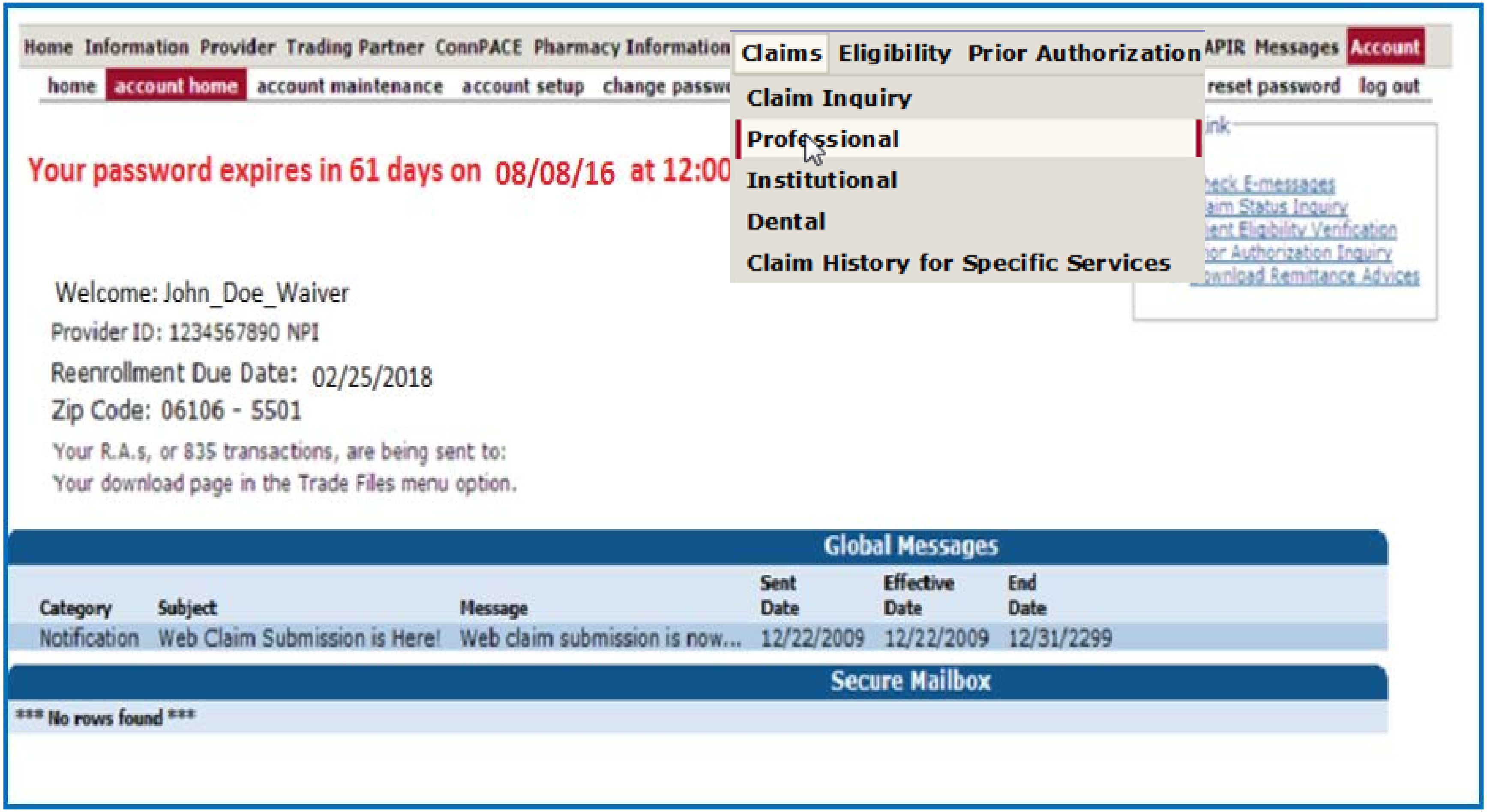
Procedure Code Crosswalks can be obtained on the www.ctdssmap.com Web site as a link in Chapter 8 of the Waiver Service Provider manual in the modifier section of the claim submission instructions.

✓ From the Home page: Information > Publications > Provider Manuals > click on “View Chapter 8” > Choose “Autism”, “Connecticut Home Care”, “Acquired Brain Injury Services”, or “Personal Care Assistance” > field 24d

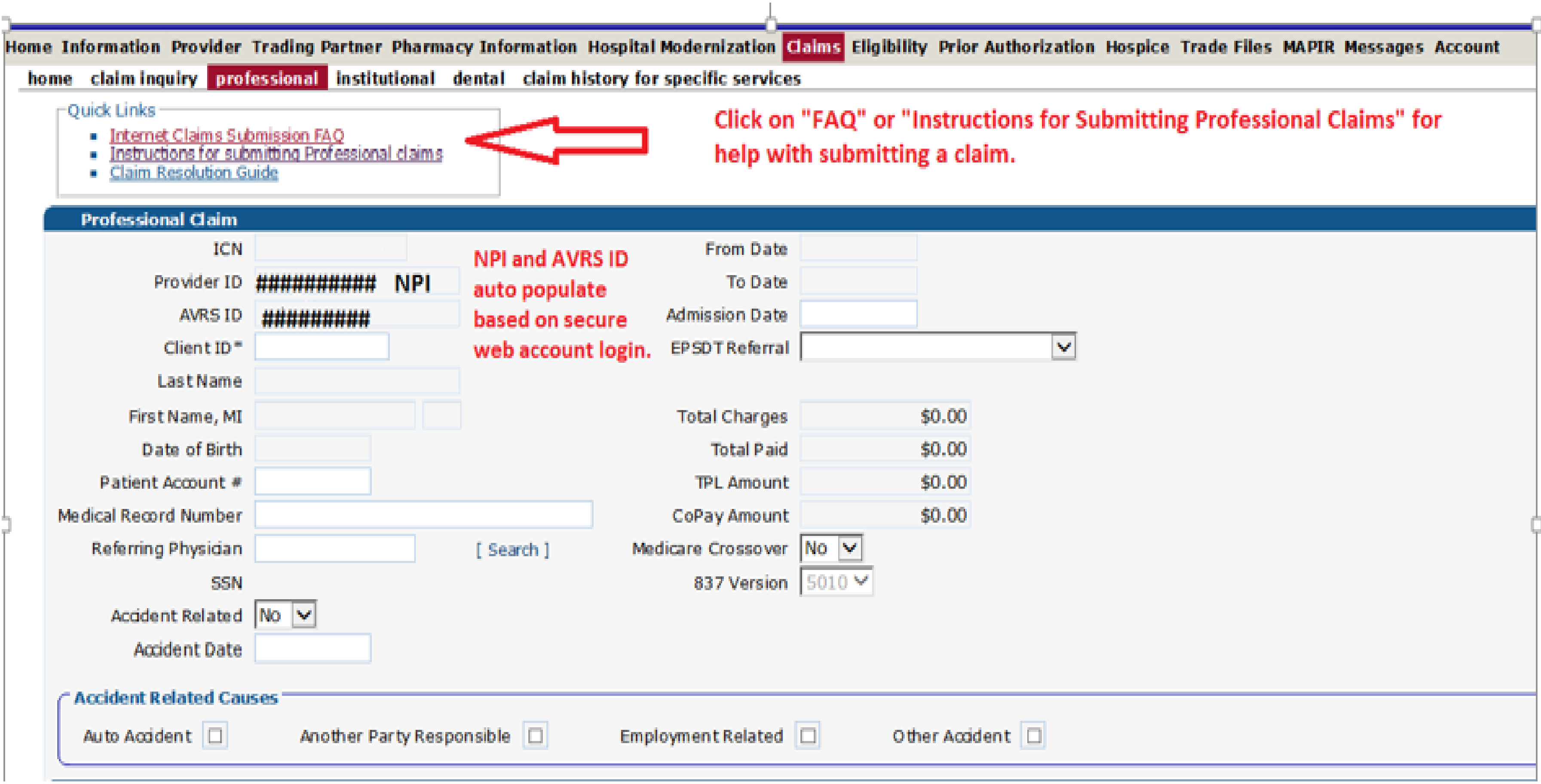
Claim Submission Guidelines

Wavier Provider Refresher Workshop

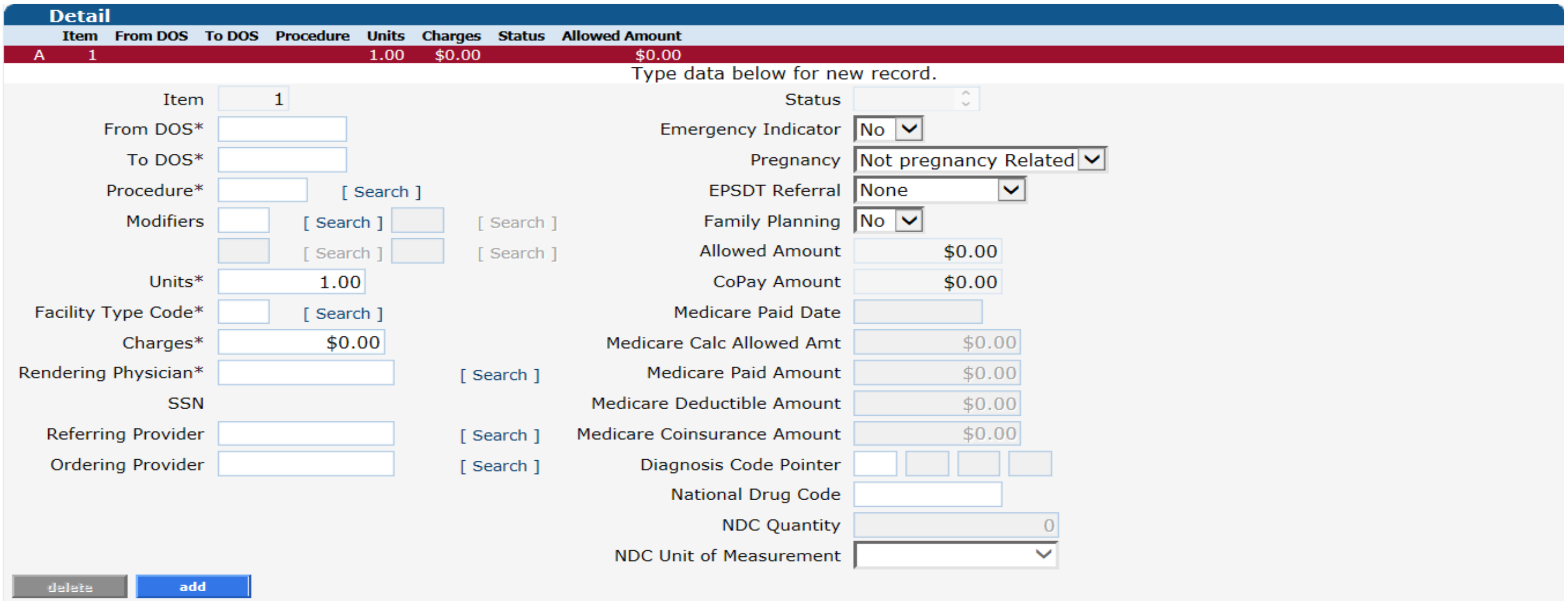
Access to Claim Submission



Access to Claim Submission



Access to Claim Submission



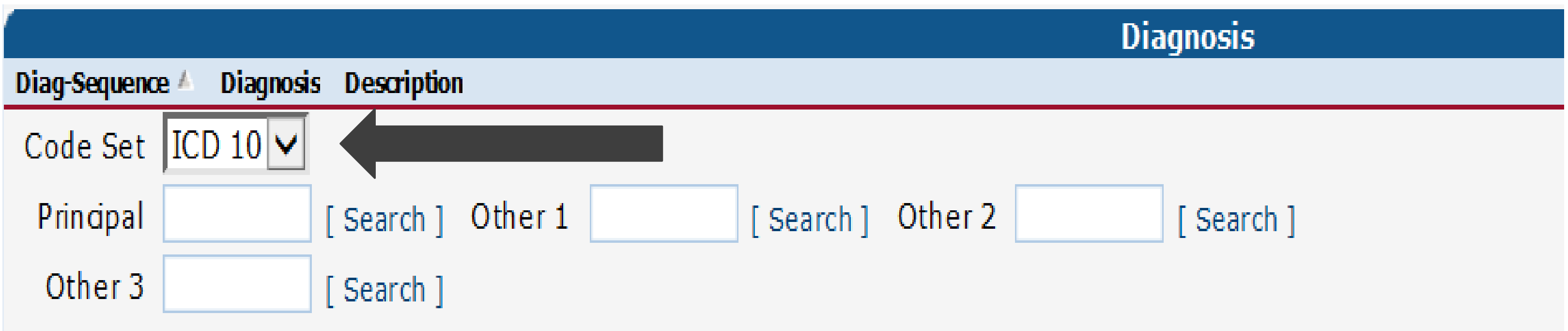
In the Detail Section enter the procedure code, date of service, units of the procedure, total charges for the service, modifier(s), if applicable.

To enter additional procedures, click on the add button within the Detail Panel and enter the required information.

Do not click on the add button after you've entered the last procedure for the client/date of service.

Access to Claim Submission

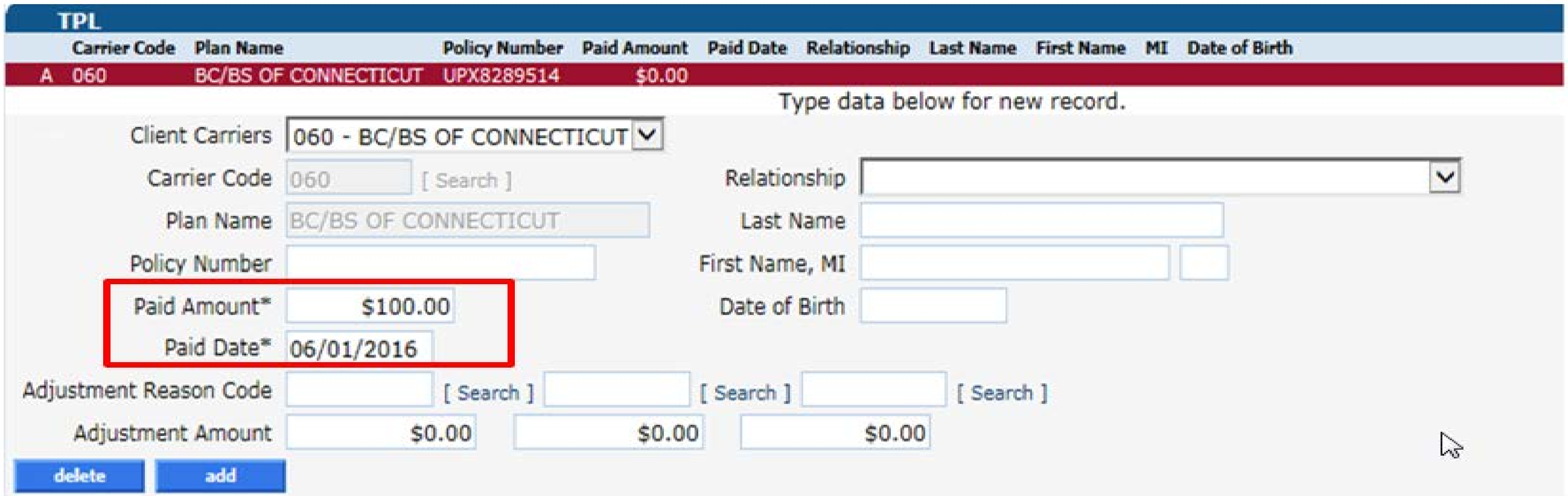
Diagnosis Panel



* Diagnosis is **NOT** required for non-medical services.

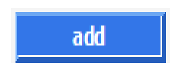
Access to Claim Submission

TPL Panel



Medicaid is always the payer of last resort. If the client has Other Insurance (OI) primary, the provider should bill that carrier first.

The OI information can be entered in the TPL panel by first clicking on the button in the TPL panel.



The required fields are Carrier Code for the OI, Paid Amount and Paid Date.

The three digit Carrier Code can be found on the client eligibility verification screen under TPL Information, or in the drop down "Client Carriers" field in the TPL panel on the Claim screen.

*** TPL is <u>NOT</u> applicable for non-medical services.**

Access to Claim Submission

Claim Status Panel

Claim Status Information

Claim Status	Not Submitted yet

Claim Status Information

Claim Status	PAID
Claim ICN	2216187050003
Paid Date	07/07/2016
Paid Amount	$85.28

Claim Status Information

Claim Status	DENIED
Claim ICN	2216190050002
Denied Date	
Paid Amount	$0.00

EOB Information

Detail Number	Code	Description
0	1802	TYPE OF BILL IS INVALID FOR THE PROVIDER.
0	0619	ZIP CODE IS NOT A VALID 9 DIGIT ZIP CODE
0	1912	BILLING PROVIDER'S TAXONOMY IS MISSING
0	0621	BILLING PROV ENTITY TYPE QUALIFIER TO PROV TYPE/SPECIALTY MISMATCH
1	9996	REFER TO HEADER EOB

Claim Status Information Panel shows the status of the claim.

Once a claim is submitted, it processes in real time and assigns an Internal Control Number (ICN) to the claim. The Claim Status will show if it has been submitted, paid, denied or suspended.

Claim Status on a paid claim will show the paid amount.

Claim Status on a processed claim will also show the Explanation of Benefit (EOB) codes that post at the header of the claim and at the details.

Access to Claim Submission

Claim Status Panel - Web Claim Function Buttons

New Claim

submit | cancel

Paid claim

cancel | adjust | void | copy claim | new claim

Denied claim

re-submit | cancel | new claim

Suspended claim

new claim

Access to Claim Submission

Web Claims Submission – Error Messages

If required information is missing or is in an incorrect format, the self editing feature of Web claims generates error messages to alert the provider and will prevent the claim from being submitted until the errors have been corrected.

The following messages were generated:

Message Description	Panel	Field	Row
A valid FTC is required	Detail	FTC	1

Detail

	Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1	07/15/2016	07/15/2016	99212	1.00	$700.00		$0.00

Type data below for new record.

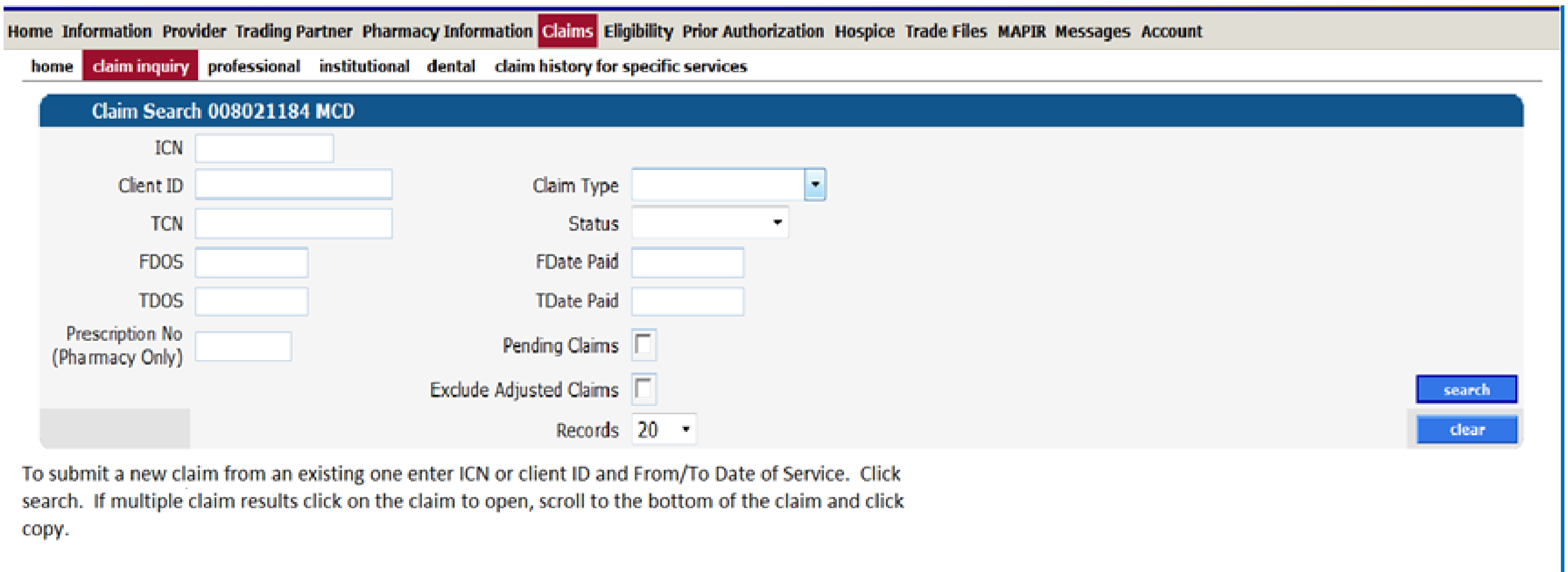
Item	1			Status	
From DOS*	07/15/2016			Emergency Indicator	No
To DOS*	07/15/2016			Pregnancy	Not pregnancy Related
Procedure*	99212	[Search]		EPSDT Referral	None
Modifiers		[Search]	[Search]	Family Planning	No
		[Search]	[Search]	Allowed Amount	$0.00
Units*	1.00			CoPay Amount	$0.00
Facility Type Code*		[Search]		Medicare Paid Date	

The error message will point to the Panel, the Field and the Row where the error has occurred. Providers should refer to chapter 8 claim submission instructions field 24B under the applicable Waiver Heading for Facility Type Codes (FTC) applicable to the place of service.

Access to Claim Submission

Enter enough information to satisfy at least one of the following criteria*:*

- *ICN*, *From* and *Through Dates of Service*, *From* and *Through Dates of Payment*, or check the *Pending Claims* box.
- The From and Through dates cannot span more than 93 days.



Access to Claim Submission

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Medical Care Advisory Committee **Claims** Eligibility Prior Authorization Hospice Trade Files MAPIR Messages Account

home **claim inquiry** professional institutional dental claim history for specific services

Claim Search [redacted] NPI

ICN
Client ID
TCN
FDOS 06/01/2016
TDOS 07/07/2016
Prescription No (Pharmacy Only)

Claim Type
Status
FDate Paid
TDate Paid
Pending Claims
Exclude Adjusted Claims
Records 20

search
clear

Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Status	Date Paid	Amount Billed	Amount Paid
[redacted]	[redacted]	[redacted]		06/27/2016	06/27/2016	Paid	07/09/2016	$200.00	$184.00
[redacted]	[redacted]	[redacted]		06/27/2016	06/27/2016	Paid	07/09/2016	$200.00	$156.8
[redacted]	[redacted]	[redacted]		07/01/2016	07/01/2016	Denied	07/09/2016	$188.00	$0.00
[redacted]	[redacted]	[redacted]		07/01/2016	07/01/2016	Denied	07/09/2016	$188.00	$0.00
[redacted]	[redacted]	[redacted]		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	$188.00	$51.48
[redacted]	[redacted]	[redacted]		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	$188.00	$85.28
[redacted]	[redacted]	[redacted]		07/06/2016	07/06/2016	Paid	07/09/2016	$100.00	$81.00
[redacted]	[redacted]	[redacted]		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	$188.00	$100.00
[redacted]	[redacted]	[redacted]		07/05/2016	07/05/2016	Paid	07/09/2016	$188.00	$85.28
[redacted]	[redacted]	[redacted]		07/05/2016	07/05/2016	Paid	07/09/2016	$188.00	$146.00
[redacted]	[redacted]	[redacted]		07/06/2016	07/06/2016	Denied	07/09/2016	$100.00	$0.00
[redacted]	[redacted]	[redacted]		07/06/2016	07/06/2016	Adj/Voided	07/09/2016	$100.00	$81.00
[redacted]	[redacted]	[redacted]		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	$188.00	$146.00

Access to Claim Submission

Claim Submission – Spanning Dates

Dates of service can only be spanned for non-medical services submitted in the professional claim format when service is provided on consecutive dates which span the from and through dates of service on the claim detail. Please note: Spanning will *NOT* occur if billed thru EVV.

Spanned dates of service cannot exceed the frequency (weekly or monthly) for the service as noted on the care plan/PA. ***For example, if the chore service is to be provided 6 hours per week on consecutive days such as Monday through Wednesday for 2 hours per day for a total of 24 units, the span dates of service must begin on the Monday of the calendar week in which the service was performed and end on the Wednesday of the same calendar week for a total of 24 units.***

Spanned dates of service cannot span multiple line details on the care plan. ***For example, in the example above a onetime only of an additional 4 hours on Thursday is needed for the above week. If the 4 additional hours on Thursday are added as an additional line detail on the PA, the services for Thursday, even though they are consecutive with the regular weekly services, must be billed on a separate line detail.***

Access to Claim Submission

Claim Submission Points to Remember

Accessing claims for inquiry or new submission

- Log in under your correct secure Web account
- Your Local Administrator must give you access/permission for Claim Submission Inquiry (Chapter 10, section 9 of the provider manual)
  - If you don't have access, you will not be able to view the Claim tab when logging in to your secure Web account.
- When accessing claims click on the claim tab and select claim inquiry or Professional (first claim for new client) and click search.
- Perform a claim inquiry by entering at minimum:
  - The claim ICN
  - Client ID
    - Narrow your search using:
      - From/To dates of service (***Note: search cannot exceed 90 days***)
      - Claim status
- Click Search

Monthly Claims Reprocessing

Waiver Provider Refresher Workshop

Monthly Claims Reprocessing

The Access or Case Management Agencies are allowed to make retroactive changes to Care Plans even when claims are paid against the Prior Authorization (PA) for a CHC, Autism waiver, PCA or ABI Waiver client.

- ❑ Access and Case Management Agencies can make changes to individual care plans without requesting the provider recoup/void claims paid for dates of service on or after the effective date of the change.

A Systematic Monthly Claims Reprocessing for all ABI, CHC and PCA claims occurs in the first financial cycle of each month to:

- ❑ Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Access or Case Management Agencies.

Monthly Claims Reprocessing

Systematic Monthly Reprocessing

In the first cycle of each month, DXC Technology will recoup (void) all paid claims impacted by the Access Agency changes made two months prior (Region 52 claims = a voided claim).

In the same cycle DXC Technology will reprocess, deny and/or pay claims posting to the correct PA/PA line detail (Region 24 claims = a new day claim).

For example: changes made to PAs in May 2019 by the Access Agency will result in claims being voided (region 52) and reprocessed (region 24) in the first cycle of July 2019.

Note:* *Region = the first two digits of the claim Internal Control Number (ICN).

Monthly Claims Reprocessing

- In the first cycle of each month, DXC Technology will recoup (void) all paid claims impacted by the Access or Case Management Agency PA changes made two months prior. (*A claim that starts with Region code 52 is a voided claim).*

- In the same cycle DXC Technology will reprocess to, deny and/or pay claims posting to the correct PA/PA line detail. (*A claim that starts with Region code 24 is a new day claim).*

- There is a two month delay between the PA change and reprocessing of the claim impacted by the change.

- For example: In the first cycle of June claims impacted by changes made in April will be reprocessed.

Note: *Region = the first two digits of the claim Internal Control Number (ICN).*

Monthly Claims Reprocessing

- **Impact to Provider Remittance Advice (RA)**

  - ❑ If there is a financial impact (change in reimbursement amount up or down) between the voided claim (**region 52**) and the reprocessed claim (**region 24**):

– **Providers will see in the adjustment section of their RA**:

  - ❑ The previously paid claim ICN (**Region 20, 22, 59, 10** etc.)
  - ❑ Recouped/Voided claim ICN **(Region 52)**
  - ❑ **EOB Code 8236** – Claim was recouped due to PA change

Monthly Claim Reprocessing

PA Changes Made by Access Agency – Claim Recouped

REPORT: CRA-HHAD-R
RA#: 7181817

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
HOME HEALTH CLAIM ADJUSTMENTS

Date: 04/09/2019
PAGE: 107

Health Service Provider
1243 Main Street
Hartford, CT 06106

PAYEE ID MCD 001234567
ISSUE DATE 04/09/2019
TAXONOMY 251E00000X
P. AVRS ID 001234567

FP	--ICN-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PATIENT LIABILTY	PAID AMOUNT
1	5919094008990 / 00205243	NPI 1255772307	091418 092118	259.00	0.00	0.00	0.00	0.00	0.00

REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
580	T1001	091418		1.00	148.00	0.00	2522 4021 4227 4980
580	G0162	092118		3.00	111.00	0.00	2522 4021 4227 4980

CLIENT NAME: SHIRLEY CLIENT NO.: 001234567

FP	ICN / PATIENT NUMBER	ATTEND PROV.	SERVICE DATES	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PATIENT LIABILTY	PAID AMOUNT
1	2219000000000 / 00001897	NPI 1114085016	082718 082718	(148.00)	(95.20)	(0.00)	(0.00)	(0.00)	(95.20)
1	5419000000000 / 00001897	NPI 1114085016	082718 082718	148.00	0.00	0.00	0.00	0.00	0.00

HEADER EOBS: 8236

Monthly Claims Reprocessing

Impact to Provider Remittance Advice (RA)

A new claim will be systematically created. Providers will see the new day claim on their RA.

- ❑ Claim ICN (**Region 24**) in the paid/denied section of the RA.
- ❑ **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change.

NOTE: If the reprocessed region 24 claim pays the same as the recouped region 52 claim, neither claim will appear on the paper RA.

Monthly Claims Reprocessing

Monthly Claim Reprocessing Due to PA Changes

Claim Reprocessed and appears on RA (paid amount region 24 claim greater than amount recouped – region 52 claim)

REPORT: CRA-HHPD-R
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
HOME HEALTH CLAIMS PAID

Date:
PAGE: 2

Home Health Agency
555 Any ST
Somewhere, CT 00000-0000

PAYEE ID NPI
ISSUE DATE
TAXONOMY 251E00000X
P. AVRS ID

FP	--ICN-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PATIENT LIABILTY	PAID AMOUNT

CLIENT NAME: Sally Client CLIENT NO.: 000000000

	2400000000000	NPI	071517	072217	600.00	396.94	0.00	0.00	0.00	396.94
	375866									

REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
580	S9124	071517		1.00	175.00	114.74	8238
570	T1004	071517		6.00	75.00	48.54	8238
580	S9123	071817		1.00	175.00	116.83	8238
580	S9123	072217		1.00	175.00	116.83	8238

Monthly Claims Reprocessing

Monthly Claims Reprocessing Due to PA Changes

Impact to provider's secure Web Portal- Claim Inquiry

Regardless of the financial impact (more, less or no $ change):

- ❑ All **region 52** and **region 24** claims will appear on the provider's secure web account when performing a claim inquiry.

Region 24 claims with no financial impact (i.e. region 24 claims paid the same as voided region 52 claims) **will appear on the web only** with:

- ❑ **EOB code 8237** – Claim Systematically Reprocessed Due to Retro Change-Information Only.

Note: These claims will not appear on the provider's RA

Monthly Claims Reprocessing

Monthly Claims Reprocessing Due to PA Changes

Impact to PA Inquiry in Provider's Secure Web Portal

- Region **24 claims** identify a change made to the care plan/PA.
- Region **24 claims** with **EOB Code 8238** – "Claim Systematically Reprocessed Due to a PA/Service Order Change" confirms there has been a change which has:
  - Positively or negatively impacted you financially.
  - May impact you financially in the future.
- Providers should investigate reprocessed claims with a **negative** impact to determine if:
  - Providing appropriate level of service currently authorized.
  - Current service order matches the PA on their secure Web account.
  - Report discrepancies to the Access or Case Management Agency.

Monthly Claims Reprocessing

Monthly Claims Reprocessing Due to PA Changes

Impact to Provider's Secure Web Portal – PA Inquiry (continued)

A PA may show negative units available, if the changes made by the Access Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.

For example:

- ❑ PA authorized for 4 units per week for 4 weeks = 16 units authorized and available.
- ❑ Claims are paid against the PA = 16 units used
- ❑ Access Agency changes the PA to 4 units a week for 3 weeks = 12 units authorized and available, due to hospitalization after the third week

Until claims are recouped and reprocessed, the PA will show 12 units authorized – 16 used = (4) negative (available) units.

Claim Denials, Resolution, and Resources

Waiver Provider Refresher Workshop

Claim Denials, Resolution, and Resources

➢Claim Denials due to Client Eligibility

✓ **Denial Reasons:**

- **EOB code 2003** - Client Ineligible for dates of service
- **EOB code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have an Autism, CHC, ABI, or PCA Waiver benefit. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021).

✓ **Resolution:**

- Client eligibility file needs to be updated with a CHC, ABI, Autism or PCA benefit plan or change in the effective dates of eligibility.

Claim Denials, Resolution, and Resources

➢Claim Denials Related to Care Plan/PA Issues

- **EOB code 3015** – CHC Care Plan Required
  - Resolution: A care plan must be created by the Access Agency or DSS Autism Case Manager and uploaded to the DXC Technology system.
- **EOB code 3016** -Service not Authorized on the CHC Care Plan
  - Resolution: A service denied for not on the care plan must be added by the Access Agency or DSS Autism Case Manager to the Care Plan.

Claim Denials, Resolution, and Resources

- **Claim Denials Related to Care Plan/PA Issues cont.**
  - **Resources:**
    - Care Managers create service orders and the Access Agencies upload care plans interactively via the portal to DXC Technology.
    - DSS Case Managers who create and enter service orders for Autism services, enter the care plans directly to DXC using the secure Web portal.
    - If the provider **has a service order** and a **PA for the service order cannot be found by doing a PA inquiry via the provider's secure Web account** within **seven (7) days** of receipt of the service order, the provider should contact the applicable Access Agency, (CHC &PCA)CM Agency (ABI) or DSS CM (Autism)

Claim Denials, Resolution, and Resources

➢Claim Denials Related to Care Plan/PA Issues cont.

✓Care plans or changes to care plans that are not viewable via the provider's secure Web portal within seven (7) days of issuance may be the result of the Access Agency or DSS Case Manager experiencing an upload issue to DXC Technology due to:

- Service overlaps

✓These types of upload issues take time to resolve so it is important to confirm service order requests or changes have been uploaded as soon as possible to avoid unnecessary claim denials or further delay in prior authorization upload.

Note: If a client is eligible under a waiver benefit plan, a care plan for the services to be billed must be in place for both Medical and non-medical services or the claim will deny.

Claim Denials, Resolution, and Resources

➢ **Claim Denials Related to Care Plan/PA Issues cont.**

- **EOB code 5151** – Units exceed the frequency units authorized on the care plan
  - Resolution: Units of service must be added to the frequency of an existing PA by the Access Agency or DSS Case Manager.
  - This could also indicate user error. Check to make sure you did not enter an incorrect number of units on the claim.
- **EOB code 3003** - Prior Authorization is required for payment of the service (units for the service are exhausted)
  - Resolution: Units of service must be added by the Access Agency to an existing PA that is currently exhausted.
  - Providers should also re-check units billed to rule out user error (i.e. wrong number of units entered on claim submission screen)

Claim Denials, Resolution, and Resources

- **Claim Denials Related to U2 Modifier.**

  - **EOB code 749** – Modifier U2 not allowed.
    - Resolution: Claim must be resubmitted without the U2 modifier.
    - The claim is submitted with a U2 modifier for one of the following services: Highly Skilled Chore, Minor Home Modifications, PERS Service Installation, Two-way PERS-ongoing service, Assistive Technologies, or Care Management

Claim Denials, Resolution, and Resources

➢Claim Denials Potentially Due to Provider Error

✓Claim denials due to

- **EOB code 3016-** Service not covered under Autism, CHC, ABI, or PCA care plan
  - May be the result of provider error due to:
  - Incorrect procedure code billed
  - Failure to communicate a change in service to the care manager
    - Example: PCA overnight **1022Z** services are authorized, the service can not be completed. Before the provider can bill the code for an incomplete shift, **3022Z**, the care manager must be notified and **3022Z** must be uploaded to the DXC Technology system. Until this occurs any claim submitted for **3022Z** will deny.

Claim Denials, Resolution, and Resources

➢**Provider Error cont.**

✓Claim denials due to:

- **EOB code 3003**- Prior Authorization is required for payment of this service, or
- **EOB code 5151**- Units exceed frequency units on CHC care plan

  May also be the result of provider over service or keying errors when entering units of service.

✓Claim denials due to:

- **EOB code 4140**- The service submitted is not covered under the client’s benefit plan.

  May be the result of submitting non-medical services under the provider’s Home Health or other Waiver provider number or by using the incorrect Wavier AVRS ID.

Claim Denials, Resolution, and Resources

- **Claim Denials Related EVV**

  - **EOB code 3327** – Confirmed visit not found
    - Resolution: The visit must first be confirmed in the provider's Santrax system.
    - It is **important** to note, the confirmed visit data used in claims processing may be up to 24 hours old, therefore, it is critical to ensure visits are confirmed in a timely manner, at least 24 hours prior to claim submission, in order to avoid unnecessary claim denials.
  - **EOB code 3328** – Confirmed visit units are exhausted
    - Resolution: The confirmed visit units in Santrax must be sufficiently increased.
    - This EOB code will post to a claim containing an EVV mandated service where there is a confirmed visit that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units have been exhausted due to a previously paid claim.

Claim Denials, Resolution, and Resources

- **Claim Denials Related EVV cont.**

  - **EOB code 0047** – Confirmed visit units are exceeded
    - Resolution: Can only be resolved if the confirmed visit units in Santrax are sufficiently increased.
    - This EOB code will post to a claim containing an EVV mandated service where there is a confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units on the confirmed visit are less than the units billed on the claim. This claim will pay, but it will cut back to the number of units on the confirmed visit.
    - Reduced units on a confirmed visit may be the result of a pending authorization change. Units on a confirmed visit in Santrax are reduced to the remaining units on the authorization in Santrax. If the authorization units are increased after the visit was confirmed, the visit must be refreshed and updated in Santrax to reflect the full number of confirmed units. Once this occurs, the claim may be adjusted in order to receive payment for the additional units.
    - EOB code 0047 may also occur if there are two visits for the same client and service on the same day and only one visit is confirmed. The second visit must be confirmed in order for the claim to pay the total number of units billed for the day.

Claim Denials, Resolution, and Resources

➢ **Claim Denials Related to EVV cont.**

- **EOB code 3329** – Detail dates of service that span 31 days cannot be verified
  - Resolution: Reducing the number of days submitted on the claim detail.
  - Claims submitted from Santrax are limited to one date of service per claim detail. Claims submitted outside of Santrax may be submitted using spanned dates. These spanned dates cannot exceed 31 days.

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

- **Check client eligibility on clients coming on service.**

  - Contact DSS Community Options unit immediately with clients who are not eligible for a CHC, ABI, or PCA benefit at **Waiver.DSS@ct.gov**

    - Be sure to include requested data to expedite the process.

    - Set up a periodic check system to determine when the client is eligible so claims may be submitted, if applicable.

Note: Most issues of client ineligibility are resolved within a few days of notification.

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

- **Check the client's care plan (PA)** to be sure the services you have been requested to provide have been authorized.

  - ✓ Review the care plan carefully to ensure all services to be provided are on the initial care plan/PA.

  - ✓ Report discrepancies to the appropriate Access Agency or DSS Autism Case Manager immediately.

  - ✓ Review the care plan when you are notified of changes to be sure the services you are being requested to provide are on the care plan/PA.

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

- **Claim submission review**

  - Prior to submitting claims be sure services provided match service authorized and services to be billed.

  - Identify discrepancies early to avoid over service or potential billing errors which may cause claims to deny such as:
    - Exceeding units on a claim frequency.
    - Omission of a modifier on a claim detail(s).
    - Spanning dates of service across frequencies or PA line details.

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

➢Claim submission review

▪Submitting claims electronically and/or via the Web:

- Minimize claim submission time by:
  - ✓ Copying a prior paid claim, especially when billing for like services, minimizes changes needed for resubmission
  - ✓ Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces key strokes and the number of details on a claim

    Example: a homemaker service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 10/3/17 to 10/5/17 1214Z for 30 units.
- Maximize reimbursement time

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

EVV System

All claims are validated in the EVV system prior to direct submission

- Right Client
- Authorized Services
- Right Caregiver Type
- Verified Visit Data

Only validated claims can be submitted for payment

EVV Check in and Check out determines visit duration for claim

Claim Denials, Resolution, and Resources

- **Claims Resolution**
  - ✓ Reconcile claims as entered via the web or leave time before claim cycle cutoff to correct and resubmit.
  - ✓ Submit eligibility issues not already addressed to DSS Community Options unit.
  - ✓ Submit care plan discrepancies not already addressed to Access Agency.
  - ✓ Reconcile RA for the current cycle before receiving next RA to identify problems early to avoid major reimbursement issues.
    - Refer to list of EOB code descriptions at the end of the RA to determine reason(s) for denial.
    - Use Claim Resolution Guide (**Chapter 12** of Provider Manual) to determine the cause of a denial and its resolution.
    - Use Claim Submission **Chapter 8** for waiver providers to determine claim resolution.
    - Contact the Provider Assistance Center at 1-800-842-8440 with issues you cannot resolve.

Program Resources

Waiver Provider Refresher Workshop

Program Resources

- **Procedure Code Crosswalk**

✓Contains authorized codes and associated billing codes

✓Valid frequency (which can be used by Access Agency to authorize the service)

✓Service descriptions

✓Unit increments

✓Billing Provider (Allied or Waiver Service Provider)

✓If spanning code is allowed

✓If a service is EVV Mandated, Optional, or N/A

✓For ABI Providers: Which ABI Benefit plan (1, 2, or both) the procedure code is applicable to

This document can be found as a link in Chapter 8 of the Home Health Provider manual in the modifier section of the claim submission instructions, field 24D.

They are also located on the training page underneath the appropriate waiver training (CHC, ABI, PCA, or Autism).

Program Resources

- ***CT Medical Assistance Program Provider Manual***

  - ✓ *Provider access from the www.ctdssmap.com Home page> Information> Publications> Provider Manuals.*

  - ✓ The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission.

  - ✓ It is the primary source of information for submitting CMAP claims and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions.

Program Resources

Provider Manual

<u>Chapter 1 – Introduction</u>

- Provides information on the CT Medical Assistance Program, (CMAP) the Department of Social Services' and DXC Technology's responsibilities and resources.

<u>Chapter 2 – Provider Participation Policy</u>

- Details the CMAP regulations for provider participation.

<u>Chapter 3 – Provider Enrollment and Re-enrollment</u>

- Provides information on provider eligibility in regards to provider enrollment and re-enrollment.

<u>Chapter 4 – Client Eligibility</u>

- Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability.

Program Resources
Provider Manual

Chapter 5 – Claim Submission Information

- Provides information on general claims processing and billing requirements.

Chapter 6 – Electronic Data Interchange Options

- Provides information on electronic claim submission and electronic Remittance Advice.

Program Resources
Provider Manual

Chapter 7- Specific Policy/Regulation

- This chapter contains the Medical Policy section that pertains to the chosen provider type.

Chapter 8 – Provider Specific Claims Submission Instructions

- Provides information on provider specific billing requirements.
- **Procedure Code Crosswalks** can be found as a link in Chapter 8 of the Home Health Provider manual, Claim Submission Instructions, field 24D.

Program Resources
Provider Manual

Chapter 9 – Prior Authorization

- Provides information on how to obtain Prior Authorization for designated services.

Chapter 10 – Web Portal/Automated Voice Response System (AVRS)

- Provides information on both the AVRS and the Web Portal functions of interChange.

Chapter 11 – Other Insurance and Medicare Billing Guides

- Provides claim-type specific information on other insurance and Medicare billing.

Chapter 12 – Claim Resolution Guide

- Provides descriptions of common EOBs and, if applicable, information to resolve the errors.

Program Resources
Provider Manual

- **Provider Manual (Important Waiver Chapters)**
  - ✓ Chapter 7 (Policies)
  - ✓ Chapter 8 (Claim Submission Instructions)
  - ✓ Chapter 12 (Claim Resolution Guide)
    - This chapter is also a link on the provider secure Web portal. Click on claims then on professional.
  - ✓ Chapter 10 (Web Portal)
- **Web Claim Submission Instructions**
  - ✓ Located on secure Web account
  - ✓ Under claims select professional
  - ✓ Click on the claim submission instructions link in the upper left portion of the screen.

Program Resources
Web Claim Submission

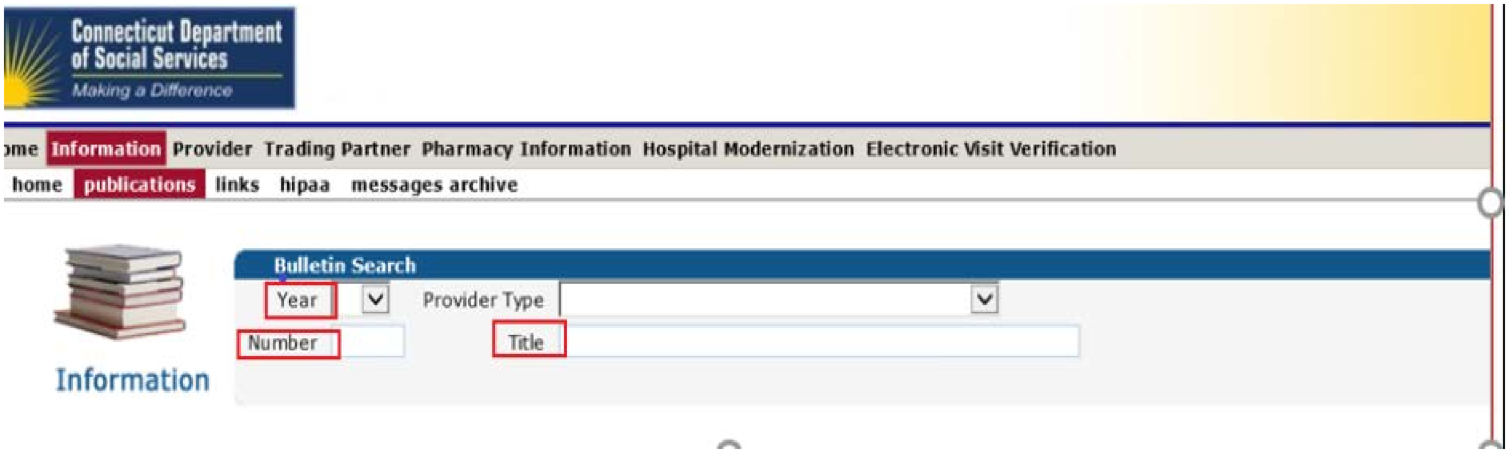
- **Web Claim Submission Instructions**
  - ✓ Located on secure Web account
  - ✓ Under claims select professional
  - ✓ Click on the claim submission instructions link in the upper left portion of the screen.

Program Resources

Information – Provider Bulletins

Publications **emailed to relevant provider types/specialties** **documenting changes or updates** **to the CT Medical Assistance Program.**

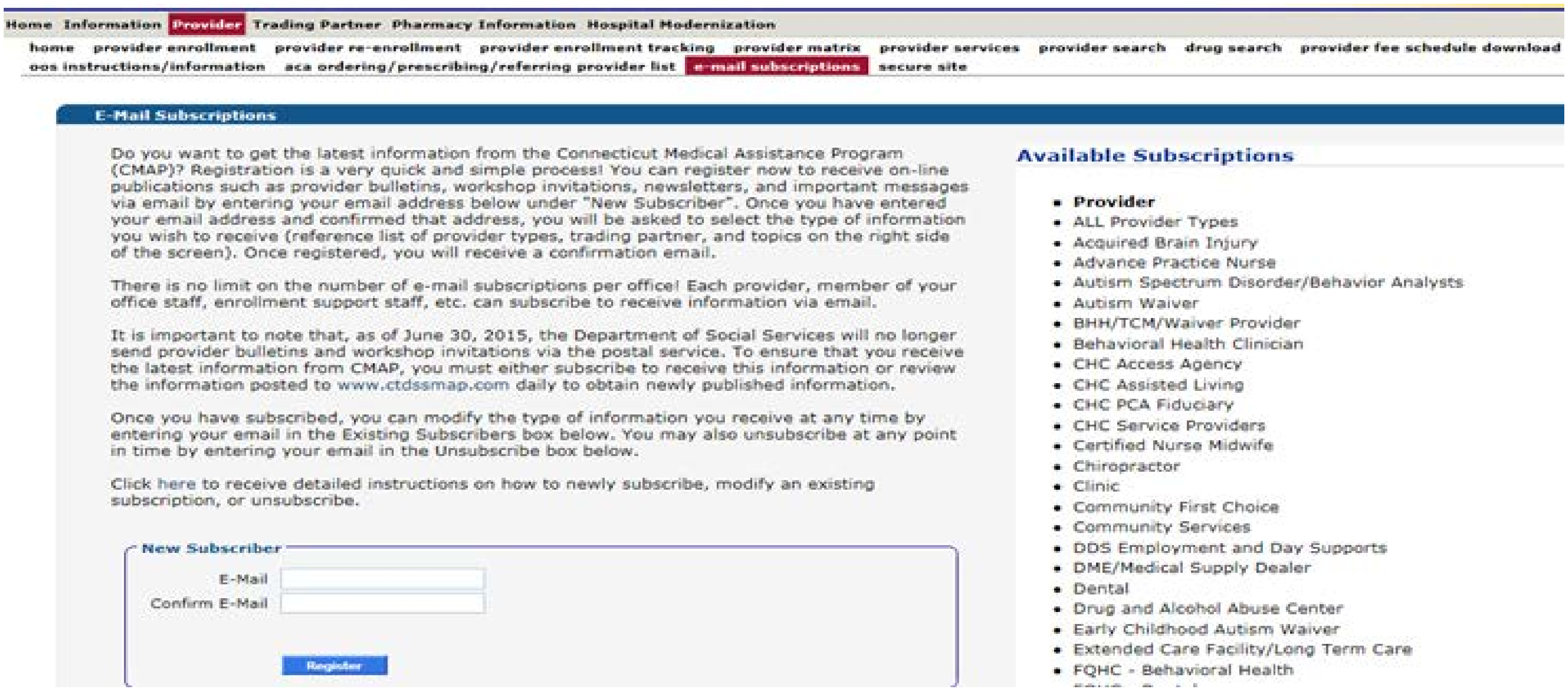
Bulletin Search **allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.**



Program Resources

Information – E-mail Subscriptions

Providers MUST register to receive information electronically for new provider publications and notifications through the email subscription function on the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com



Program Resources
Contacts

DXC Technology Provider Assistance Center (PAC)

- ❑ 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
- ❑ www.ctdssmap.com
- ❑ ctdssmap-ProviderEmail@dxc.com

This should be your first call resource to answer all **enrollment, eligibility** and **billing** related questions. Should your issue require a higher level of research, it will be escalated to your provider representative. Please be sure to ask the PAC representative for your call tracking number for future call reference.

DXC Technology Electronic Data Interchange (EDI) Help Desk

- ❑ 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

Program Resources

Contacts

EVV Email Mailbox

- ctevv@dxc.com.

If you are:

- missing a client from your Santrax system and have verified that the client is eligible on their waiver benefit plan and has a valid PA;
- or if a prior authorization (PA) is present on the www.ctdssmap.com portal but is not present in the Santrax system

then contact the EVV email box for assistance.

Sandata Customer Care

- 1-855-399-8050 or ctcustomercare@sandata.com

If you are experiencing issues with the **Santrax system and its functionality** please contact Sandata Customer Care for assistance.

If you are unsure who to contact for assistance, please send an e-mail to ctevv@dxc.com.

- You are also encouraged to send an e-mail to the ctevv@dxc.com mailbox if you feel you need additional support resolving your issue. Please be sure to include your Sandata ticket number if applicable.

Program Resources
Contacts
Access Agencies

Connecticut Community Care (CCCI)- ServiceAuthIssues@ctcommunitycare.org

❑Providers must include the following information when submitting service authorization issues to CCCI: provider name, client name, client Medicaid ID number, CCCI number, EOB code on rejecting claim at DXC Technology, from and to dates of service, the type of service (SNV, Med Admin, etc.), the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available and any comments the provider wishes to communicate to CCCI.

South Western Connecticut Area on Aging (SWCAA)- SWCAABillings@swcaa.org

❑Please have the following information available when contacting SWCAA:
Client name, the client Medicaid ID number, the type of service (SNV, Med Admin, etc.),
the dates of service, the frequency of service and the number of units or hours per visit.

Agency on Aging of South Central CT (AOASCC) chcbilling@aoascc.org

❑Companies without secure e-mail, please fax service order inquiries to (203) 528-0455. Due to the high volume of inquiries AOASCC requests your primary source of communication to them be by e-mail or fax.

Program Resources Contacts
Access Agencies- Cont.

Western Connecticut Area on Aging (WCAA)- contact WCAA directly at (203) 465-1000

- ❑Please have the following information available when contacting WCAA: client name, the client Medicaid ID number, the type of service (SNV, Med admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Department of Social Services (DSS) – For Self Directed clients on the CHCPE Program, please contact Melva Cooper, RN directly via e-mail at melva.cooper@ct.gov or by phone at (860)424-5863.

Community Option Unit at DSS- For assistance in correcting a waiver clients eligibility file, please send an email to **Waiver.DSS@ct.gov**

Program Resources

Electronic Visit Verification (EVV) – At Your Fingertips

‘At Your Fingertips’ is a monthly tip sheet designed to help providers navigate Electronic Visit Verification (EVV) by answering common questions and providing assistance for resolving common issues encountered by providers in their use of the EVV system. The tip topics are generated by questions submitted to Sandata Customer Care, the EVV mailbox found at ctevv@dxc.com or in communications to DSS for assistance. These tip sheets reflect real questions and issues that providers have as they use the EVV system.

What should I do with the tip sheet?

We recommend saving the tip sheet for easy access when EVV questions arise at your office. These sheets are designed to educate you and your staff and provide useful tips to successfully use EVV. We strongly encourage that these tip sheets be shared with the staff that use the EVV system.

We hope that you enjoy these tips and find them useful in your continued use of the EVV system. If you have suggestions for future tip topics, please email the EVV mailbox at ctevv@dxc.com.

Questions?

Thank you.