Hewlett Packard Enterprise

Acquired Brain Injury (ABI)

Billing and Web Claim Submission Workshop

Presented by:
The Department of Social Services & Hewlett Packard Enterprise
for Billing Providers

Training Topics

- ***Introduction to ABI Program Changes***
- ***Access and Set-up of Secure Web Account***
- ***Web Account Capabilities***
  - ***Demographic Maintenance***
  - ***Clerk Account Maintenance/Set-up***
    - ***Switch Provider***
  - ***Client Eligibility***
  - ***Prior Authorization (PA)***
  - ***Claim Inquiry/Submission Guidelines***
- ***Common Claim Errors and Resolution***
- ***Remittance Advice (RA)***
  - ***Access to Claim and Financial Reporting***
    - ***Components of RA***
- ***Monthly Recoupment/Reprocessing due to Care Plan/PA Changes***
- ***Web Information – Resources***
  - ***www.ctdssmap.com***
    - ***Important Messages***
    - ***EVV IM***
    - ***Procedure Code Crosswalk***
    - ***Fee Schedule***
    - ***Banner / IM Archive***
    - ***Bulletins***
    - ***E-Messaging***
    - ***Provider Manuals***
- ***Contacts***
- ***Questions/Comments***

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ ***Effective* for dates of service, *September 1, 2016***

- Organizations and Self Employed Individuals must enroll as **“ABI Service”** providers to be reimbursed by the Department of Social Services (DSS) for performing a wide range of non-medical, home and community based services to help maintain adults who have an acquired brain injury (not a developmental or degenerative disorder) in the community, **who do not self direct their own care**, and are eligible for either the **ABI I or ABI II Waiver.**

  - Organizations and Self-Employed Individuals **must be credentialed by Allied Community Resources before their application will be considered complete to send to DSS for approval.**

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ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ ***Effective* for dates of service, *September 1, 2016***

- Providers who are ready, may begin using EVV for both mandated and optional services effective for dates of service **September 1, 2016**.

- Providers who are not ready may bill both EVV mandatory and optional services directly to Hewlett Packard Enterprise until **November 1, 2016.**

- Providers who's services are not mandated or optional must submit all services with dates of service effective **September 1, 2016** directly to Hewlett Packard Enterprise for payment.

- Providers should refer to the EVV Service Code Listing link in the Electronic Visit Verification Implementation Important Message on the www.ctdssmap.com Home page for EVV mandated and optional services.

ABI Billing and Web Claim Submission Workshop

➢ **Effective for dates of service <u>November 1, 2016:</u>**

- Provider's **must utilize the EVV system** for services that are **mandated** by EVV.
- Providers may choose to implement the EVV check-in/check-out process for optional service.
- Services entered into the EVV system will be **submitted directly from the EVV system** to **Hewlett Packard Enterprise**, the Department of Social Services Fiscal Agent, when the **service matches the authorization**.

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢**Effective for dates of service September 1, 2016:**

- Claims that require correction for services that are **EVV mandated** that have been **submitted** to Hewlett Packard Enterprise via the **EVV system**:
  - must be **recouped** via **Hewlett Packard Enterprise.**
  - must be **resubmitted** via **the EVV system.**

- Claims that require correction for services that are **EVV optional** that have been **submitted** to Hewlett Packard Enterprise via the **EVV system**:
  - must be **recouped** via **Hewlett Packard Enterprise.**
  - can be **resubmitted** via **the EVV system or Hewlett Packard Enterprise.**

- Claims that require correction for services that are **not EVV mandated or optional** that have been **submitted** directly to Hewlett Packard Enterprise by the provider
  - must be **recouped or adjusted** via **Hewlett Packard Enterprise.**
  - must be **resubmitted** via **Hewlett Packard Enterprise.**

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Introduction to ABI Program Changes cont.

➢ ***Effective*** ***for dates of service,*** ***September 1, 2016*** ***and*** ***Mandated*** ***for dates of Service*** ***November 1, 2016:***

Self Directed Services

- All claims for CFC services, regardless of the EVV check-in/check-out election, will continue to be billed by Allied Community Resources, the Department of Social Services ABI Fiduciary.
- The EVV check-in/check-out process is either optional or not required for ABI services rendered to clients who self direct their own care through the Community First Choice (CFC) services option.
  - Although CFC services are optional, the client may choose to implement the EVV check-in/check-out process.

Secure Web Account Set-up

www.ctdssmap.com

Secure Web Account

ABI Billing and Web Claim Submission Workshop

Secure Web Account Set-up – Access to Secure Web Portal

Providers who have successfully enrolled as ABI Service Providers will receive:

- ✓ An approval letter with their new AVRS/Medicaid ID
- ✓ Additional letter under separate mailing containing their Personal Identification Number (PIN)

– The AVRS ID and PIN allow the provider initial access to the Connecticut Medical Assistance Program Secure Web Portal for the purpose of creating a **secure Web account.**

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Secure Web Account Set-up – Access to Secure Web Portal

- **Users have multiple access to logging on to their secure Web account from the www.ctdssmap.com Home page.**

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Secure Web Account Set-up – Access to Secure Web Portal

To ensure your access to the www.ctdssmap.com Web portal to utilize the self-service features of interchange:

> If your office/company has security measures blocking your access you will need to contact the individual responsible for your firewall and internet permissions and request access to the Connecticut Medical Assistance Program (CMAP) Web site.

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Secure Web Account Set-up – Access to Secure Web Portal

Login

The Connecticut Department of Social Services Medical Assistance Program secure website is intended for providers, clerks and billing agents.

If you have received your Personal Identification Number letter,
click on the setup account button.

set up account

Click to access Account Setup.

User ID*

Password*

login

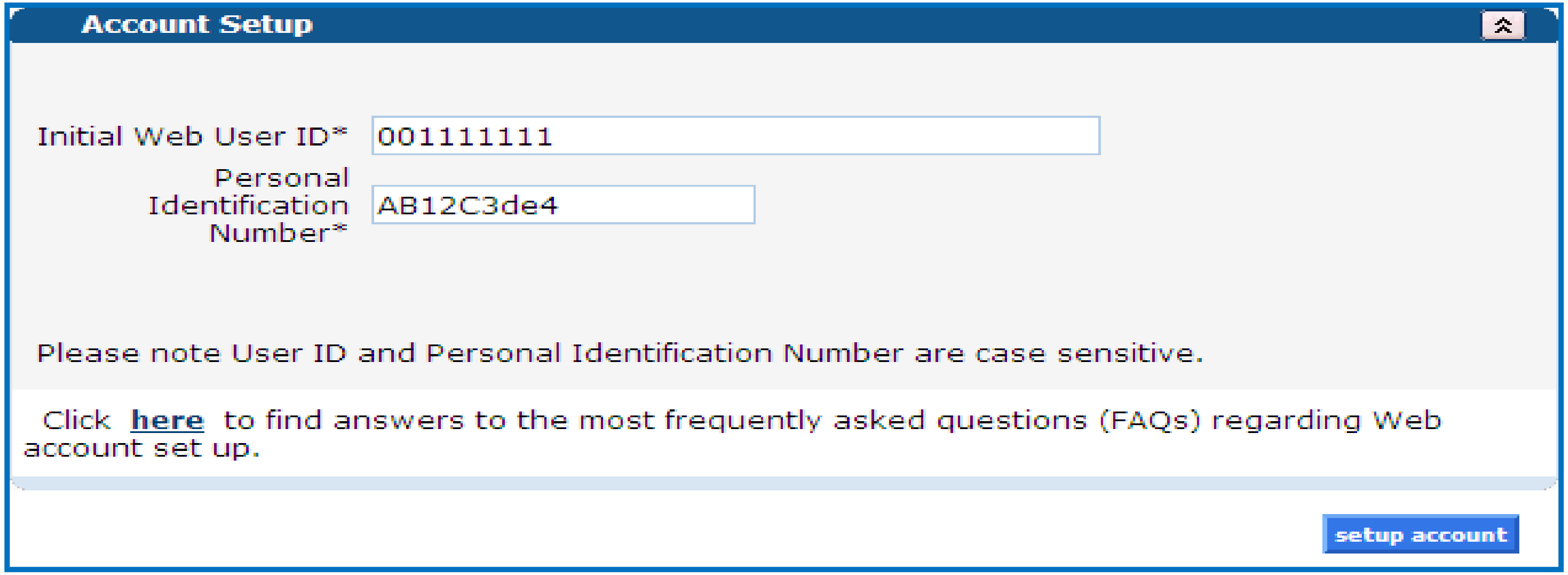
If you have forgotten your password please click the reset password button.

reset password

ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

- Account Setup- Allows providers to set up a local administrator user account.
- Enter the provided *Initial Web User ID* and *PIN* (which can be found in the enrollment and PIN letters), in the appropriate fields; click ***setup account*.**



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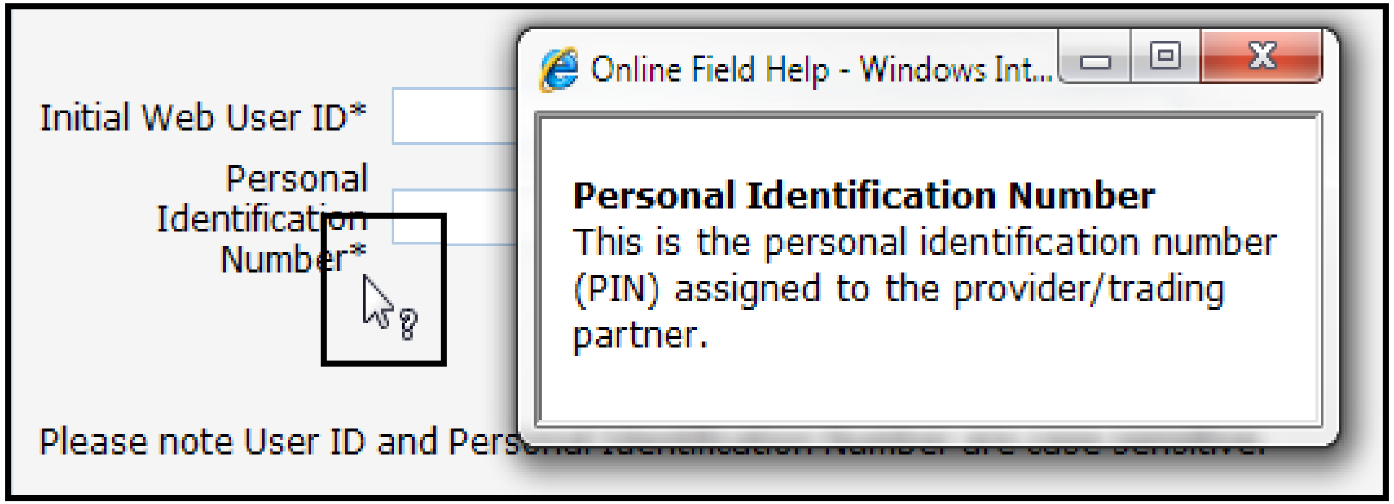
Secure Web Account - Online Field Help

– The ctdssmap.com Web site features an ***Online Field Help Window*** to assist providers with accessing and submitting information.

– Placing your mouse over a data field name will create a small question mark beside the cursor. Click the left mouse button when the question mark is displayed to open the ***Online Field Help*** window relevant to the selected field.



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Secure Web Account Setup

➢Once on the ***Account Setup*** screen, fill in the fields with the appropriate information.


Required fields are indicated with an asterisk (*).

User ID* John_Doe_Waiver

Contact Last Name* Doe

Contact First Name* Jonathan

Phone Number* (800)555-5555 5555

1st Secret Question* Mothers maiden name

1st Answer* Smith

2nd Secret Question Name of first pet

2nd Answer Buster

Password* •••••••

Confirm Password* •••••••

EMail* john.doe@waiverabi.com

Confirm EMail* john.doe@waiverabi.com

Security Agreement

Provider agrees to meet all applicable state and federal laws and regulations pertaining to confidentiality, privacy, and security and to maintain and safeguard, in accordance with all state and federal laws and regulations, the confidentiality of all information concerning DSS clients, including, but not limited to, personal, financial, and medical information. Provider agrees that this agreement is an

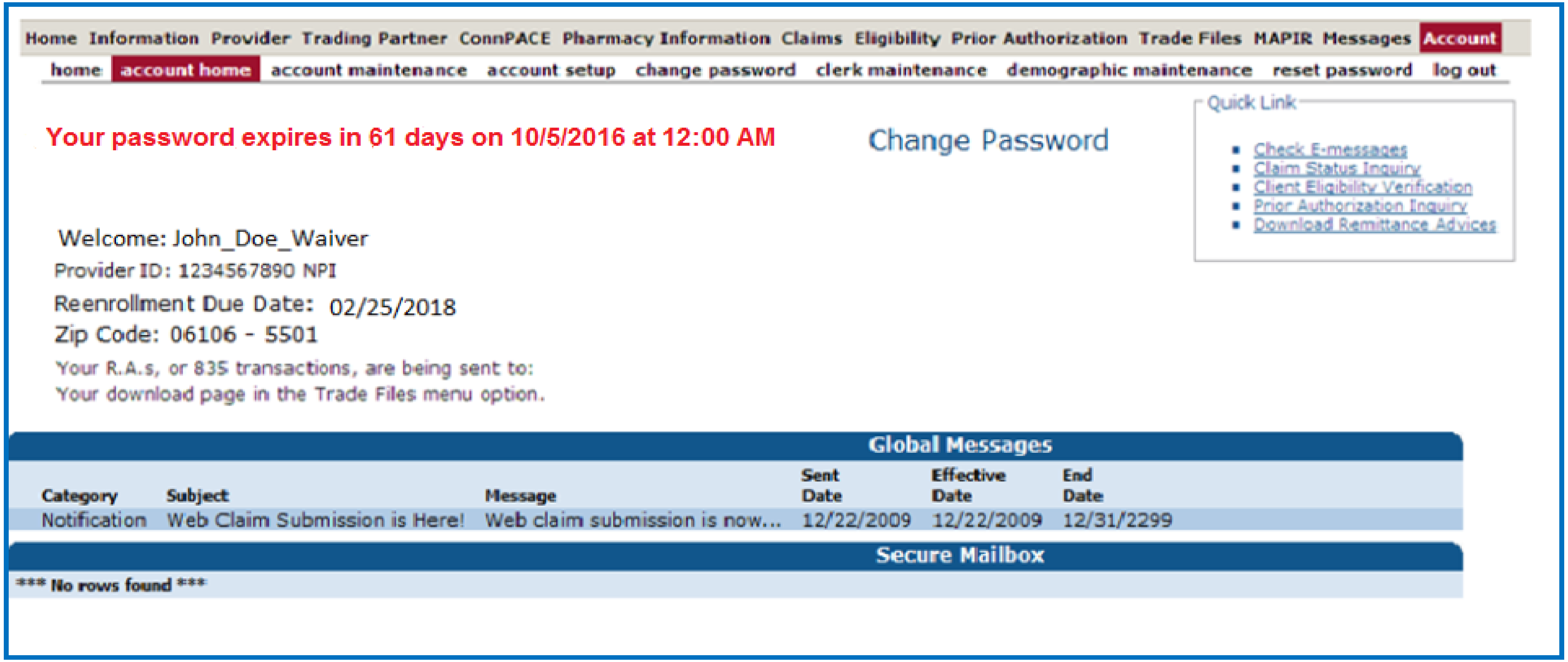
I Agree

****Before clicking submit, be sure to write down the chosen User ID, Password, and security question/answer(s) and keep them in a secure location.****

ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

– You have successfully set up your ctdssmap.com *Secure Site* account



Web Account Capabilities

www.ctdssmap.com

ABI Billing and Web Claim Submission Workshop

Web Account Capabilities

Accessing your Secure Site provider account allows you to:

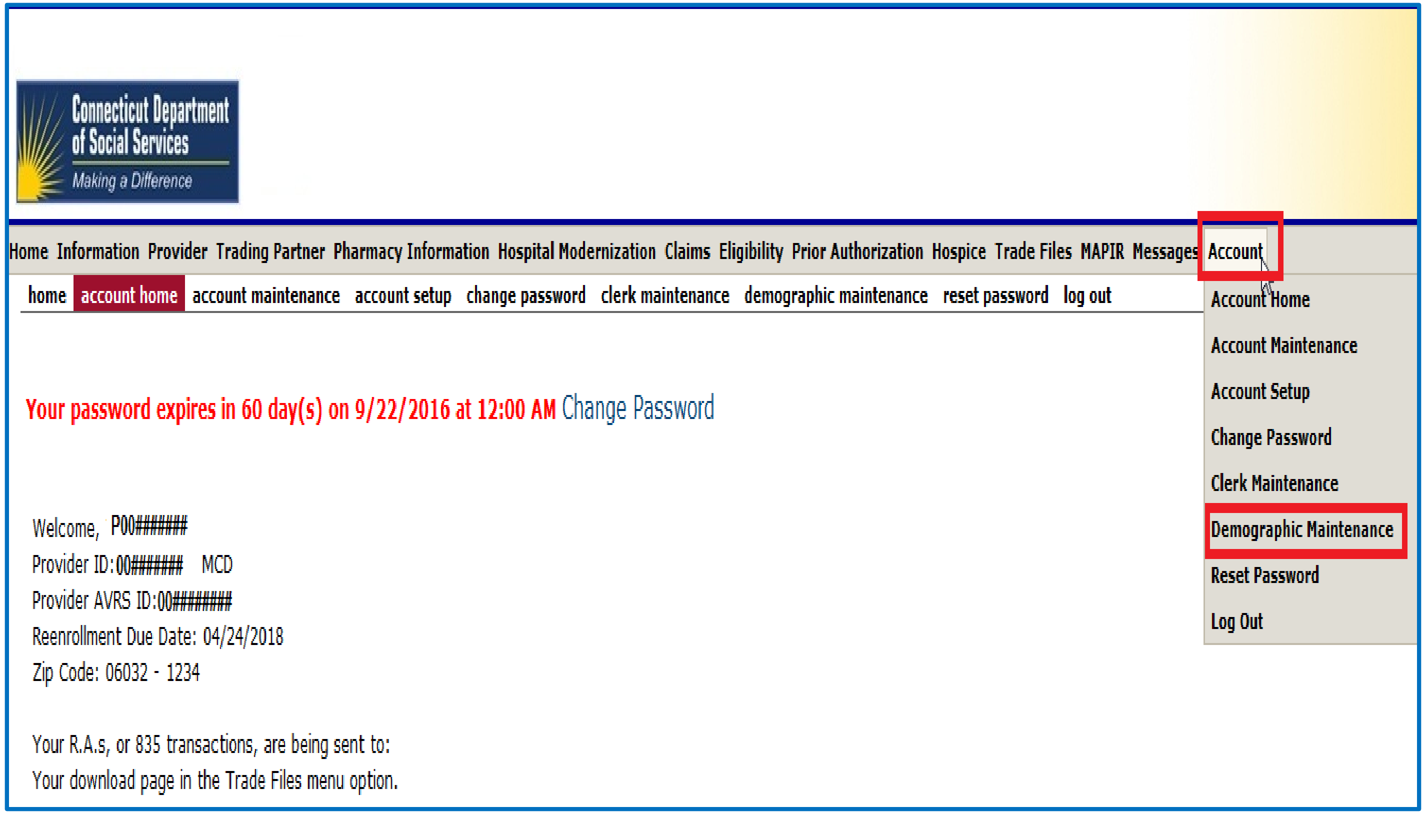
- Update your demographic information (addresses/phone numbers/bank accounts/organization members)
- Verify re-enrollment due date(s)
- Set up clerk accounts to allow multiple users access to specified roles
- Check client eligibility via the Web
- Perform claim and prior authorization (PA) inquiries
- Create, submit, resubmit, adjust, void, and copy claims
  - Even those claims submitted through other means (EVV, electronic, paper)
- Obtain your Remittance Advice (RA)

Demographic Maintenance

ctdssmap.com

Web Account Capabilities

Web Account Capabilities
Demographic Maintenance



The Demographic Maintenance section of the Secure Site allows you to alter and maintain demographic information:

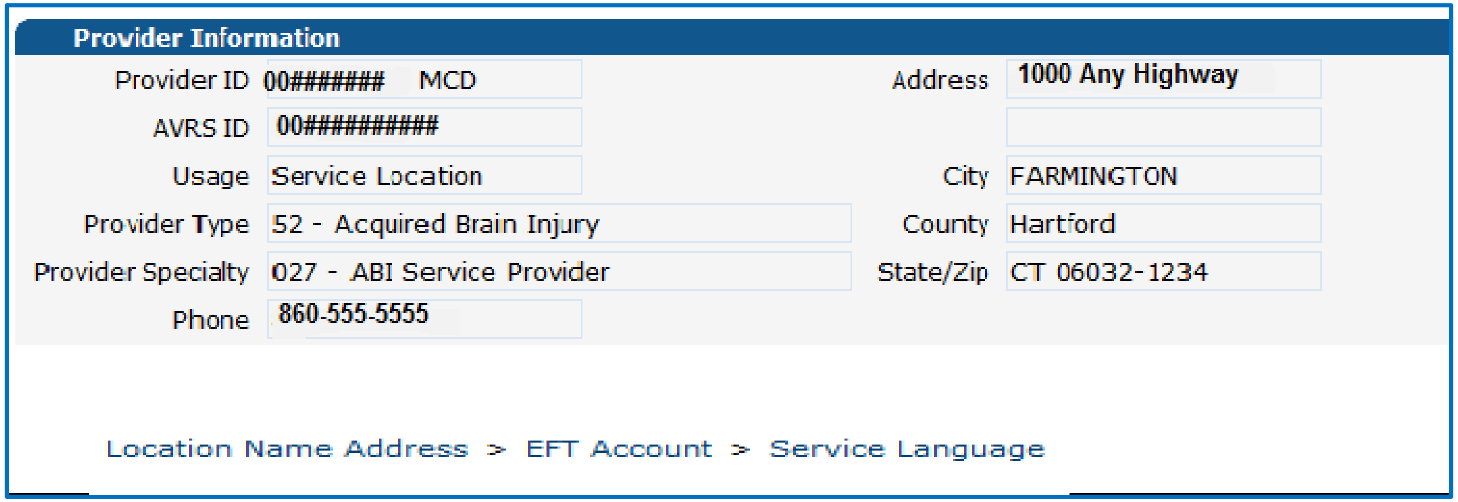
– Mail to, Pay to, Service Location, and Enrollment addresses

– EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)

– Service Language

Access this section by selecting demographic maintenance from either the Account submenu or the Account drop-down menu

Web Account Capabilities
Demographic Maintenance cont.



Provider Information

Provider ID	00####### MCD	Address	1000 Any Highway
AVRS ID	00###########		
Usage	Service Location	City	FARMINGTON
Provider Type	52 - Acquired Brain Injury	County	Hartford
Provider Specialty	027 - ABI Service Provider	State/Zip	CT 06032-1234
Phone	860-555-5555		

Location Name Address > EFT Account > Service Language

The Demographic Maintenance page displays the provider information panel as well as a submenu

– Clicking the submenu options will open a panel with related information:

– Location Name Address

– Electronic Funds Transfer (EFT Account)

– Service Language - Language, Effective Date, End Date

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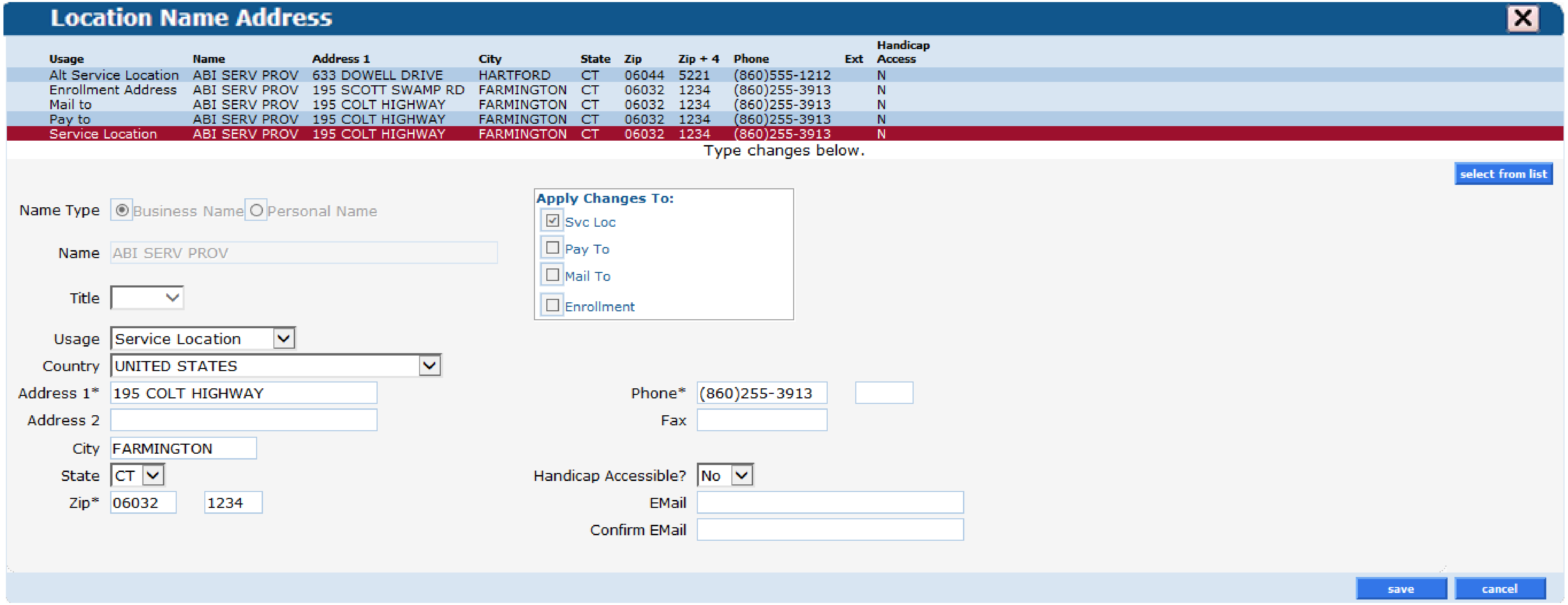
Web Account Capabilities
Demographic Maintenance cont.

– **Specify different mailing, payment, service location and enrollment addresses.**



Location Name Address

Usage	Name	Address 1	City	State	Zip	Zip + 4	Phone	Ext	Handicap Access
Alt Service Location	ABI SERV PROV	633 DOWELL DRIVE	HARTFORD	CT	06044	5221	(860)555-1212		N
Enrollment Address	ABI SERV PROV	195 SCOTT SWAMP RD	FARMINGTON	CT	06032	1234	(860)255-3913		N
Mail to	ABI SERV PROV	195 COLT HIGHWAY	FARMINGTON	CT	06032	1234	(860)255-3913		N
Pay to	ABI SERV PROV	195 COLT HIGHWAY	FARMINGTON	CT	06032	1234	(860)255-3913		N
Service Location	ABI SERV PROV	195 COLT HIGHWAY	FARMINGTON	CT	06032	1234	(860)255-3913		N

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Web Account Capabilities

Demographic Maintenance cont.

– **To alter address information, simply select the applicable row from the provided list (Enrollment Address, Mail to, Pay to, or Service Location); then click maintain address**

Usage	Name	Address 1	City	State	Zip	Zip + 4	Phone	Ext	Handicap Access
Alt Service Location	ABI SERV PROV	633 DOWELL DRIVE	HARTFORD	CT	06044	5221	(860)555-1212		N
Enrollment Address	ABI SERV PROV	195 SCOTT SWAMP RD	FARMINGTON	CT	06032	1234	(860)255-3913		N
Mail to	ABI SERV PROV	195 COLT HIGHWAY	FARMINGTON	CT	06032	1234	(860)255-3913		N
Pay to	ABI SERV PROV	195 COLT HIGHWAY	FARMINGTON	CT	06032	1234	(860)255-3913		N
Service Location	ABI SERV PROV	195 COLT HIGHWAY	FARMINGTON	CT	06032	1234	(860)255-3913		N

Type changes below.

maintain address

– **Select/fill in the appropriate information (address, phone number, etc); click save**

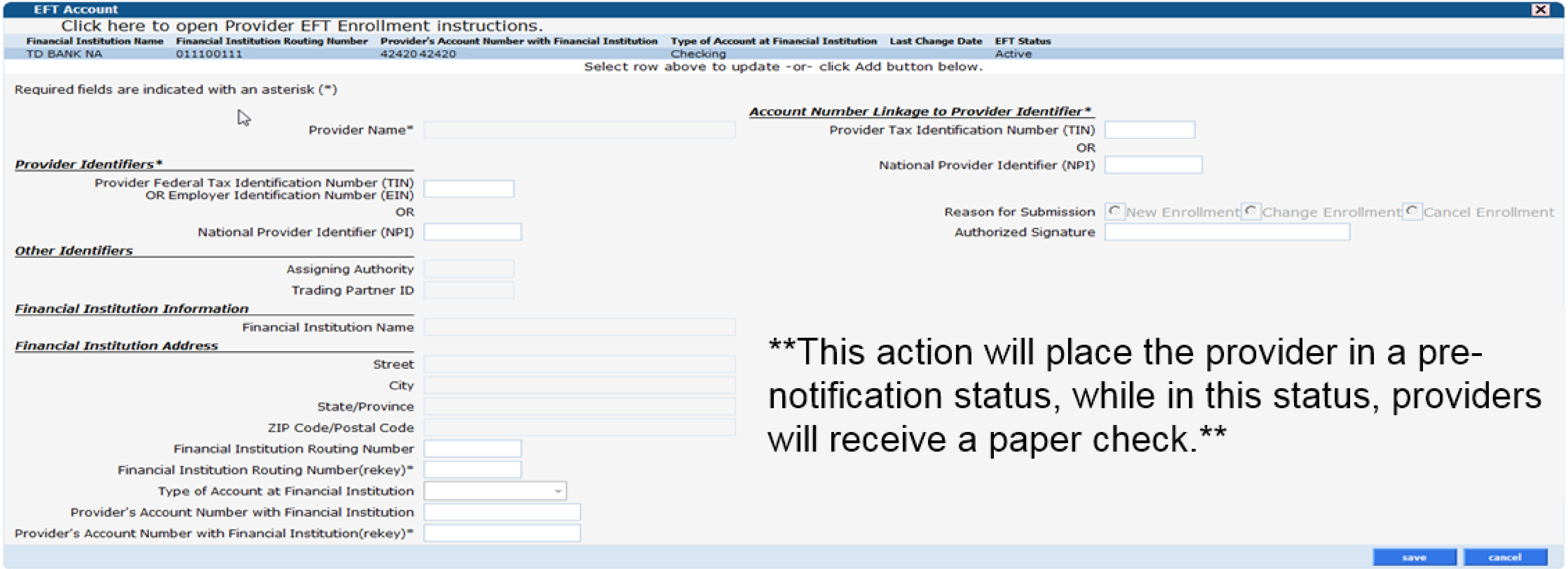
The following messages were generated:

Message Description	Panel	Field
Save was Successful		

Web Account Capabilities

Demographic Maintenance cont.

The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited. Click add; enter the appropriate information; and click save.



This action will place the provider in a pre-notification status, while in this status, providers will receive a paper check.

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Clerk Maintenance

www.ctdssmap.com

Web Account Capabilities

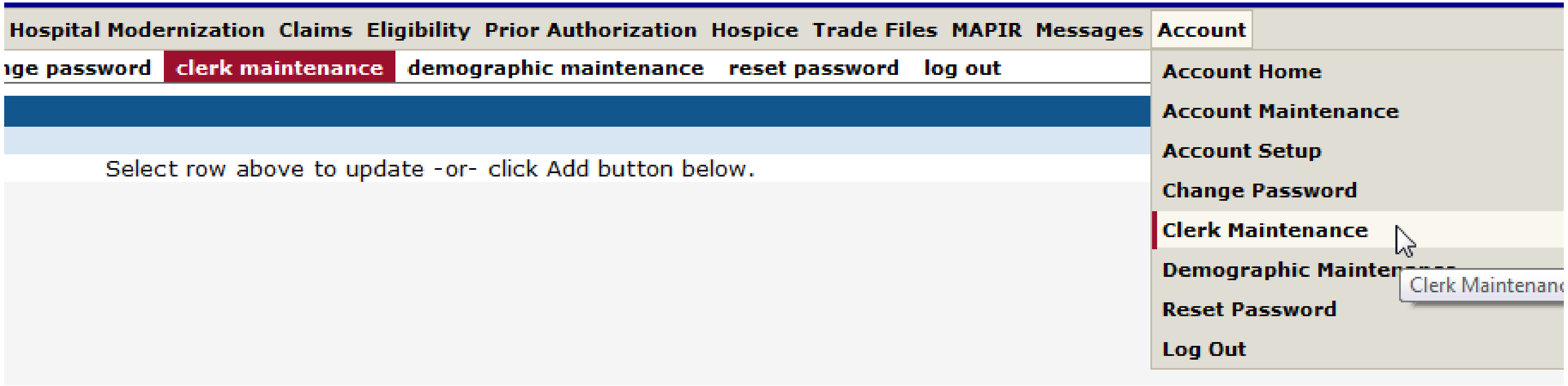
Web Account Capabilities

Clerk Maintenance

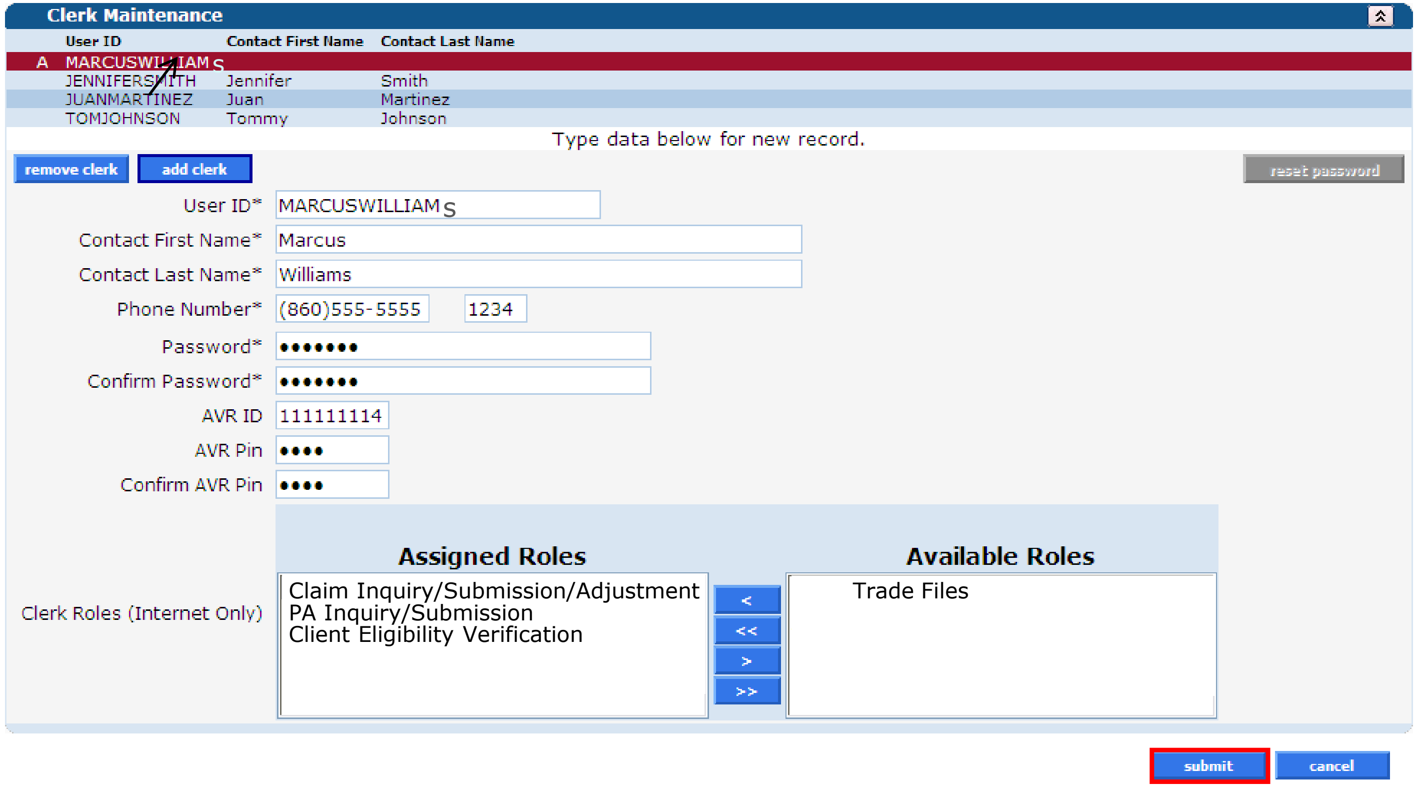
– Clerk accounts grant Web access to staff members allowing them to perform functions based on their job responsibilities

– The main account administrator is responsible for maintaining clerk accounts within their organization. This includes adding clerks, changing the role(s) for clerks, removing clerks, and resetting passwords

– Access the Clerk Maintenance section of the Secure Site by selecting clerk maintenance from either the Account submenu or the Account drop-down menu



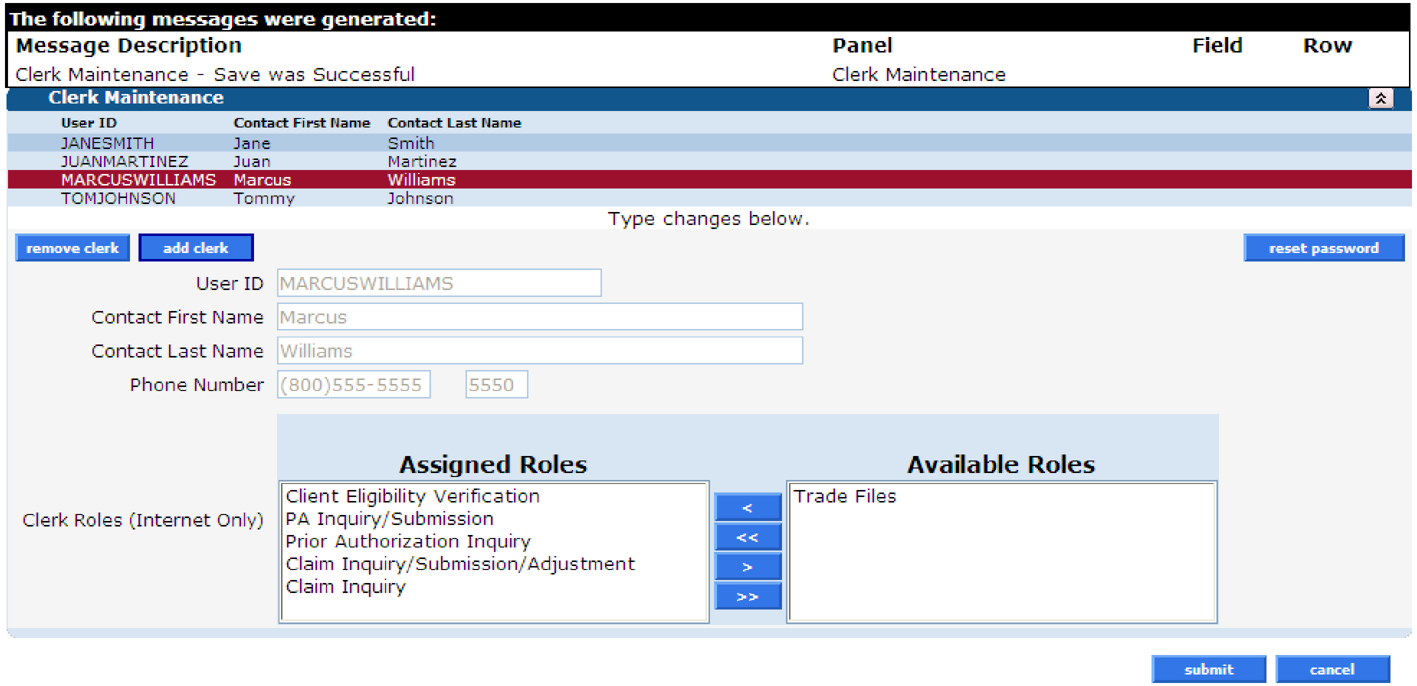
Web Account Capabilities
Clerk Maintenance



– To create a new clerk account, click add clerk

– Fill in the required fields, click submit

Web Account Capabilities
Clerk Maintenance



– Return to the Clerk Maintenance menu to add additional clerks, reset an existing clerk’s password, or to alter clerks’ Assigned Roles

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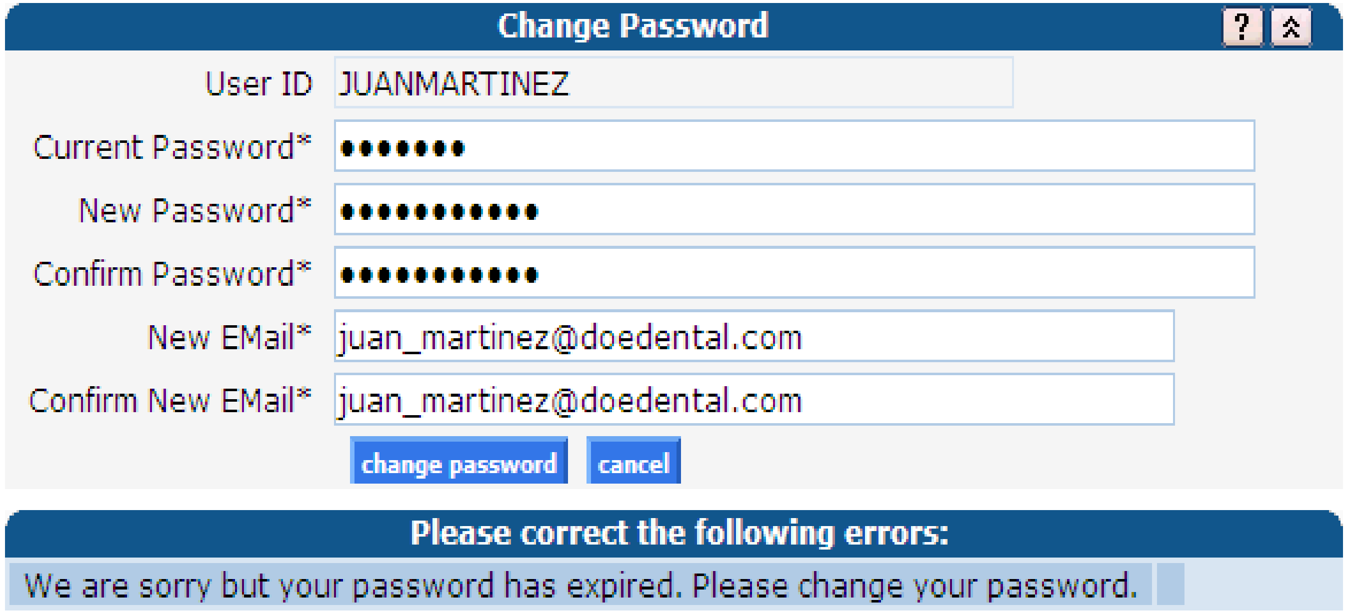
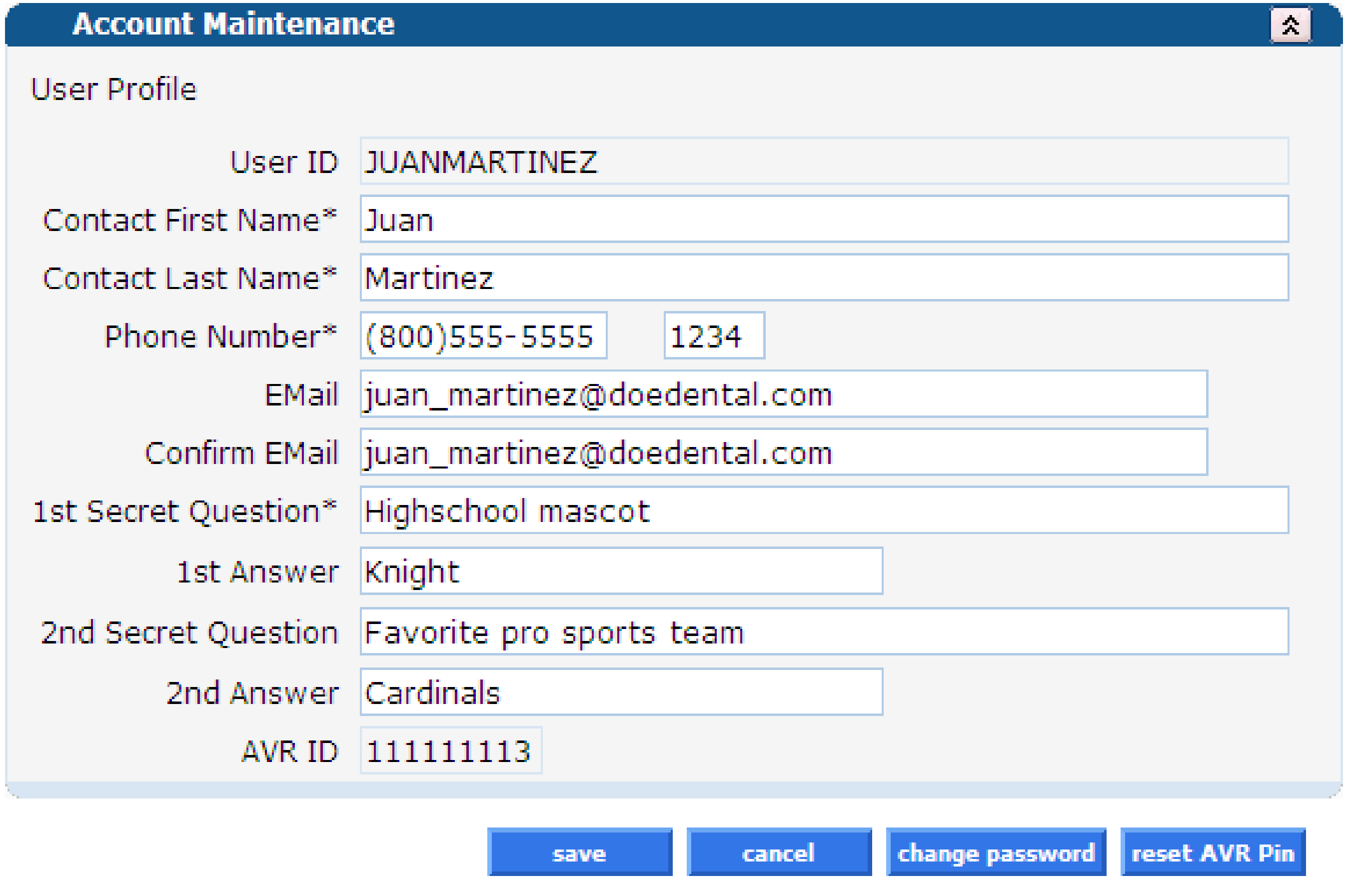
Web Account Capabilities
Clerk Maintenance



- When a new clerk logs into the Secure Site for the first time, they will be required to change their password from the one created by the account administrator
- Fill in the fields with the appropriate information; click change password
  - The clerk is now ready to perform the job duties allowed under the Assigned Roles chosen by the account administrator

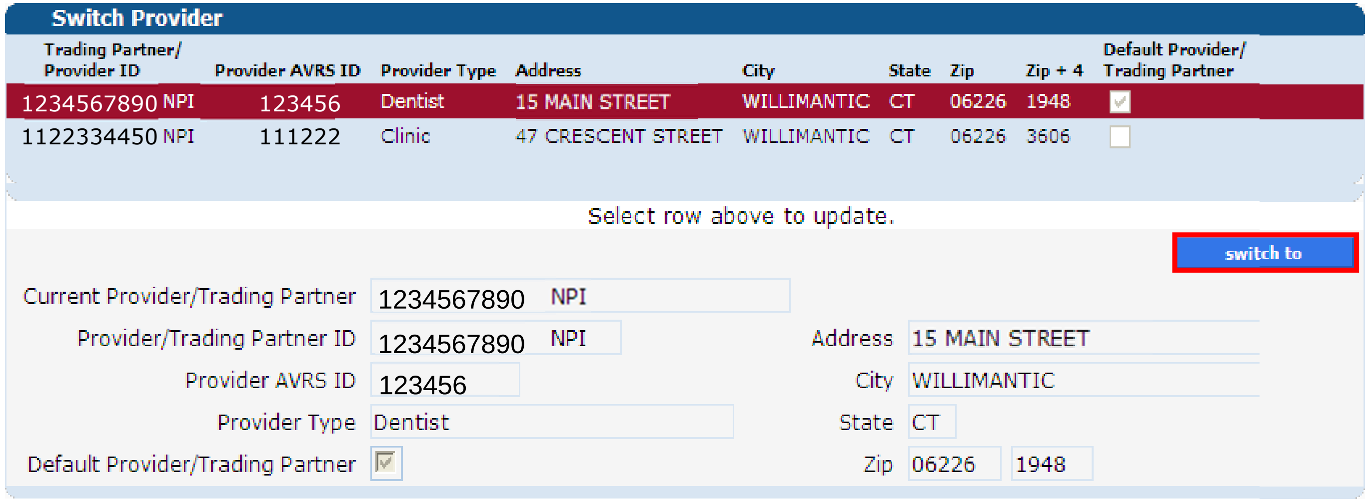
Web Account Capabilities
Clerk Maintenance



– Once a clerk is signed in, they can update their information by selecting account maintenance from either the Account submenu or the Account drop-down menu

– Fill in the appropriate information; click save

Web Account Capabilities
Clerk Maintenance



– Once a clerk ID is created by the local administrator, the same clerk ID can be added to more than one main account, this will allow the clerk the ability to switch back and forth between submitting online transactions for those providers

– Select switch provider from either the Account submenu or the Account drop-down menu

– Select the appropriate provider; click switch to. A window will appear asking you to verify the switch; click OK

Web Account Capabilities

Clerk Maintenance

– To delete a clerk account – select that account from the list of existing clerks and click on remove clerk

– A window will appear asking to you verify that you want to mark that clerk account for deletion; click OK

– The D indicates that the clerk has been marked for deletion

– Click Submit to finalize the clerk account removal

Clerk Maintenance

	User ID	Contact First Name	Contact Last Name
D	JANESMITH	Jane	Smith
	JUANMARTINEZ	Juan	Martinez
	MARCUSWILLIAMS	Marcus	Williams
	TOMJOHNSON	Tommy	Johnson

The following messages were generated:

Message Description	Panel	Field	Row
Clerk Maintenance - Save was Successful	Clerk Maintenance		

Clerk Maintenance

User ID	Contact First Name	Contact Last Name
JUANMARTINEZ	Juan	Martinez
MARCUSWILLIAMS	Marcus	Williams
TOMJOHNSON	Tommy	Johnson

Eligibility Verification

www.ctdssmap.com

Web Account Capabilities

ELIGIBILITY VERIFICATION

Eligibility Verification Methods

- Receipt of a service order from the Case Management Agency confirms the client is ABI Waiver eligible, however, the client's eligibility file may not yet reflect the client's ABI Waiver eligibility. To avoid unnecessary claim denials such as:

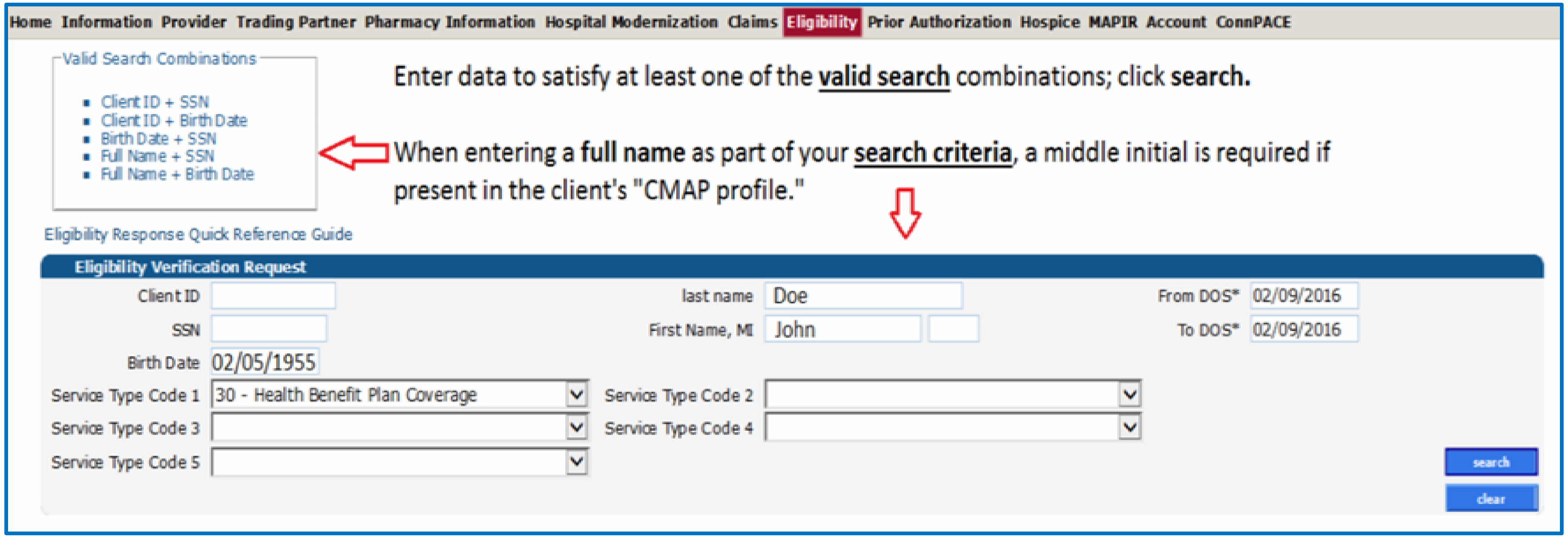
  - The client was not eligible on the date of service.
  - The service provided was not a covered service under the client's benefit plan.

  Verify client eligibility upon receipt of the initial service order.

- Eligibility verification can be performed in the following ways:
  - Internet Web site at www.ctdssmap.com.
  - Automated Voice Response System (AVRS).
  - Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.
  - Provider Electronic Solutions (PES) software.

Web Account Capabilities
Eligibility Verification

– To verify a CMAP client's eligibility through the Secure Site – click on the Eligibility tab on the main menu



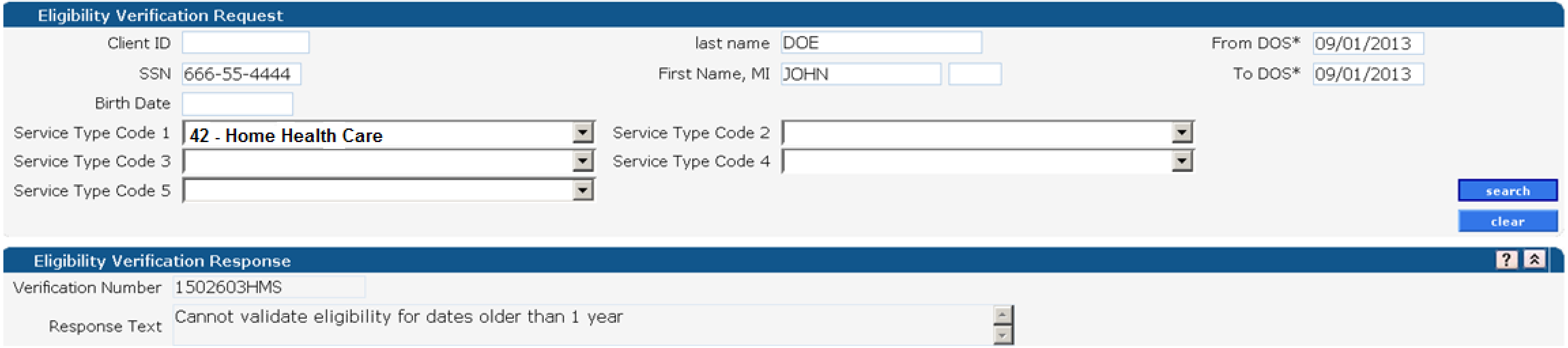
Web Account Capabilities

Eligibility Verification

The Eligibility Verification Response window provides the search results

– In this specific case – the client’s eligibility cannot be verified for the requested dates (Sept. 1, 2013) – eligibility verification can only look back one year

– Changing the dates of the eligibility request to within the allowable one year window creates a different result.



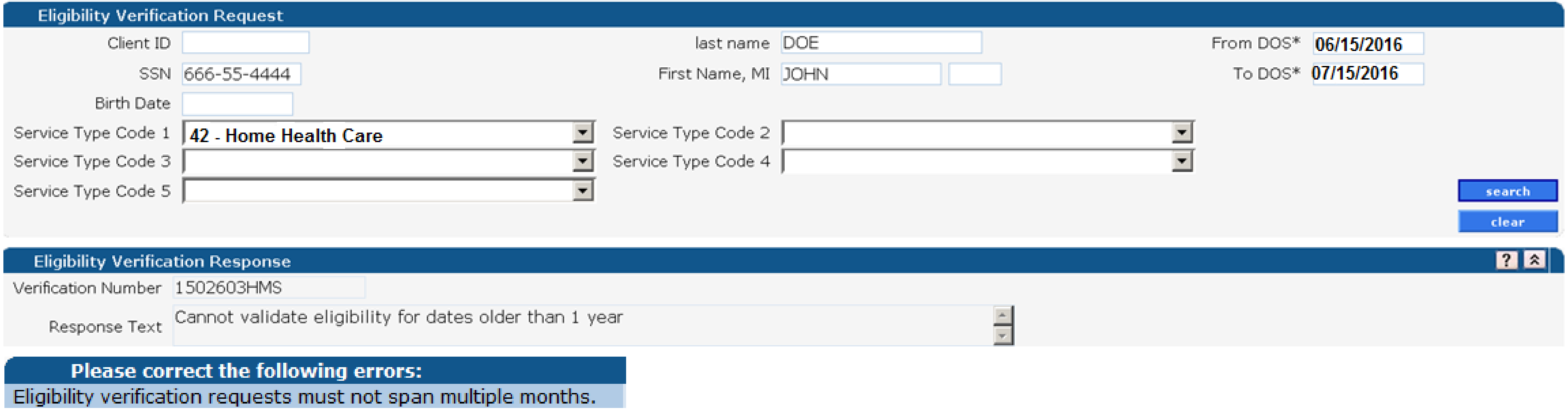
Web Account Capabilities

Eligibility Verification

Eligibility searches cannot span multiple months

– 12/01/2015 – 12/31/2015 is valid, 12/31/2015 – 1/15/2016 is not valid

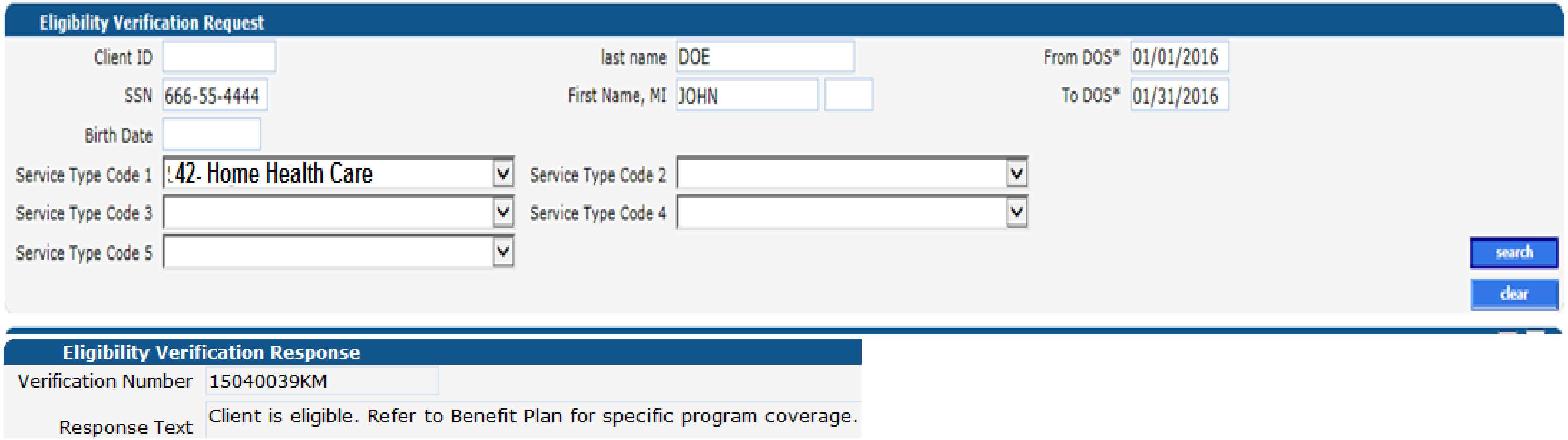
– Submitting a request that spans multiple months will result in an error message.



Web Account Capabilities

Eligibility Verification

Positive eligibility responses provide greater detail…



Eligibility Verification Request

Client ID		last name	DOE	From DOS*	01/01/2016
SSN	666-55-4444	First Name, MI	JOHN	To DOS*	01/31/2016
Birth Date					
Service Type Code 1	42- Home Health Care	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.

Web Account Capabilities

Eligibility Verification

What does all this information mean?

Eligibility Verification Response

– Provides a verification number that should be kept on record in case the client’s coverage is retroactively changed at a later date

– Reports client’s eligibility status for the requested date(s) of service

Eligibility Verification Response

Verification Number	1120900015
Response Text	Client is eligible. Refer to Benefit Plan for specific program coverage.

Client Information

Client Information

Client ID	009999999	Last Name	THOMAS
SSN	111-99-9999	First Name, MI	THOMAS
Birth Date	01/20/1997	Street	1 MAIN ST
Gender	M	City, State, Zip	TORRINGTON, CT 06790

Web Account Capabilities

Eligibility Verification

Benefit Plan

The benefit plan(s) with which the client was an active member on the date(s) of service requested

- The client must have an ABI I or ABI II Waiver benefit plan for the ABI Service provider to be reimbursed for services provided to an ABI client and billed via EVV or directly by the ABI Service provider.
- The client must also have a HUSKY A, C or D benefit for Community First Choice (CFC) services that may be provided to an ABI Self Directed Waiver client by an ABI Service provider. Services are billed and payable to Allied Community Resources who will reimburse the ABI Service provider directly.

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
ABI II Acquired Brain Injury	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

Web Account Capabilities

Eligibility Verification

Service Type Codes – Hewlett Packard Enterprise

– A list of services for which the client was eligible that would be submitted for payment to Hewlett Packard Enterprise

Service Type Codes - HP Services

Service Type Code	Service Type Information	Copay	Coinsurance
1	Medical Care		
33	Chiropractic	$0.00	0%
35	Dental Care		
4	Diagnostic X-Ray	$0.00	0%
42	Home Health Care	$0.00	0%
45	Hospice	$0.00	0%
47	Hospital	$0.00	0%
48	Hospital - Inpatient	$0.00	0%
5	Diagnostic Lab	$0.00	0%
50	Hospital - Outpatient	$0.00	0%

1 2 3 Next >

Web Account Capability

Eligibility Verification

Lockin

– Some clients are locked into receiving certain health care services only from specific providers or pharmacies; those providers or pharmacies will be listed here

Lockin				
Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	08/05/2011	08/05/2011	HOSPICE AGENCY2	(860)255-3913

Medicare

– Types of Medicare coverage active for the client on the date(s) of service requested

Medicare
Coverage
Medicare A
Medicare B

Web Account Capabilities

Eligibility Verification

Benefit Plans payable for CFC Services

HUSKY A	HUSKY C	HUSKY D
Family Medicaid – Low income families with dependent children	Previously referred to as fee–for–service Medicaid, or Adult Medicaid – Individuals that are aged, blind, or disabled	Previously referred to as Medicaid for Low-Income Adults (MLIA) or State Administered General Assistance (SAGA) – Individuals aged 19 through 64 who do not receive federal Supplemental Security Income or Medicare and who are not pregnant

Prior Authorization

www.ctdssmap.com

Web Account Capabilities

Prior Authorization

CARE PLAN ACCESS

Effective September 1, 2016, ABI Service providers *will have access to the care plans of the client's they service via the* ***secure Web portal*** *within the* ***Prior Authorization (PA) subsystem.***

- Each service on the care plan has its own **unique PA#** and **viewable** to the **servicing provider** via a **PA inquiry.**

- All ABI services billed directly by an ABI Service provider ***must be on the care plan*** for the **services** to be ***reimbursed.***

- All ABI services billed via EVV must have the **client care plan (PA) uploaded** from the PA subsystem that **matches** the caregiver **service check-in/check-out**.

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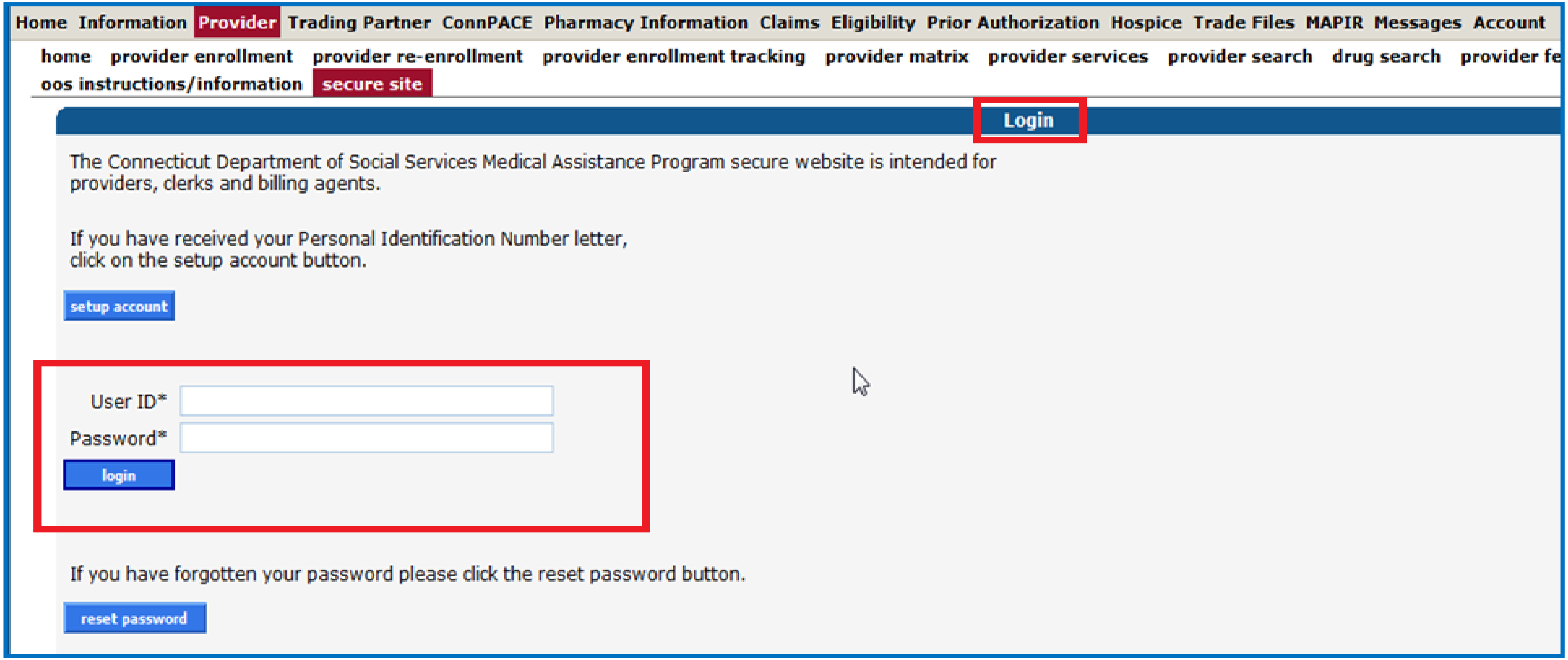
Prior Authorization

Care Plan Access Via Secure Web Portal



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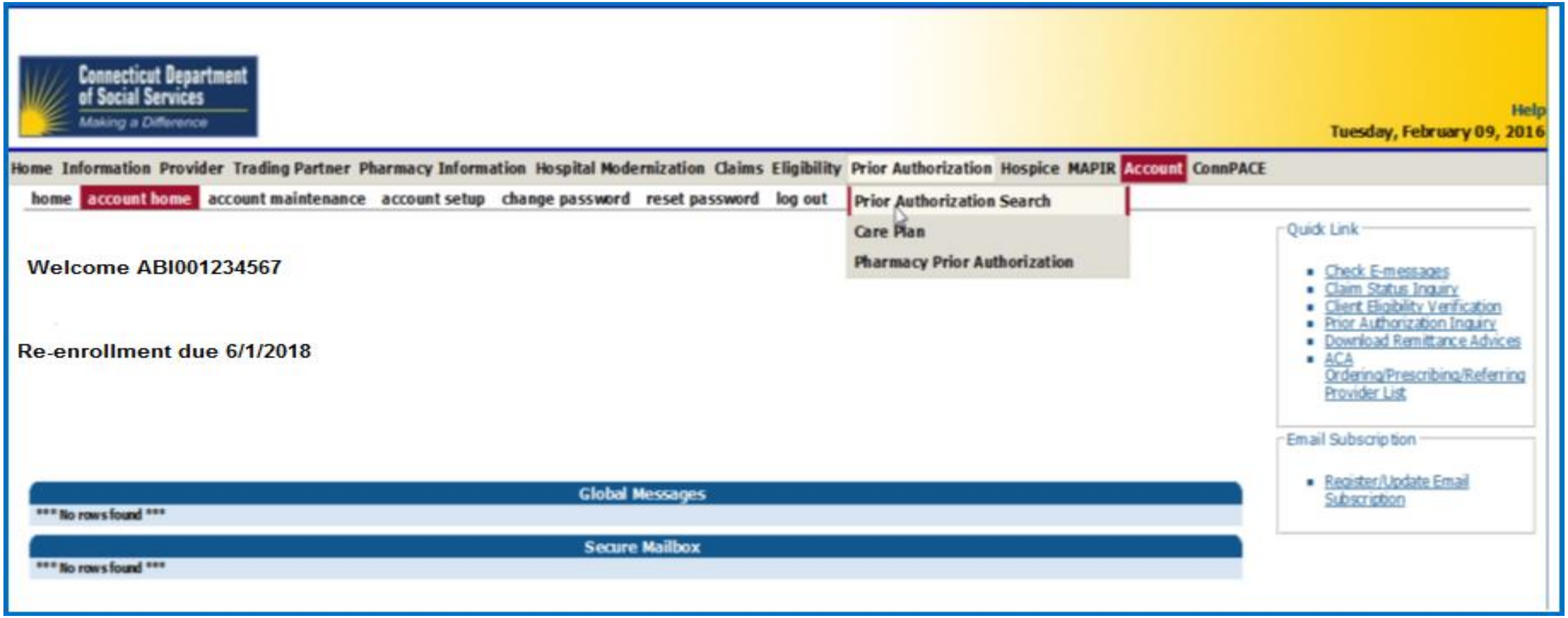
Prior Authorization

ABI CARE PLAN ACCESS - (PA) SEARCH

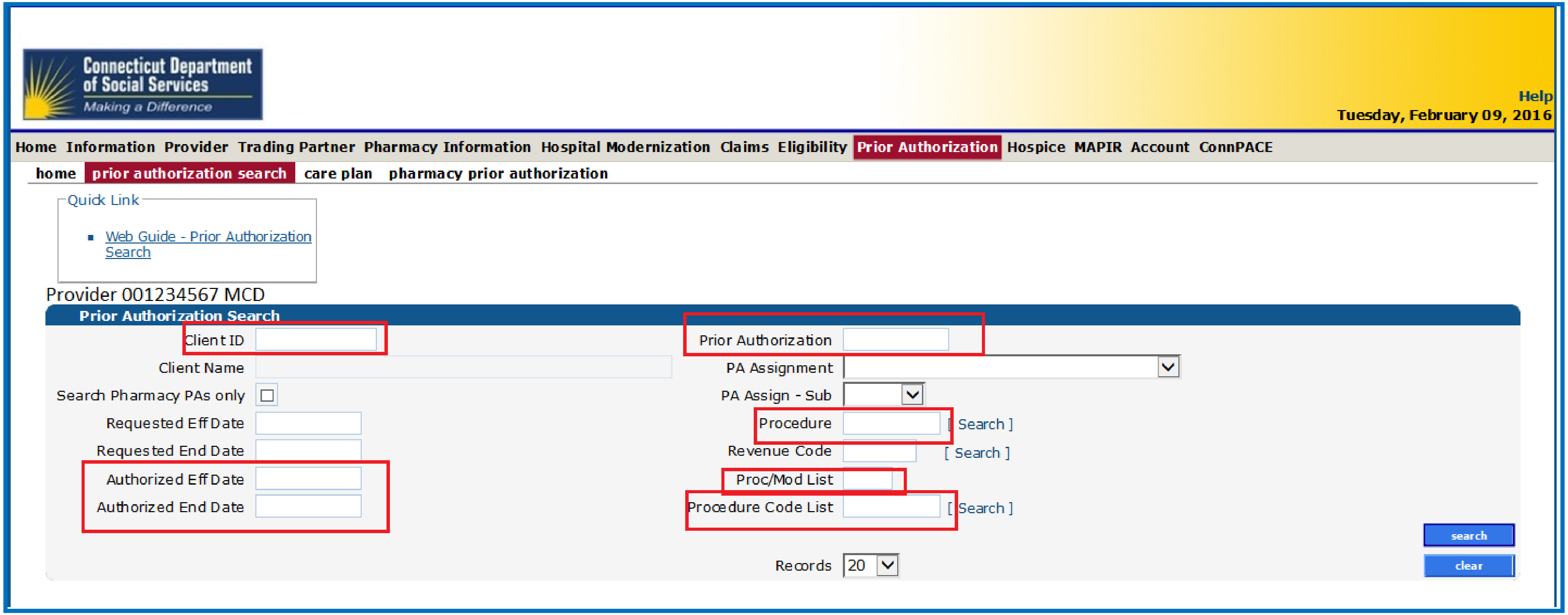
Once on the secure site, click ***Prior Authorization*** > ***Prior Authorization Search*****.**



Prior Authorization

ABI CARE PLAN ACCESS - (PA) SEARCH

Search by ***Client ID or PA Number***. Further define search by ***date, procedure or list code.***



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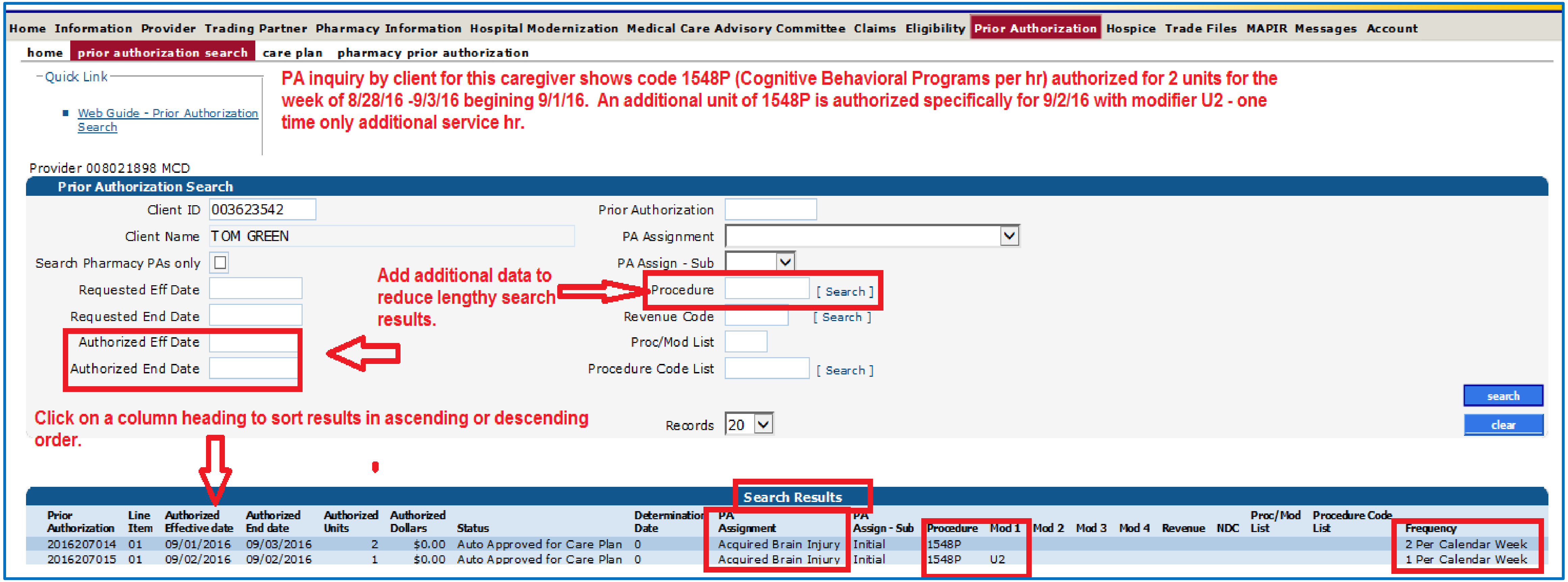
Enterprise

Prior Authorization

ABI PA Search Results

– Search results by client ID provide all PAs authorized for the client under the provider’s care. Results can be more defined by increasing the amount of data used in the search.

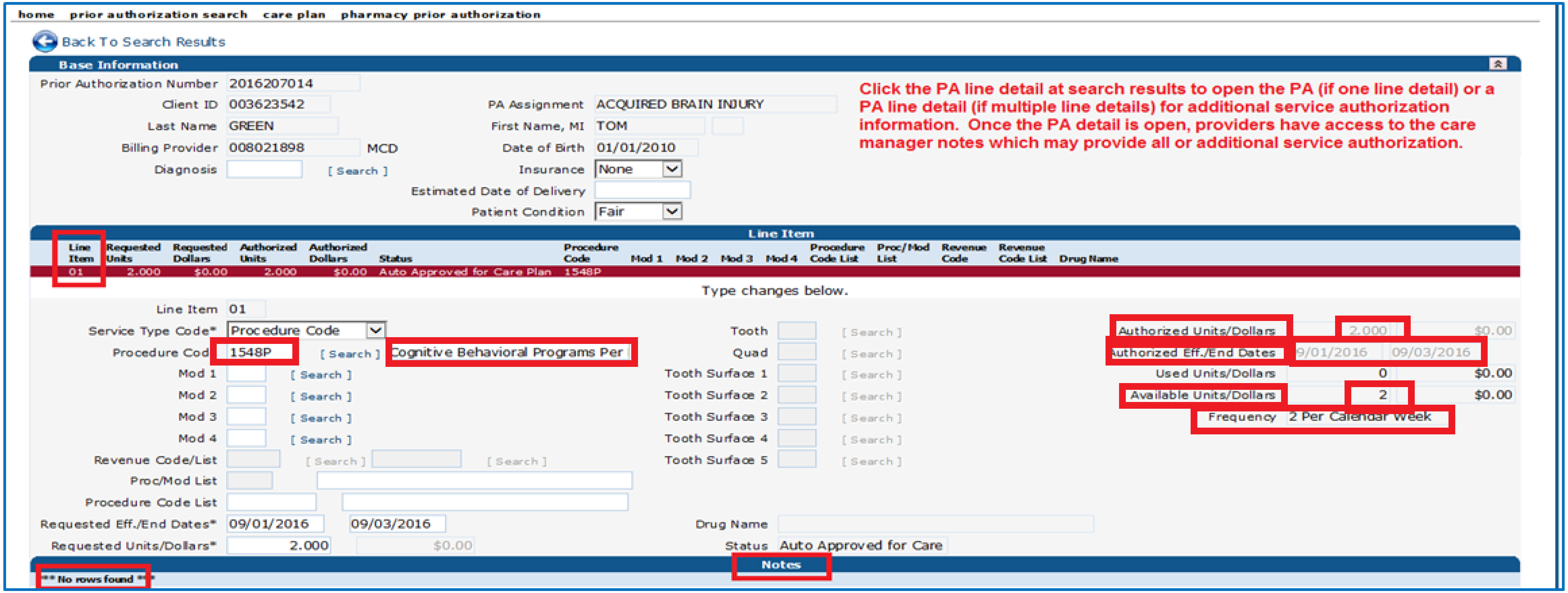


Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2016207014	01	09/01/2016	09/03/2016	2	$0.00	Auto Approved for Care Plan	0	Acquired Brain Injury	Initial	1548P									2 Per Calendar Week
2016207015	01	09/02/2016	09/02/2016	1	$0.00	Auto Approved for Care Plan	0	Acquired Brain Injury	Initial	1548P	U2								1 Per Calendar Week

Prior Authorization

Access to Additional Service Authorization Information

– Additional Care Plan Information can be Viewed by opening a PA from the PA Search Results Inquiry. A one-line detail PA will auto populate when the PA is opened.



Prior Authorization

Access to Additional Service Authorization Information

– ABI Services can be authorized via a procedure code or procedure code with one or more modifiers.

Base Information

Prior Authorization Number	2016207015		
Client ID	003623542	PA Assignment	ACQUIRED BRAIN INJURY
Last Name	GREEN	First Name, MI	TOM
Billing Provider	008021898 MCD	Date of Birth	01/01/2010
Diagnosis	[Search]	Insurance	None
		Estimated Date of Delivery	
		Patient Condition	Fair

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	Revenue Code	Revenue Code List	Drug Name
01	1.000	$0.00	1.000	$0.00	Auto Approved for Care Plan	1548P	U2								

Type changes below.

Line Item	01				
Service Type Code*	Procedure Code	Tooth	[Search]	Authorized Units/Dollars	1.000 $0.00
Procedure Code	1548P [Search] Cognitive Behavioral Programs Per	Quad	[Search]	Authorized Eff./End Dates	09/02/2016 09/02/2016
Mod 1	U2 [Search]	Tooth Surface 1	[Search]	Used Units/Dollars	0 $0.00
Mod 2	[Search]	Tooth Surface 2	[Search]	Available Units/Dollars	1 $0.00
Mod 3	[Search]	Tooth Surface 3	[Search]	Frequency	1 Per Calendar Week
Mod 4	[Search]	Tooth Surface 4	[Search]		
Revenue Code/List	[Search] [Search]	Tooth Surface 5	[Search]		
Proc/Mod List					
Procedure Code List					
Requested Eff./End Dates*	09/02/2016 09/02/2016	Drug Name			
Requested Units/Dollars*	1.000 $0.00	Status	Auto Approved for Care		

Notes

*** No rows found ***

Prior Authorization
Use of Modifiers

➢ **The following Modifiers may be authorized when ABI Service Provider Services are authorized by Procedure Code:**

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

- Additional units needed on a day an **ABI** service is provided
- Another day of service in an existing care plan when **Adult Day Health** is provided
- An additional frequency to an existing service when **additional services are required outside of the existing frequency.**
  - For example: Client receives 1534P – Community Living Support Services(1/2 day) 5 x per week, M-F). Client also receives an additional unit (1/2 day 1 x per month on any given Saturday.

Prior Authorization

Use of Modifiers

✓Modifier **TT** - Subsequent Client, can be used to authorize:

– **ABI** services for an additional client residing in the home of a client already receiving the same service.

– If the **TT** modifier is authorized, it must be associated to the procedure code on the care plan/PA.

– The **TT** modifier reduces the subsequent client payment for service by **50%**.

Prior Authorization

Use of List Codes

– **List Codes may be authorized when ABI services are authorized by a code associated with a list of procedure codes with and/or without modifiers.**

Base Information

Prior Authorization Number 2016207016

Client ID 003623542 | PA Assignment ACQUIRED BRAIN INJURY

Last Name GREEN | First Name, MI TOM

Billing Provider 008021931 MCD | Date of Birth 01/01/2010

Diagnosis [Search] | Insurance None

Estimated Date of Delivery

Patient Condition Fair

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	Revenue Code	Revenue Code List	Drug Name
01	3.000	$0.00	3.000	$0.00	Auto Approved for Care Plan						969				

Type changes below.

Line Item 01

Service Type Code* Procedure Code | Tooth [Search] | Authorized Units/Dollars 3.000 $0.00

Procedure Code [Search] | Quad [Search] | Authorized Eff./End Dates 09/01/2016 09/03/2016

Mod 1 [Search] | Tooth Surface 1 [Search] | Used Units/Dollars 0 $0.00

Mod 2 [Search] | Tooth Surface 2 [Search] | Available Units/Dollars 3 $0.00

Mod 3 [Search] | Tooth Surface 3 [Search] | Frequency 3 Per Calendar Week

Mod 4 [Search] | Tooth Surface 4 [Search]

Revenue Code/List [Search] [Search] | Tooth Surface 5 [Search]

Proc/Mod List

Procedure Code List 969 Meals - ABI

Requested Eff./End Dates* 09/01/2016 09/03/2016 | Drug Name

Requested Units/Dollars* 3.000 $0.00 | Status Auto Approved for Care

Notes

*** No rows found ***

Hewlett Packard Enterprise

Prior Authorization

Meals Procedure Code list and Procedure Code/Modifier Code List.

Meals	**List Code = 969** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Home Delivered Meals Per Day *(single meal)*	1550P
Home Delivered Meals Per Day *(double meal)*	1551P
Meals – ***(One Time Only)***	**List Code = AB** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Home Delivered Meals Per Day *(single meal)*	1550P U2
Home Delivered Meals Per Day *(double meal)*	1551P U2

Prior Authorization

Adult Day Health Procedure Code list and Procedure Code/Modifier Code List.

Adult Day Health	**List Code = 971** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Adult Day Health -Full Day (Non-Medical Model)	1200Z
Adult Day Health – Full Day (Approved Medical Model)	1201Z
Adult Day Health – Half Day (Less than or equal to 4 hrs.)	1202Z
Adult Day Health – ***(One Time Only)***	**List Code = AD** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Adult Day Health -Full Day (Non-Medical Model) – *one time only*	1200Z U2
Adult Day Health – Full Day (Approved Medical Model) – *one time only*	1201Z U2
Adult Day Health – Half Day (Less than or equal to 4 hrs.) – *one time only*	1202Z U2

Prior Authorization

Viewing and Understanding the ABI Care Plan – PA Inquiry

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 service request (via telephone, paper or notes on PA via secure Web account.)
  - ✓ the service order noted in the notes section of the PA on your secure Web account (Case Management Agency Upload of Service Orders)

Note: Discrepancies should be reported to the Case Management Agency

Prior Authorization

Viewing and Understanding the Care Plan Points to Remember

- **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 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/PA notes.

Prior Authorization

Viewing and Understanding the Care Plan Points to Remember cont.

– If the procedure code on the **PA**

– 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.

Web Claim Submission

www.ctdssmap.com

Web Claim Submission

Web Account Capabilities

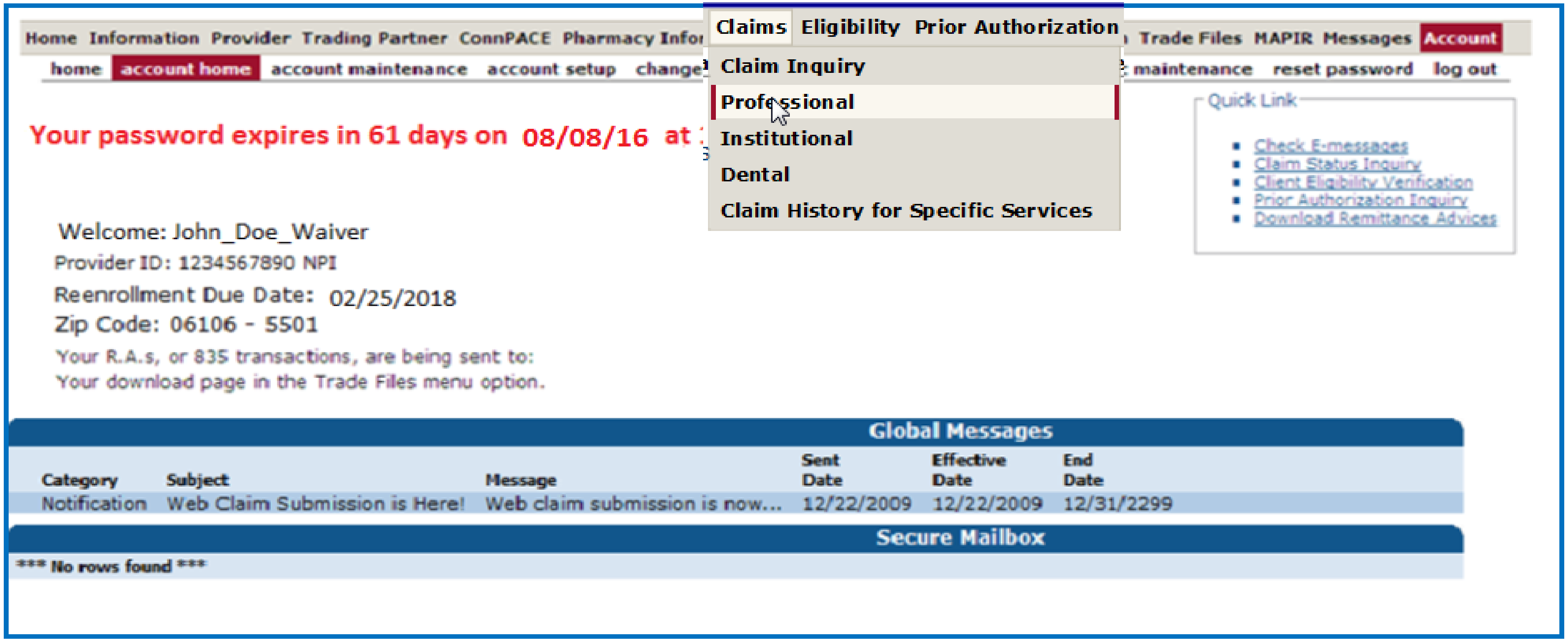
Web Claim Inquiry/Submission

- Internet Web site at www.ctdssmap.com
  - Interactive with ***immediate response*** of claim payment or denial.
  - Allows providers to **query claims** in order to ***adjust, void, or re-submit*** within the ***same claims processing cycle.***

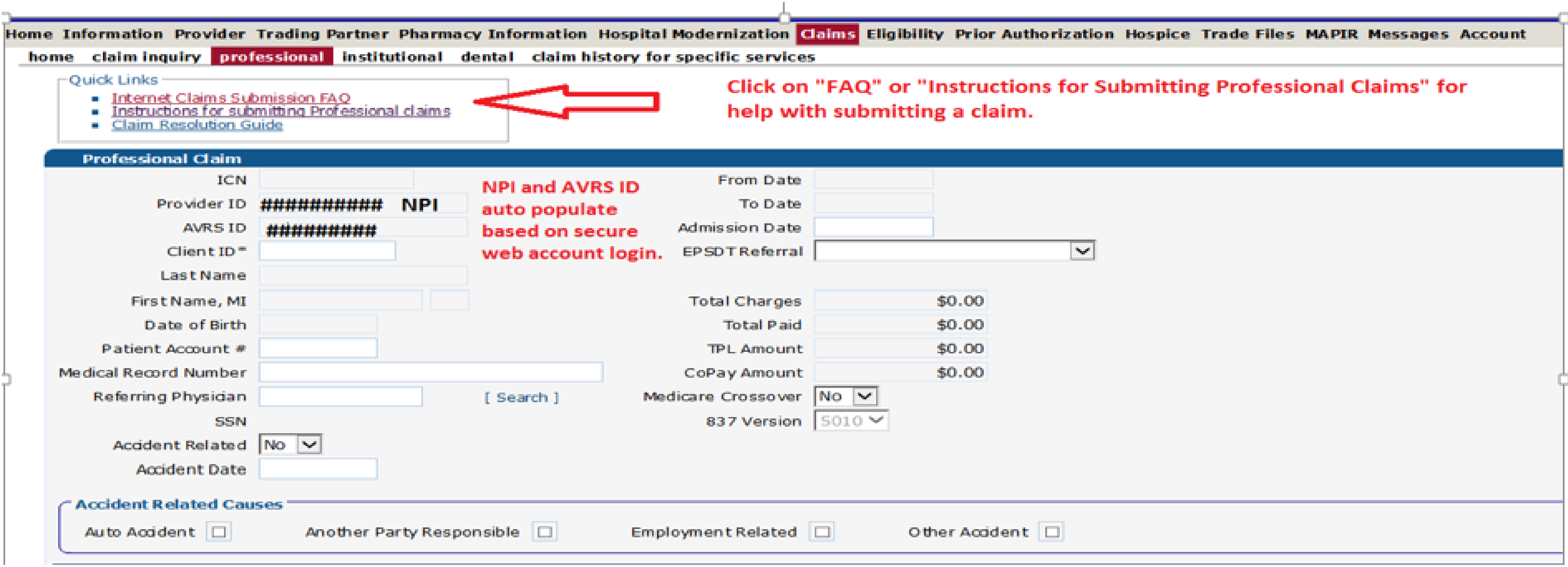
Hewlett Packard Enterprise

Web Claim Submission
Access to Claim Format

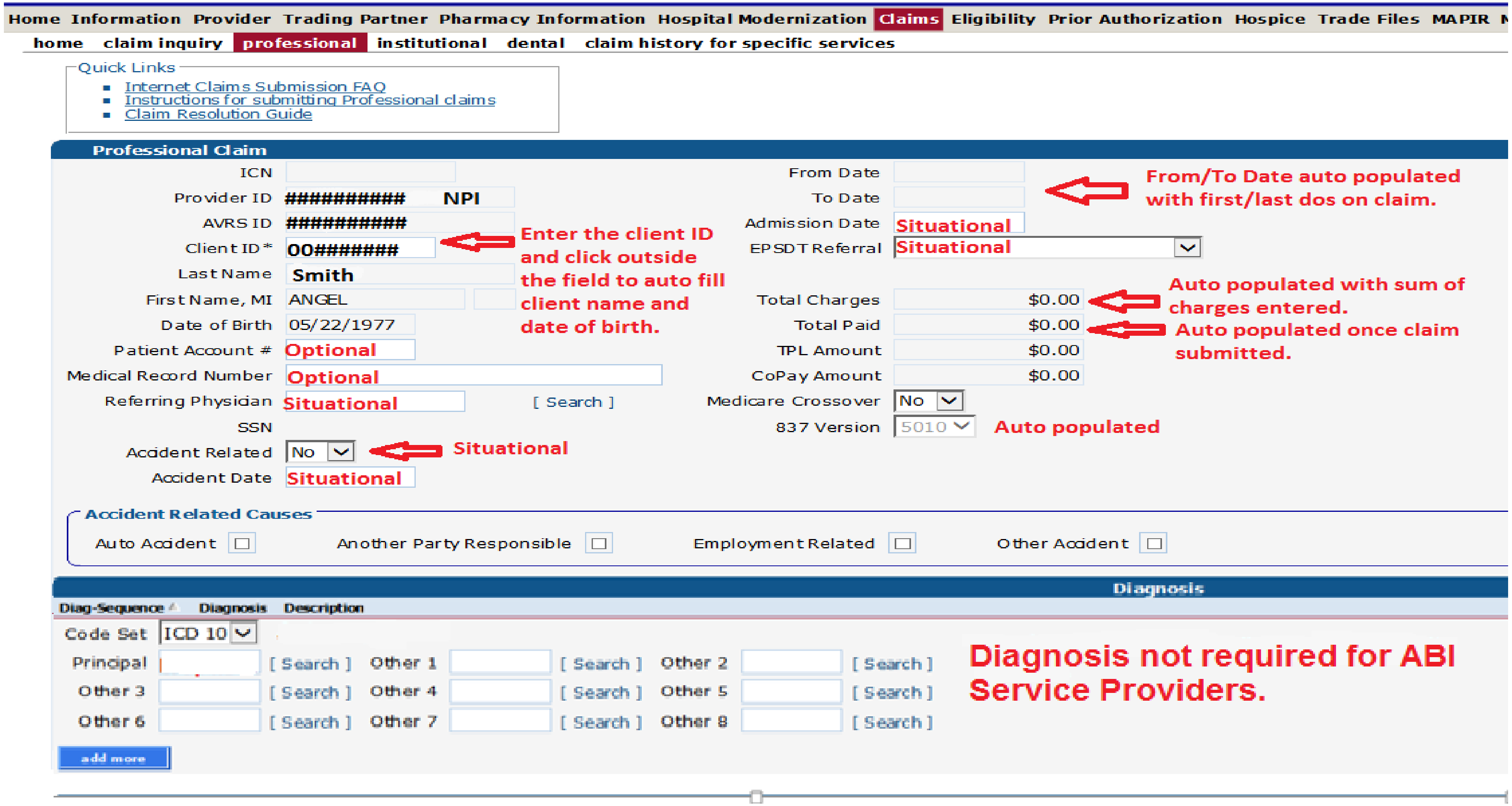
– Click Claims and Select the Professional Format



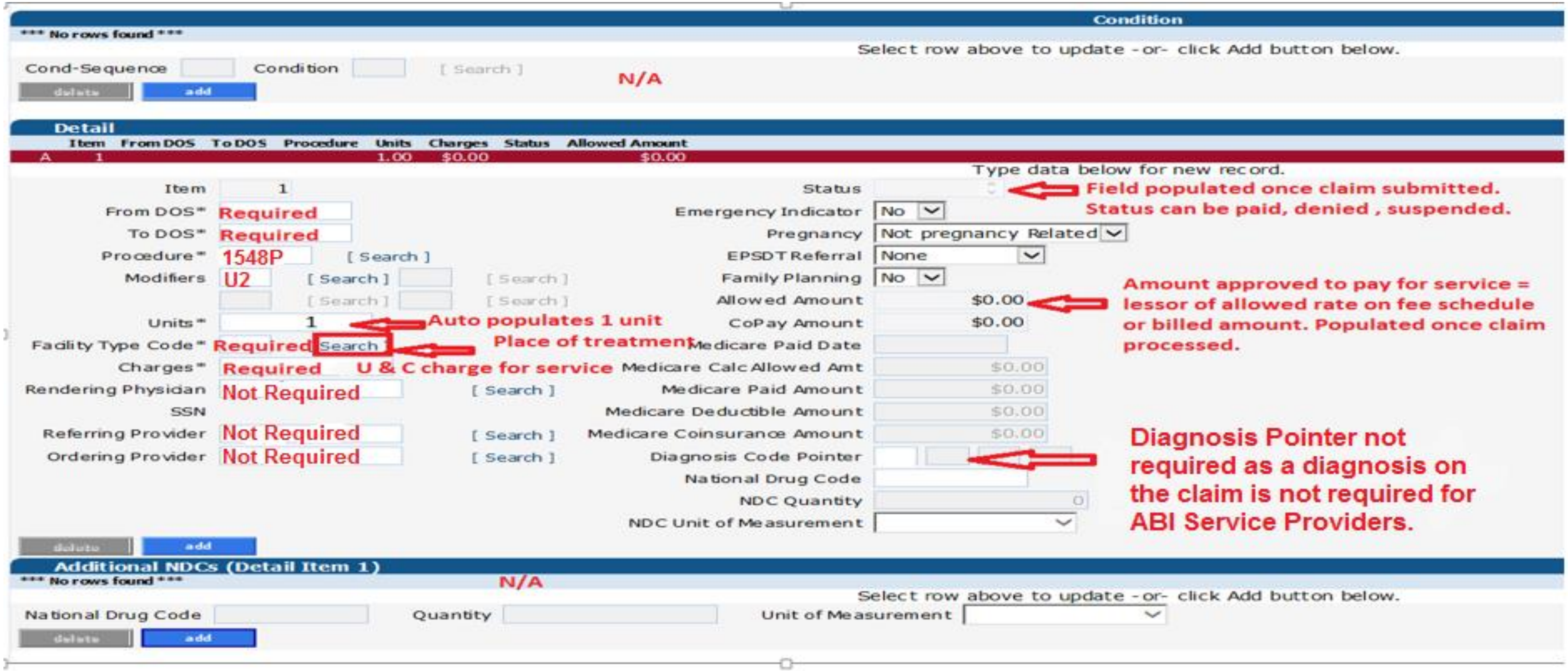
Claims Processing/Submission Information
Claim Submission Resources



Claims Processing/Submission Information



Claims Processing/Submission Information



Condition
*** No rows found ***
Select row above to update -or- click Add button below.
Cond-Sequence | Condition | [Search]
N/A
delete | add

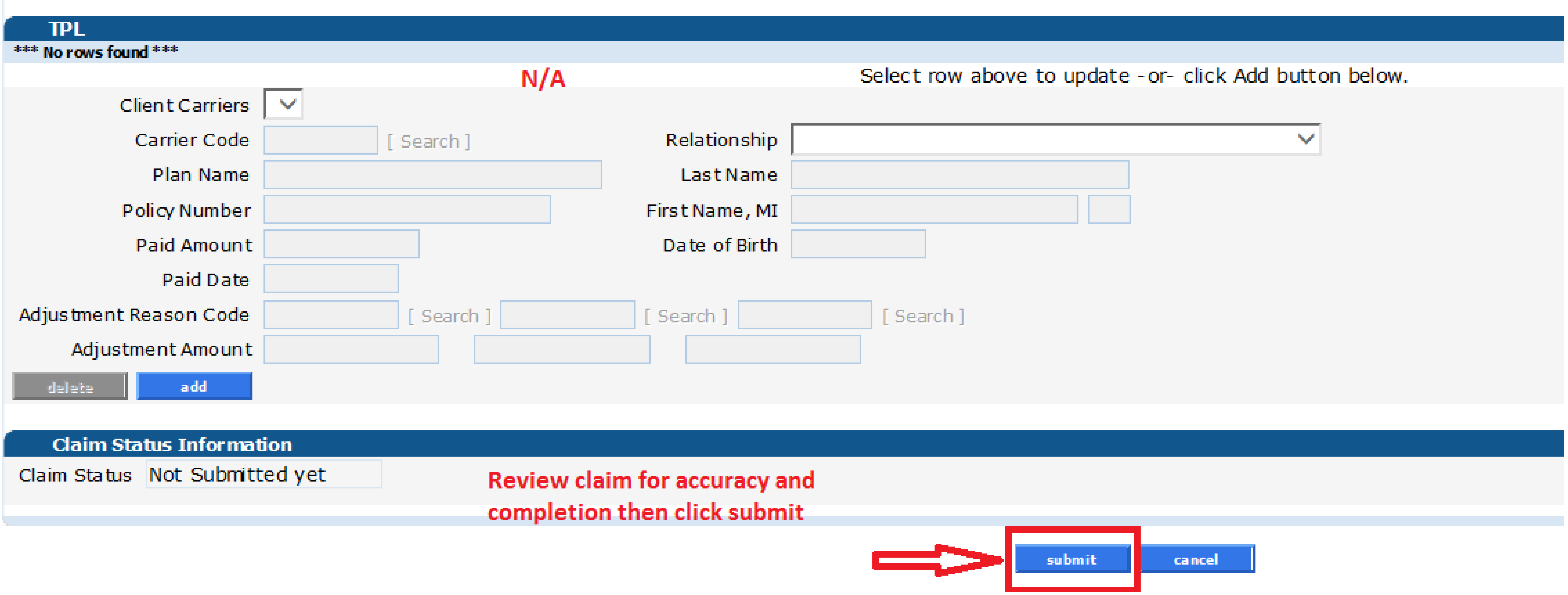
Detail
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A 1				1.00	$0.00		$0.00

Type data below for new record.
Item: 1
From DOS*: Required
To DOS*: Required
Procedure*: 1548P [Search]
Modifiers: U2 [Search] [Search]
[Search] [Search]
Units*: 1
Auto populates 1 unit
Facility Type Code*: Required [Search]
Place of treatment
Charges*: Required
U & C charge for service
Rendering Physician: Not Required [Search]
SSN
Referring Provider: Not Required [Search]
Ordering Provider: Not Required [Search]

Status
Field populated once claim submitted. Status can be paid, denied , suspended.
Emergency Indicator: No
Pregnancy: Not pregnancy Related
EPSDT Referral: None
Family Planning: No
Allowed Amount: $0.00
Amount approved to pay for service = lessor of allowed rate on fee schedule or billed amount. Populated once claim processed.
CoPay Amount: $0.00
Medicare Paid Date
Medicare Calc Allowed Amt: $0.00
Medicare Paid Amount: $0.00
Medicare Deductible Amount: $0.00
Medicare Coinsurance Amount: $0.00
Diagnosis Code Pointer
Diagnosis Pointer not required as a diagnosis on the claim is not required for ABI Service Providers.
National Drug Code
NDC Quantity: 0
NDC Unit of Measurement
delete | add

Additional NDCs (Detail Item 1)
*** No rows found ***
N/A
Select row above to update -or- click Add button below.
National Drug Code | Quantity | Unit of Measurement
delete | add

Claims Processing/Submission Information



Claims Processing/Submission Information

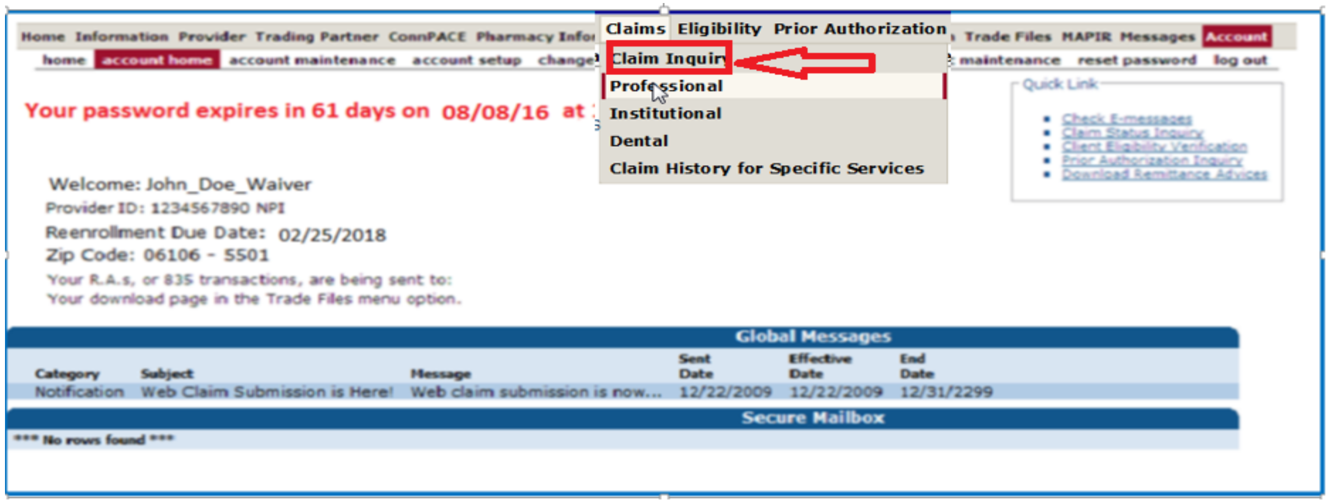
Claim Status Information	
Claim Status	PAID
Claim ICN	2216165600002
Paid Date	
Paid Amount	$12.00
Applied Income	$0.00
Client Contribution	$0.00
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

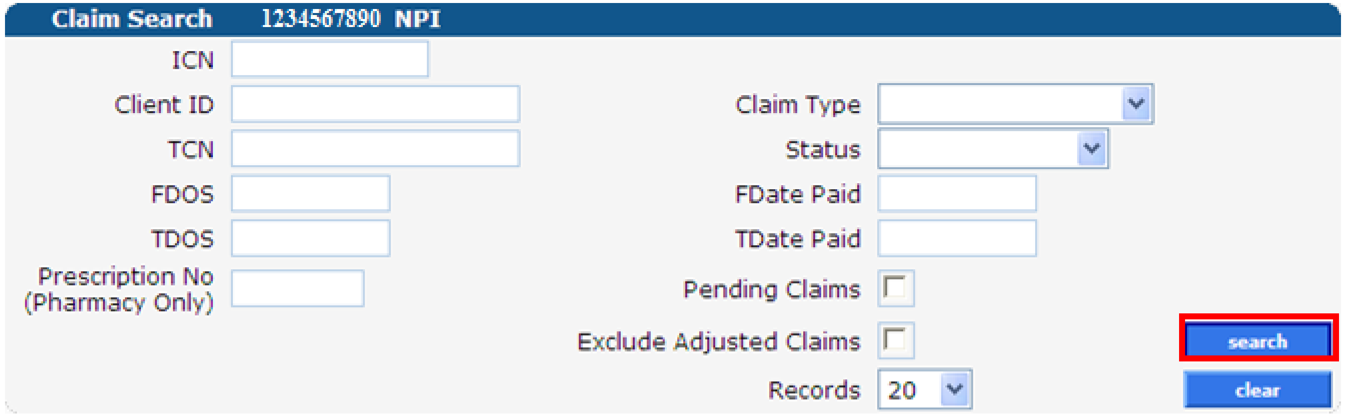
Paid date of 6/13/16 will populate after the next financial cycle.

EOB Information

Detail Number	Code	Description
0	9997	REFER TO DETAIL EOB
1	9918	PRICNG ADJUSTMENT - MAX FEE PRICING APPLIED

Web Claim Inquiry





- Once you have submitted a claim to Hewlett Packard Enterprise using the ctdssmap.com Secure Site:
  - click on the “Claims” tab on the main menu and select “**Claim Inquiry**”
- Enter enough information to satisfy at least one of the following criteria:
  - ICN
  - Client ID FDOS/TDOS or Fdate Paid/Tdate Paid (spanning 91 days or less)
  - check the Pending Claims box

Web Claim Inquiry

Search Results

– When more than one claim matches the claim inquiry search criteria, a list of claims will appear in the Search Results panel

– Search results may be sorted by clicking on the column headings

– Click anywhere on a given row to select the claim to view

Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2016026600026				12/31/2015	01/05/2016	Professional Claims	Paid	01/29/2016	$500.00	$105.73
5616026001001				12/31/2015	01/02/2016	Professional Claims	Denied	01/29/2016	$500.00	$0.00
5616025001001				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2016025600026				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$100.00
2016022600037				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016022600039				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$5.73
5616025002001				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2016025600023				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$5.73
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2216019600005				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600004				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600010				09/05/2015	09/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600009				08/05/2015	08/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600008				08/05/2015	08/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600006				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00

Claim Submission Guidelines

Claim Inquiry

Claims submitted to Hewlett Packard Enterprise are each assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research.

- **1** Claim Region – Identifies the manner in which the claim was submitted. (**20** = Electronic Claims with No attachments)
- **2** *Year of Receipt* – Indicates the year in which the claim was received by Hewlett Packard Enterprise. (**16** = ***2016***)
- **3** *Julian Date of Receipt* – The Julian calendar date of receipt (**244** = *the two hundred forty fourth day of the year = September 1, 2016.*
- **4** *Batch Number* – An internal number assigned by Hewlett Packard Enterprise to uniquely identify a batch. (**123**)
- **5** *Claim Number* – A sequential number assigned to uniquely identify claims within a batch. (**456**)

Hewlett Packard Enterprise

Web Claim Inquiry

Results searching by FDOS and TDOS (no greater range than 93 days)

Claim Search 1414141414 NPI

ICN
Client ID
TCN
FDOS 10/01/2015
TDOS 01/01/2016
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	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2215315600003				11/08/2015	11/08/2015	Professional Claims	Denied	11/18/2015	$85.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

Web Claim Inquiry

Exclude Adjusted Claims

– Removes claims that have been altered since their initial submission

– Results in a more accurate representation of your total reimbursement

Claim Search 1414141414 NPI

ICN			
Client ID		Claim Type	
TCN		Status	
FDOS	10/01/2015	FDate Paid	
TDOS	01/01/2016	TDate Paid	
Prescription No (Pharmacy Only)		Pending Claims	☐
		Exclude Adjusted Claims	☑
		Records	20

search

clear

Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2215315600003				11/08/2015	11/08/2015	Professional Claims	Denied	11/18/2015	$85.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

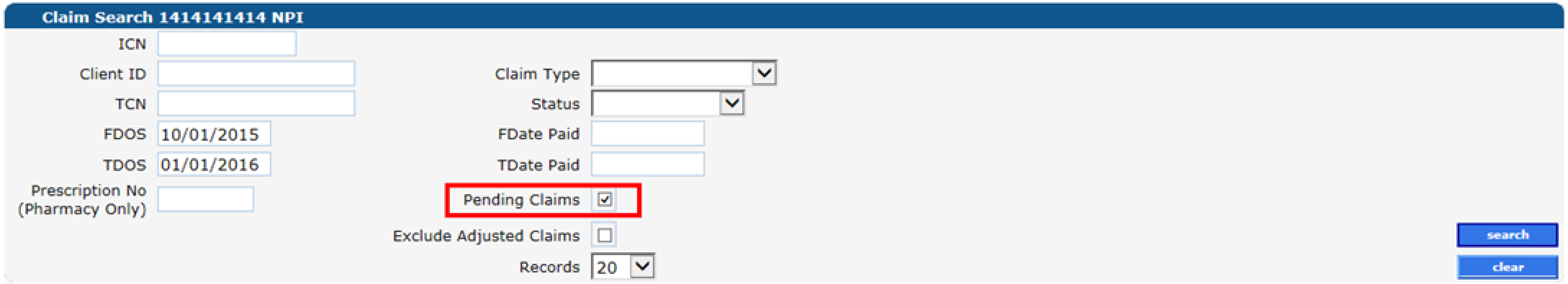
Web Claim Inquiry

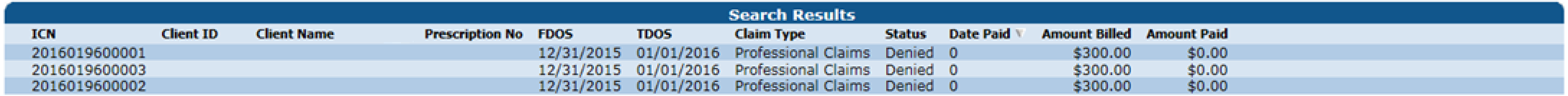
Pending Claims

– Claims submitted since the last Remittance Advice (RA) was issued

– Convenient way to see all claims that will impact your reimbursement for the current cycle

– Click any line in the Search Results panel to view the corresponding claim





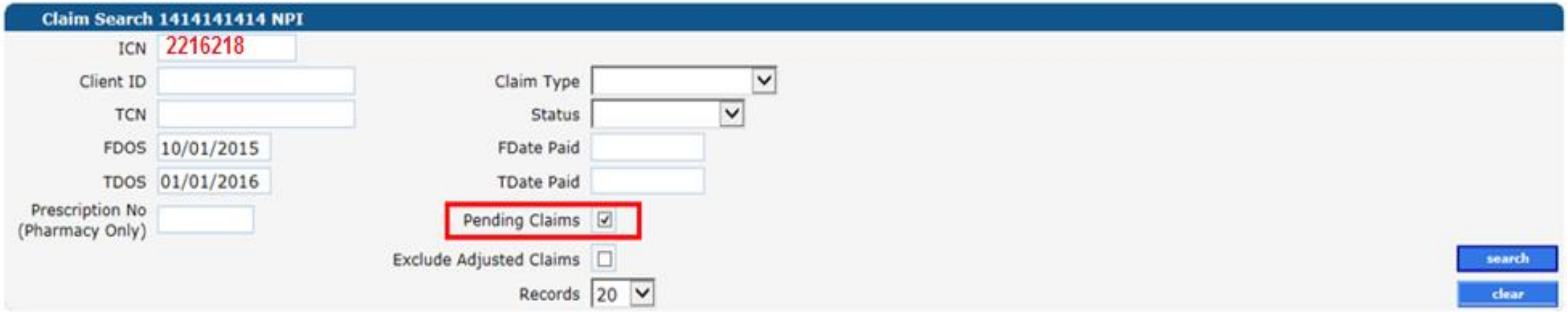
Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

Web Claim Inquiry

Pending Claims

- To narrow search results for pending claims by region on a given date, enter the first 7 digits of the Claim Internal Control Number (ICN).
- This search will provide claims submitted via the Web on August 5, 2016 that have not yet processed through a financial cycle.



Hewlett Packard Enterprise

Claim Submission Options

www.ctdssmap.com

Web Claim Submission

Web Claim Inquiry

What can I do with these claims?

– Paid claims allow you to:
  - cancel Cancel any alterations you have made
  - adjust Adjust the claim
  - void Void the claim
  - copy claim Copy the claim and use it as a template to create a new claim
  - new claim Create a brand new claim

– Denied claims allow you to:
  - re-submit Resubmit the claim (with or without making changes)
  - cancel Cancel any alterations you have made
  - new claim Create a brand new claim

– Suspended claims allow you to:
  - new claim Create a brand new claim

Web Claim Submission

Void

Perform the following steps to void or completely recoup a paid claim:

– Select *Claim Inquiry*

– Enter the paid claim ICN (found on your RA) in the ICN field

– Click the **search** button

– Once the claim is retrieved, click the ***void*** button at the bottom of the claim page

– **The void will process immediately and return a message that the claim has been successfully adjusted / voided with a new ICN**

Web Claim Submission

Adjustment

Perform the following steps to easily adjust a paid claim:

– Select *Claim Inquiry*

– Enter the paid claim ICN (found on your RA) in the ICN field

– Click the ***search*** button

– Once the claim is retrieved, make any necessary changes to the claim

– Click the ***adjust*** button at the bottom of the claim page

– **The adjustment will process immediately and return a status of Paid, Denied or Suspended**

Web Claim Submission

Web claim adjustment limitations

Timely Filing

– Claims that are over the *Timely Filing* guidelines cannot be adjusted, unless the adjustment is submitted to pay the same or less than the original claim; otherwise, claim adjustments outside of the timely filing limit will be fully recouped

Special Handled Claims

– Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by Hewlett Packard Enterprise and are, therefore, not able to be adjusted via the **www.ctdssmap.com** Web site

Web Claim Submission
Copy

Paid claims may be copied and submitted as a new claim

– *This feature is helpful for reoccurring services*

Copy - Perform the following steps to easily copy a paid claim for submission as a new claim:

– Select *Claim Inquiry*

– Enter the paid claim ICN (found on your RA) in the ICN field

– Click the ***search*** button

– Once the claim is retrieved, click the ***copy*** button at the bottom of the claim page

– Make the necessary changes to the claim

– Click the ***submit*** button at the bottom of the claim page

The new claim will process immediately and return a status of *Paid, Denied* or *Suspended*

Web Claim Submission
Resubmit

Resubmission - Perform the following steps to easily resubmit a *denied* claim:

– Select *Claim Inquiry*

– Enter the denied claim ICN (found on your RA) in the ICN field

– Click the ***search*** button

– Once the claim is retrieved, make any necessary changes to the claim

– Click the ***re-submit*** button at the bottom of the claim page

The claim will process immediately and return a status of *Paid, Denied* *or* ***Suspended***

Claim Submission Methods

ABI Services

Claim Submission Methods

EVV Services

EVV Mandated Services

– Claims for the following services rendered to ABI Waiver I or II clients are **mandated for EVV check-in/check-out** and will be systematically **submitted via Sandata's Santrax Electronic Visit Verification (EVV) System** when the **caregiver's check-in/check-out matches the Prior Authorization (PA)** uploaded from Hewlett Packard Enterprise PA subsystem.

- **1021Z** - Personal Care Services per 15 min
- **1211P** - Recovery Assistant
- **1212P** – Recovery Assistant II
- **1232Z** – Respite Care in the Home per hr. – other
- **1531P** – Community Living Support Services Per ½ Day
- **1532P** – Chore Services Per ¼ hr.
- **1534P** – Community Living Support Services Per ½ Day
- **1536P** – Companion Services per ¼ hr. (18 hr. per day max)
- **1542P** – Homemaker Services Per 1/4/hr.
- 1546P – Independent Living Skill Development Per hr, (agency)

These services must first be authorized by the client's case manager, associated to the client's care plan and uploaded by the Case Management Agency, associated to the client, to Hewlett Packard Enterprise.

Claim Submission Methods

EVV Services cont.

EVV Optional Services

– Claims for the following service rendered to ABI Waiver I or II clients are **optional** and will be systematically submitted via the Sandata Santrax Electronic Visit Verification (EVV) System, **should the caregiver choose to check-in/check-out via the EVV system** and the check-in/check-out matches the Prior Authorization (PA) uploaded from Hewlett Packard Enterprise PA subsystem.

- 1**562P** – Respite Care Per hr.

This service must first be authorized by the client's case manager, associated to the client's care plan and uploaded by the Case Management Agency, associated to the client, to Hewlett Packard Enterprise.

Claim Submission Methods

Direct ABI Provider Billing

– Claims submitted for ABI Waiver services, directly by ABI Service providers must be submitted via:

- Internet Web site at www.ctdssmap.com
  - Interactive with ***immediate response*** of claim payment or denial.
  - Allows providers to **query claims** in order to ***adjust, void, or re-submit*** within the ***same claims processing cycle.***

- Vendor Software utilizing the following HIPAA ASC X12N transactions:
  - 837P – Health Care Claim Professional
  - Requires provider to enroll as a Trading Partner

- Paper
  - CMS-1500 Claim Form

Effective October 1, 2016 the Department of Social Services (DSS) will no longer accept paper claims for processing. Paper claims submitted on or after October 1, 2016 will be returned to the provider.

Ref: PB 2016-31.

Claim Submission Guidelines

ABI Services

Claim Submission Guidelines

Edits and Audits

– Regardless of the claim submission method, all claims are processed through the Connecticut interChange system and are subject to a series of ***edits*** that check the validity of claim data such as:

  – ***Submitting*** provider must be actively enrolled on the date of service.
  – ***Client*** must be eligible on date of service.
  – ***Procedure Code*** submitted must be valid for the ***Provider Type.***

– Claims are then subject to a series of ***audits*** such as:

  – Is the ***procedure code(s)*** billed ***on*** the client's ***plan of care***?
  – If the billed ***procedure code*** requires prior authorization (PA), has the ***PA*** been ***approved?***
  – The claim is compared to previously paid claims
    – Is the current claim a ***duplicate*** of a ***paid claim***?

Claim Submission Guidelines

Timely Filing

– Timely Filing Guidelines

  – The timely filing limit, under the ***ABI Waiver Benefit*** plan for the submission of ABI Services by an ABI Service Provider:

    – ***One (1) year*** *from the date of service (initial claim).*
    – ***One (1) year*** *from date of last payment or denial, if not for timely filing.*

Claim Submission Guidelines

Spanning Dates of Service

- 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.

- Spanned dates of service cannot exceed the frequency (weekly or monthly) for the service as noted on the care plan.

  - **For example, if adult day health service is to be provided 6 days per week on consecutive days such as Monday through Saturday for 1 per day for a total of 6 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 Saturday of the same calendar week for a total of 6 units.**

Claim Submission Guidelines

Spanning Dates of Service

– 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 day of adult day health services on Sunday is needed for the above week. If the additional day on Sunday is added as an additional line detail on the PA, the services for Sunday, even though they are consecutive with the regular weekly services, must be billed on a separate line detail.**

Claim Denials and Resolutions

ABI Services

Hewlett Packard Enterprise

Claim Denials and Resolution

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 ABI Waiver benefit plan. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021). Please Note: **The system attempts to process under the HUSKY benefit plan first, if not a covered service it will set 4021 for the HUSKY benefit plan. The system will then attempt to process under the ABI benefit plan. If the claim denies for 00X EOB, the system will attempt to process under any other benefit plan the client may have. It is the 00X EOB that should be acted upon and disregard all 4021 EOB codes**

Resolution:

- Client eligibility file needs to be updated with an ABI Waiver benefit plan or change in the effective dates of eligibility.

Claim Denials and Resolution

Determining and Resolving Eligibility Issues

- The Home and Community Based Unit 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 alternateCare.dss@ct.gov.
  - The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "ABI Waiver Client Eligibility Issue" in the subject line of the email.
- Providers who identify an eligibility issue upon claim denial should contact the DSS Home and Community Services Unit as noted above. To avoid further claim denial, check eligibility before resubmitting claim.

Claim Denials and Resolution

Claim Denials due to Care Plan not on File

Denial Reasons:

- **EOB Code 3015** –Care Plan Required

Resolution: A care plan must be created by the ABI Case Management Agency and uploaded to the Hewlett Packard Enterprise system. **Contact the Case Management Agency.**

Claim Denials and Resolution

Claim Denials due to Service not Authorized

Denial Reason:

- **EOB Code 3016** -Service not Authorized on the Care Plan.

Resolution 1: A service denied for not on care plan must be added by the Case Management Agency to the Care plan.

Resolution2: Incorrect Procedure code billed by provider or PA/claim mismatch.

Hewlett Packard Enterprise

Claim Denials and Resolution

Claim Denials due to Units Billed Exceeding Frequency

Denial Reason:

- **EOB Code 5151**- Units exceed the frequency units authorized on the care plan.

Resolution 1: Units of service must be added to the frequency of an existing PA by the Case Management Agency.

Resolution 2: Units exceeded due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution

Denial due to PA Exhausted

Claim Denial

- **EOB Code 3003** - Units of service must be added by the Case Management Agency to an existing PA that is currently exhausted.

Resolution 1: Prior Authorization is required for payment of the service (units for the service are exhausted).

Resolution 2: PA exhausted may be due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution

Resources for Care Plan Issues

- Case Mangers create service orders and enter them in the Case Management Agencies Care Management System. **DSS cannot make care plan or prior authorization changes in the portal.**

- The Case Management Agency is responsible for uploading initial care plans and changes to care plans to Hewlett Packard Enterprise, in Prior Authorization format, within seven (7) days of issuing the service order.

- 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 Case Management Agency.

Remittance Advice

www.ctdssmap.com

Web Account Capabilities

Hewlett Packard Enterprise

Remittance Advice

Access to Claim and Financial Reporting

All claims activity is reported to providers twice a month on a Remittance Advice

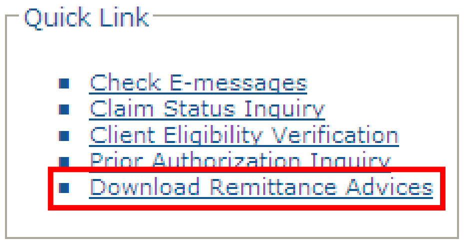
– RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider’s claim activity

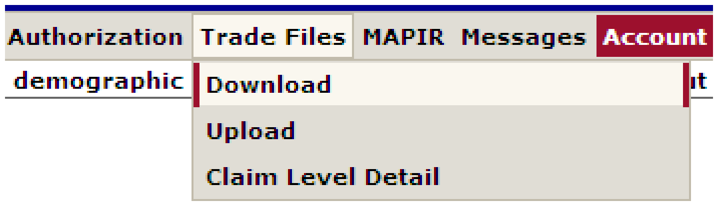
– Providers receive RAs electronically via the secure Provider Web site at www.ctdssmap.com

– Available in either the ASC X12N 835 Payment/Advice standard transaction format, which is a string of raw data that must be configured by the provider/vendor for download into their system or in the Comma Separated Format (CSV) which provides the paper version of the RA

– Only the last 10 RAs are maintained on the Hewlett Packard Enterprise Web site; it is highly recommended that providers save a copy of their RAs to their local computer system for future access

– Click Download Remittance Advice from the Quick Link box on the account home screen or select Download from the Trade Files drop-down menu:





Remittance Advice

CSV - Comma separated Value

- ABI Service providers will have access to their Remittance Advice (RA) in an excel format. This allows providers to sort the file and search for specific claim approvals and denials. To access the RA, go to our Web site at www.ctdssmap.com and log onto the secure Web portal. Under "Trade Files", choose "Download" from the drop down menu. Select "CSV" from the "Transaction Type" on the File Download Search screen. This will populate the current files available to download. The following provides an example of the data available in this excel format:

Provider ID	Client ID	Client Last Name	Client First Name	Client Acct Number	ICN	Paid Date (MMDDYY)	Detail Num	FDOS(MMDDYY)	TDOS(MMDDYY)	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Billed Amt	Paid Amt	EOB1	EOB2	EOB3	Medical Record Num	Adj Xref ICN
#########	#########			FFS	5916249001001	09012016	1	08202016	08202016	1021Z					18	8.5	9918	0	0	TC1FORANDIE	201624059045
#########	#########			FFS	5916244001002	09012016	2	08232016	08232016	1021Z					36	17	9918	0	0	TC1FORANDIE	201624008245
#########	#########			FFS	5916244001003	09012016	1	08292016	08292016	1021Z	TT				18	8.5	9918	0	0	TC1FORANDIE	2016240082051

Remittance Advice

Components of the RA – 7 Sections

- Banner Page
  - Important messages from DSS or Hewlett Packard Enterprise
- Claims Information (Paid, Denied, and Adjustments)
  - Sorted by claim type and status; reports up to 20 EOB codes per claim
- TPL Information
  - The primary insurance that is on file for clients whose services appear on the RA
- Financial Transactions Processed
  - Payouts, Refunds, Account Receivables
- RA Summary
  - Month-to-day and year-to-day summaries of financial activities, account receivables
- EOB Code Descriptions
  - Descriptions of the EOB codes that posted to claims on the RA
- Claims in Process
  - Lists claims that were in suspense when the financial cycle was run

Monthly Claims Reprocessing

Care Plan Changes

ABIO Services

Monthly Claims Reprocessing
Care Plan Changes –ABI Services

Systematic Monthly Claims Reprocessing to:

– Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Case Management Agency such as:

– End dating and restarting a care plan due to periods of hospitalization.

– Increasing or decreasing services.

– End dating a care plan when the client leaves the Agency’s service.

Monthly Claims Reprocessing cont.

Care Plan Changes ABI Services

Systematic Monthly Reprocessing:

- In the **first cycle of each month**, Hewlett Packard Enterprise will recoup (void) all paid claims impacted by the Case Management Agency changes made two months prior(Region 52 claims = a voided claim).

- In the **same cycle Hewlett Packard Enterprise 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 **Jan. 2017** by the Case Management Agency will result in claims being voided (region 52) and reprocessed (region 24) in the **first cycle of March 2017**.

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

Hewlett Packard Enterprise

Monthly Claims Reprocessing cont.
Care Plan Changes – ABI Services

Impact to Provider Remittance Advice (Paper RA)

– If there is a financial impact (Change in $ 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
Care Plan Changes – ABI Services

Impact to Provider Remittance Advice (Paper 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 RA.

Hewlett Packard Enterprise

Monthly Claims Reprocessing
Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – PA Inquiry:

- 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 continue to 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 Case Management Agency.

Monthly Claims Reprocessing
Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – PA Inquiry cont.

- A PA may show negative units available, if the changes made by the Case Management 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 7 units per week for 4 weeks = 28 units authorized and available.
    - Claims are paid against the PA = 14 units used
    - Case Management Agency changes the PA to 5 units a week for 2 weeks = 10 units authorized and available.
    - Until claims are recouped and reprocessed, the PA will show 10 units available – 14 used = (4) negative units.

Monthly Claim Reprocessing Due to PA Changes Made by Case Management Agency Claim Recouped

REPORT: CRA-PHAD-R
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIM ADJUSTMENTS

Date: 10/15/201
PAGE: 33

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

PAYEE ID MCD
ISSUE DATE 10/15/201
TAXONOMY ---------
P. AVRS ID

FP	--ICN-- --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.

PL SERV PROC CD MODIFIERS UNITS SERVICE DATES FROM THRU RENDERING PROVIDER BILLED AMOUNT ALLOWED AMOUNT DETAIL EOBS

CLIENT NAME: Sally Client CLIENT NO.: 0000000000

FP	ICN	FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.
1	2200000000000	060314	061214	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	5200000000000	060314	061214	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEADER EOBS: 8236

Hewlett Packard Enterprise

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-PHPD-R                    interChange MMIS                         Date:  10/15/2014
  RA#:                     MEDICAID MANAGEMENT INFORMATION SYSTEM                PAGE:          2
                                PROVIDER REMITTANCE ADVICE
                                   CMS 1500 CLAIMS PAID
```

Home Care Agency
555 Any ST
Somewhere, CT00000-0000

PAYEE ID	MCD
ISSUE DATE	10/15/2014
TAXONOMY	----------
P. AVRS ID	

FP	--ICN-- --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.
	CLIENT NAME: Sally Client			CLIENT NO.:								
	2400000000000	060214	061214	116.16	75.00	0.00	0.00	0.00	0.00	0.00	75.00	0
	HEADER EOB 8238											

DL	SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
	12	1542P		20	060214	061214	MCD	116.16	75.00	

Hewlett Packard Enterprise

Monthly Claims Reprocessing

Care Plan Changes – ABI Services

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
- **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 with:
  - **EOB code 8237** – Claim Systematically Reprocessed Due to PA Change- Information Only.

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

Program Reminders for Successful Claim Submission

www.ctdssmap.com

Information

Program Reminders for Successful Claim Submission
Client Care Plan

- **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 Case Management Agency 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.

Program Reminders for Successful Claim Submission

Claim Submission

➢ **Claim submission review**

- Prior to submitting claims be sure services provided match services 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.

Program Reminders for Successful Claim Submission

Claim Submission Review cont.

➢Claim submission review

- Minimize claim submission time by:

  ✓Submitting claims via 837 batch or interactively via the web. Paper claims submitted on or after 10/1/16 will be returned unless the claim needs special handling.

  ✓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 PCA service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 9/5/16 to 9/7/16 1021Z for 30 units.

Program Reminders for Successful Claim Submission

Claim Resolution

- **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 Home and Community Based Services unit.**
  - ✓ Submit care plan discrepancies not already addressed to **Case Management 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 CHC Providers to determine claim resolution.
    - Contact **HPE Provider Assistance Center** with issues you cannot resolve.

Information-Resources

www.ctdssmap.com

Information

Information – Important Messages

www.ctdssmap.com contains a wealth of information for providers:

– Important Messages

- Available on the Home page. Also available on the Information page
- Contains urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes

Important Messages

Electronic Visit Verification Implementation (Updated 7/28/16)

CMAP Medicaid Access Monitoring Review Plan (AMRP)

Outpatient Hospitals Prior Authorization Issue (Updated 7/22/16)

Hospital interChange Issues (Updated 7/12/2016)

Revised Provider Manual Chapters (Updated 7/6/16)

Revised Joint Guidance by DSS and CTDOL Regarding USDOL's Home Care Final Rule

Pediatric Dental Fee Schedule Reduction Postponed (Posted 7/6/16)

Provider Bulletin PB-37 New Autism Spectrum Disorder Services Being Rescinded

System Down Time 06/30/2016

Frequently Asked Questions (FAQs) - Provider Bulletin PB16-31

Clarification of Provider Bulletin PB16-33

DSS Issues RFP for Medicaid Quality Improvement and Shared Savings Program

Revised Provider Manual Chapters (Updated 6/7/16)

Attention: Out of State Providers - Where to Send Updated License Information (Updated 5/16/16)

Inpatient Delivery Stays (Updated 5/12/16)

Hospital interChange Issues (Updated 5/11/16)

ABI Individual Provider On-line Enrollment (Effective 5/11/16)

Information- Resources

Important Messages

Electronic EVV Implementation Message

interChange Provider Important Message

Welcome to the Connecticut Medical Assistance Program
Electronic Visit Verification Implementation Important Message

(Last updated on 07282016) Please note: Revised data will appear in red.

The Department of Social Services (DSS) has recently finalized contract negotiations with Hewlett Packard Enterprise, their MMIS contractor, to implement Electronic Visit Verification (EVV) in the CT Medical Assistance Program (CMAP). Hewlett Packard Enterprise is partnering with Sandata to implement their suite of products (Santrax™) that will be integrated with interChange. Detail system design has begun, and this Important Message will provide up to date information on the implementation. Providers are encouraged to visit this site often to obtain the most current information published to the provider community.

DSS has received feedback from the Home and Community Based provider community regarding the initial implementation date of July 1, 2016. After careful consideration, DSS has moved the implementation date of non-medical services to November 1, 2016 and all Home Health related services to January 1, 2017 in order to provide more time for providers to incorporate DSS' EVV into their systems. Non-medical service providers who would like to begin using the EVV system on September 1, 2016 are encouraged to do so.

Important Message References

– Providers can reference links to Important Documentation published regarding EVV as noted below

Important Documentation:

EVV Service Code Listing
Frequently Asked Questions
Proposed Task List
Proposed Reason Code List
CT DSS EVV Interface Specification Data Mapping
CT DSS EVV Interface Testing Process
CT DSS EVV Sandata Standard Interface Specification Schedules
CT DSS EVV Sandata Standard Extract Completed Visits
CT DSS EVV Sandata Standard Extract Payroll

Workshop Presentations:

Introductory Webinar
Introduction to Electronic Visit Verification

Publications:

PB16-44 - Electronic Visit Verification Notification to Clients

Information - Resources

ABI Procedure Code Crosswalk

- **ABI 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 ABI Waiver Program.
- Providers should access the **ABI Procedure Code Crosswalk** 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 Value Options)
  - ✓ Funding Source that covers the service

Information- Resources

ABI Procedure Code Crosswalk

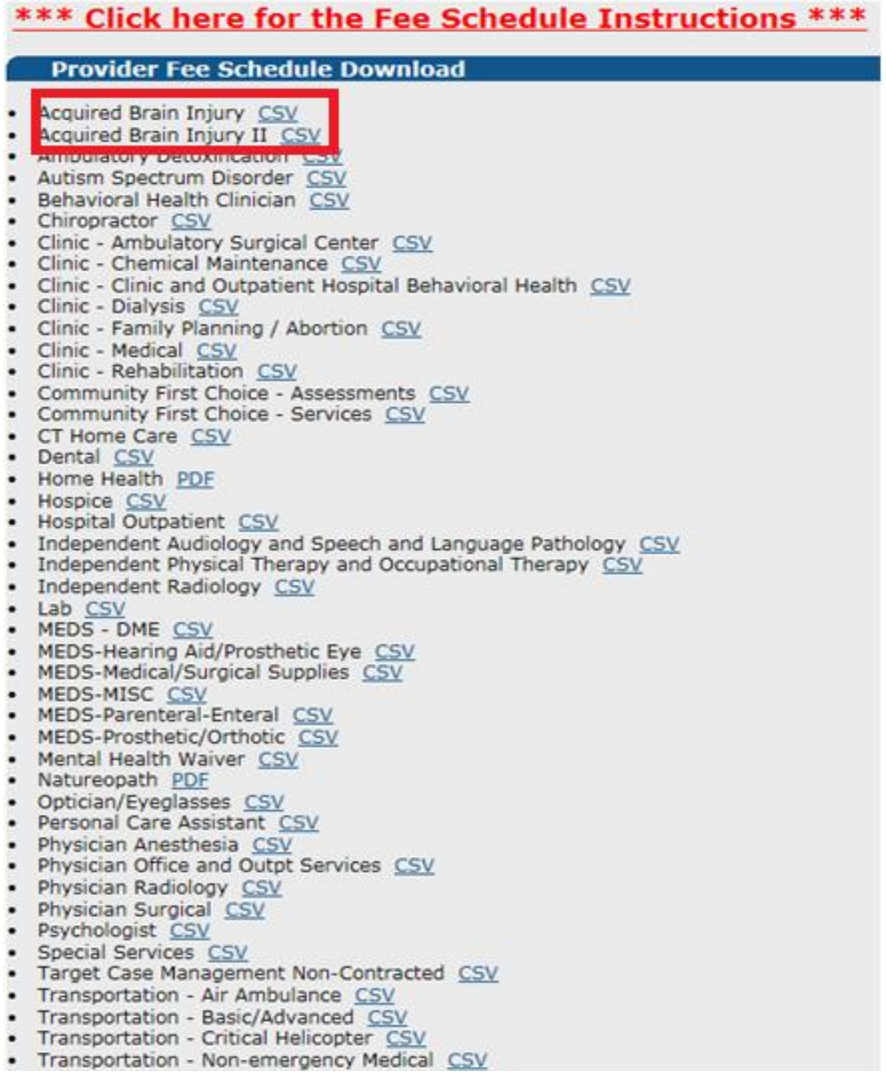
- **ABI Procedure Code Crosswalk –** can be obtained on the www.ctdssmap.com Website.

  - ✓ From the Home page >publications > provider manuals > chapter 8 ABI Provider Manual > Claim Submission Instructions > field 24d.

Information – Resources

Fee Schedules

- CMAP fee schedules are available for download from the Web site
  - Select Provider Fee Schedule Download from the Provider drop-down menu
    - You must read and accept the End User License Agreement prior to downloading the fee schedule; click I Accept
  - Provider Fee Schedules are listed by provider type and specialty
  - See Information “What is CSV” at the bottom of the Web page for accessing the CSV file



Information – Resources
Banner Page Announcements

– RA Banner Announcements

  – Available by selecting the Information tab or clicking on RA Banner Announcements in the Information box on the left hand side of the home page

  – Messages originally published for providers on the first page of their remittance advice. Some banner announcements are provider specific and therefore are only sent to the relevant provider types/specialties

  – Often published in regards to reprocessed claims; explaining the reasons behind the reprocessing as well as the claim types affected

02/05/2016-02/12/2016	Attention Select Providers	Attention Select Providers. CLAIMS PROCESSING ISSUE: Hewlett Packard Enterprise has identified a claims reprocessing issue where claims originally processed with a temporary ID incorrectly denied when they were reprocessed with the client's true (permanent) 9-digit Connect Medical Assistance Program (CMAP) ID. The denied claims have been identified and reprocessed and will appear on the February 9, 2016 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 27.

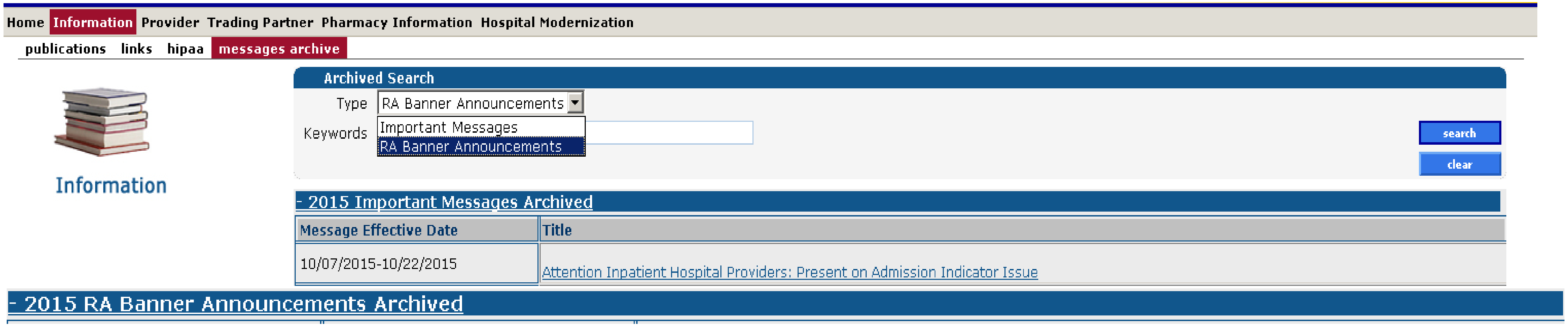
Hewlett Packard Enterprise

Information – Resources

Archive Important Messages and Banner Announcements

– Important Messages and RA Banner Announcements are available on the Home page of the www.ctdssmap.com Web site. Only the most current messages will be posted in the main areas on the Web for a limited time; thereafter, providers will have to retrieve previously published Important Messages and Banner Announcements from messages archive. To access the messages archive page, select messages archive from the Information drop-down menu on the home page.

– RA Banner Announcements and Important Messages dated January 1, 2014 and forward are saved on the Web site and are available for review.

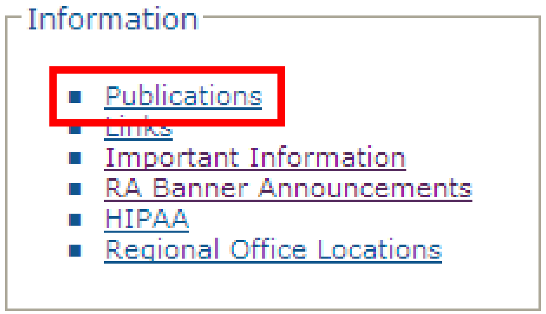


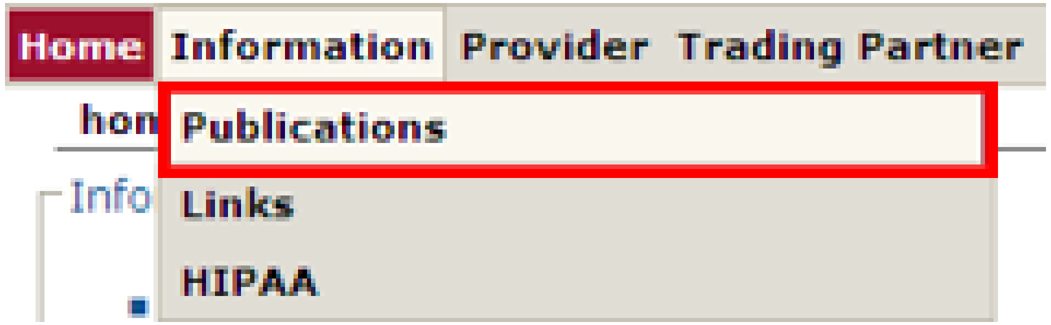
Information - Resources

Publications

– A majority of the information available on the www.ctdssmap.com Web site is located on the Publications page

– Access the Publications page by selecting Publications from either the Information box on the left hand side of the home page or from the Information drop-down menu





Information – Resources

Provider Bulletins

– Provider Bulletins

- – Publications posted 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

Information

Bulletin Search

Year: 15 | Provider Type: ALL PROVIDER TYPES

Number: | Title:

Search Results

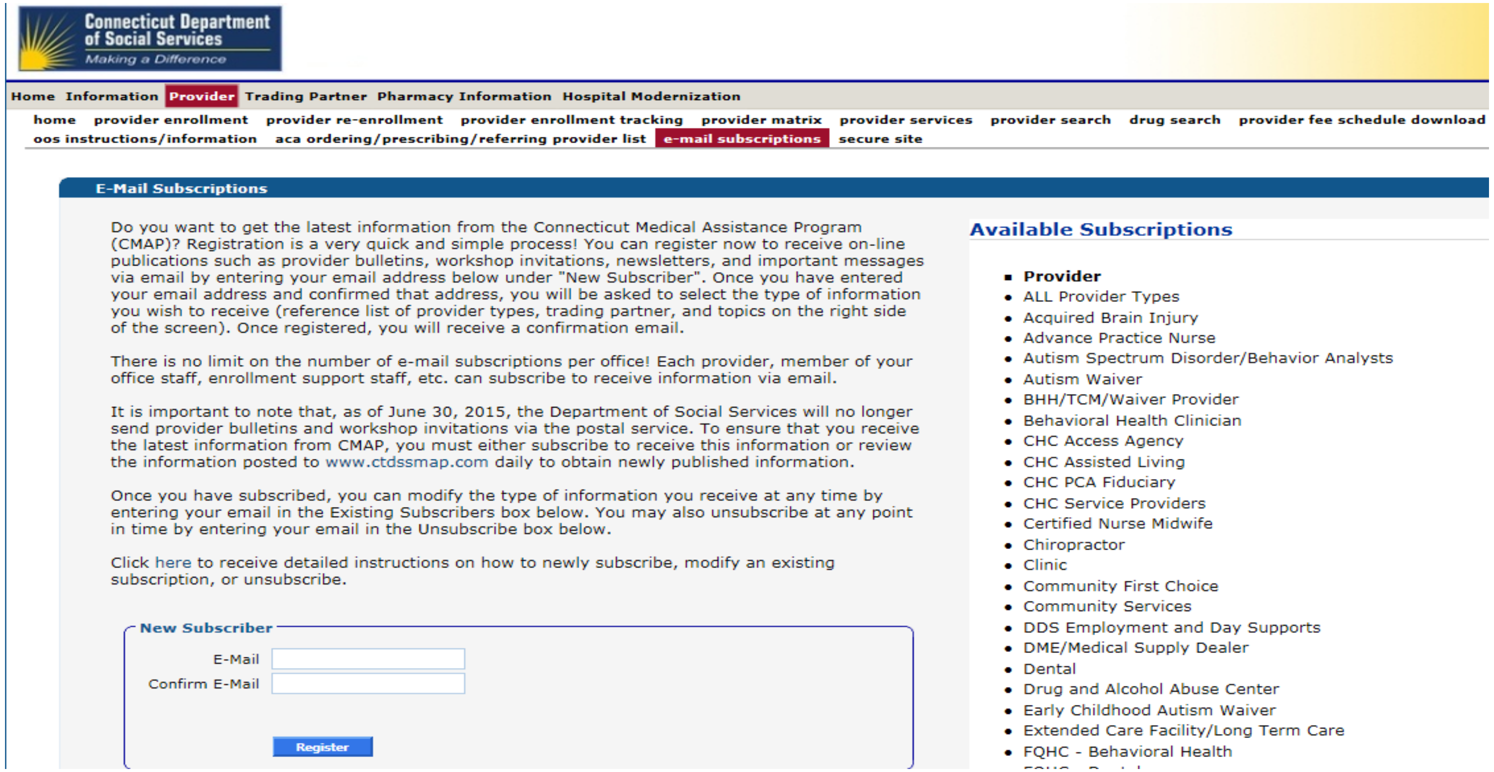
Bulletin Number	Title	Published Date
PB15-85	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/08/2015
PB15-61	Claims Processing Guidance for Implementing ICD-10 Codes	08/04/2015
PB15-60	Eligible Clients under the Affordable Care Act Part IV (Temporary ID Update)	07/28/2015
PB15-55	Upcoming Changes to the Automated Voice Response System Menu Options	07/16/2015
PB15-54	Elimination of Mailing Paper Remittance Advices	07/14/2015
PB15-47	Fee Schedule Updates for ICD-10 Diagnosis Codes	06/30/2015
PB15-47	ICD-10 Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assista...	06/30/2015
PB15-50	Payment Error Rate Measurement (PERM) Program Audit Requests	06/30/2015
PB15-45	Billing Procedures for Services Ordered by Residents and Interns	06/22/2015
PB15-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/19/2015
PB15-35	Expedited Medicaid Eligibility Processing for Individuals with Medical Emergenci...	05/05/2015
PB15-23	Implementation of Electronic Messaging - Replacement to the Mailing of Bulletins...	03/10/2015
PB15-05	Billing Clients for Missed Appointments	01/20/2015

Information- Resources
E-mail Subscriptions

Register for 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

– *For complete E-mail subscription information, please see provider bulletin PB-23 on the CMAP Web site



Information – Resources
Provider Manual

- Provider Manual
- 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, prior authorizations, 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
- The Provider Manual is divided into twelve (12) chapters
  - Click on the chapter title to open the document (disable pop-up blockers)
  - Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter
  - Chapter 11 is claim-type specific

Information – Resources
Provider Manual

- Chapter 1 – Introduction
  - Provides information on the CT Medical Assistance Program, the Department of Social Services’ and Hewlett Packard Enterprise’s responsibilities and resources
- Chapter 2 – Provider Participation Regulations
  - Details the CMAP regulations for provider participation
- Chapter 3 – Provider Enrollment
  - Provides information on provider eligibility in regards to provider enrollment and re-enrollment
- Chapter 4 – Client Eligibility
  - Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability
- Chapter 5 – Claim Submission Information
  - Provides information on general claims processing and billing requirements
- Chapter 6 – EDI Options
  - Provides information on electronic claim submission and electronic RAs

Information – Resources
Provider Manual

- Chapter 7 – Regulations/Program Policy
  - This section contains the Medical Services Policy sections that pertain to the chosen provider type
- Chapter 8 – Billing Instructions
  - Provides information on provider specific billing requirements and instructions
- 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
- Chapter 11 – Other Insurance/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

Information – Resources
Other

– Provider Newsletters
  – Quarterly publications to providers on a wide range of topics

Provider Newsletters

- December 2015 interChange Newsletter
- September 2015 interChange Newsletter
- June 2015 interChange Newsletter
- March 2015 interChange Newsletter

– Claims Processing Information
  – **Guides and FAQs to assist with billing/claims processing**

Claims Processing Information

- Eligibility Response Quick Reference Guide
- Internet Claims Submission FAQ
- Hospice Procedure Code Exception List
- ICN Region Code List
- CT Medical Assistance Program EOB Crosswalk
- CT Medical Assistance Program EOB Crosswalk - Pharmacy and Non-Pharmacy
- Medically Unlikely Edit (MUE) Updates
- OPR Enrollment FAQ

Contacts

www.ctdssmap.com

Contacts

Resources

Contacts

- **Hewlett Packard Enterprise 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@HPE.com
  - This should be your first call resource to answer all enrollment 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.

- **Hewlett Packard Enterprise Electronic Data Interchange (EDI) Help Desk**
  - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

- **Sandata (EVV) Technologies, LLC (EVV)**
  - Sandata Customer Care:
    - 1-855-399-8050 or ctcustomercare@sandata.com
      Monday thru Friday 8:00 AM – 6:00 PM

Case Management Agency Contact Information

Contacts

- **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 EMS number, CCCI number, EOB code on rejecting claim at Hewlett Packard Enterprise, from and to dates of service, the type service (PCA srvs. per 15 min, Recovery Assistant, Meals, double per day 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 EMS number, the type of service (PCA srvs. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit.

Case Management Agency Contact Information

Contacts

- **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 EMS number, type of service (adult family living/foster care, support broker services, CFC or home health services) the dates of service, the frequency of service and the number of units or hours per visit.

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Questions/Comments

www.ctdssmap.com

Question and Comments

Hewlett Packard
Enterprise

Thank You For Attending

The Connecticut Medical Assistance Program

Acquired Brain Injury (ABI) Web Claim Submission Workshop

All questions and comments regarding this training are welcome.

Please fill out the provided workshop survey:

Your feedback helps us to improve future workshops