## WHAT IS "AT YOUR FINGERTIPS"?

"At Your Fingertips" is a bi-monthly tip sheet 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.

This tip will help you understand some of the most common EOB reason codes and how to correct them prior to claim resubmittal. This tip also provides additional resources to help you in resolving claim denials.


*Not sure who to contact when you have a question or issue?*

Contact DXC Technology via e-mail to: ctevv@dxc.com

Please only send client PHI in an encrypted/ secured email.


# EVV TIP # 17

# COMMON REASONS FOR A CLAIM DENIAL

Providers often contact DXC Technology and Sandata Technologies for assistance in resolving claim denials that they see on the Remittance Advice (RA). This tip sheet is intended to be used in conjunction with the many other resources given to providers to assist them in reconciling their RA.

## WHY DO MY CLAIMS GET DENIED?

When a claim processes through the Connecticut Medical Assistance Program (CMAP), it is subject to a series of edits and audits that check the validity of the claim data. If the claim data is not able to be validated, the claim will deny payment and an explanation of benefit (EOB) code will be posted to the claim that will help explain why the claim did not pay.

Examples of claim editing ensure:

- ❑ The submitted provider is actively enrolled on the date of service.
- ❑ The client is eligible on date of service.
- ❑ The procedure code submitted is valid for the provider type.
- ❑ The claim is not a duplicate of an already paid claim.
- ❑ The billed procedure code has a prior authorization (PA) in a care plan for the services provided.

When a claim is denied payment, the issue that prevented payment must be corrected, if possible, prior to claim resubmittal or the claim will again deny payment.

## WHAT ARE SOME COMMON EOB CODES IN THE EVV PROGRAM?

**EOB Code 2003 -** Client Ineligible for dates of service
**Resolution:** This EOB code will set when the client is not eligible on their appropriate waiver at the time of service. The client eligibility file will need to be updated with an EVV mandated waiver benefit plan or a change made to the effective dates of eligibility prior to resubmittal of the claim(s).

For assistance with the client's waiver benefit plan, providers can contact the Community Options Unit at DSS via an encrypted email at HomeAndCommunityBasedServices.dss@ct.gov.

**EOB Code 4021 -** Procedure Billed is not a Covered Service under the Client's Benefit Plan.
**Resolution:** If EOB code 4021 is the only EOB that sets on the claim, the client does not have an EVV mandated waiver in their benefit plan. If any other EOB is on the claim, take action on the other EOB code and disregard EOB code 4021.

**EOB Code 3015** – Care Plan Required
**Resolution:** The service is not payable unless the care manager creates a care plan and adds the service being provided to the care plan. Please contact the care manager for assistance and request that they upload the care plan to the DSS web portal.

**EOB Code 3016 -** Service not Covered under Care Plan
**Resolution:** This EOB codes will set when a care plan is present on the DSS web portal but there is not a prior authorization (PA) on the care plan for the services being provided. A PA by the Access or Case Management Agency, must be created and associated with a care plan.

**EOB Code 3003** -Prior Authorization is required for payment of the service (units for the service are exhausted)
**Resolution:** This EOB code will set when the units on an existing PA are exhausted. To remedy this EOB, a one-time only PA will have to be uploaded to the DSS care plan or additional units must be added to the frequency of the existing PA.

**EOB Code 5151** - Units exceed frequency units on care plan.
**Resolution:** This EOB code will set when the units exported for claims processing exceed the remaining units related to the frequency on the PA. Additional units must be added to the frequency of an existing PA by the Access/Case Management Agency in order for a resubmitted claim to be paid.

**EOB Code 8236** - Claim was Recouped due to PA Change
**Resolution:** This EOB code will set when a claim is voided due to a PA change. A new claim is systematically created when claims are reprocessed due to a PA change by an Access or Case Management agency. The claims that were billed against the original PA will be systematically reprocessed to sync them to the new PA. This EOB code will be attached to an Internal Control Number (ICN) that starts with region code 52.

**EOB Code 8237** – Claim Systematically Reprocessed Due to Retro Change-Information Only
**Resolution:** This EOB will set when a claim is systematically created due to a PA change by an Access or Case Management agency. The claims that were billed against the original PA were voided and a new claim will be systematically created to sync the services performed to the new PA. This EOB code will be attached to an Internal Control Number (ICN) that starts with region code 24. This claim will not appear on the PDF RA because there was no financial impact due to the recoup and reprocess of the claim, however, the affected claim will be displayed on the DSS web portal and on the ASC X12N 835.

**EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Charge
**Resolution:** This EOB will set when a claim is systematically created due to a PA change by an Access or Case Management agency. The claims that were billed against the original PA were voided and a new claim will be systematically created to services performed to the new PA. This EOB code will be attached to an Internal Control Number (ICN) that starts with region code 24.

## WHERE CAN I FIND HELP WITH OTHER EOB'S I ENCOUNTER?

If you have additional questions regarding claims that have denied payment, there are additional resources that can assist you. On the DSS web site you can access Provider Manual chapter 12 – Claim Resolution Guide by navigating to www.ctdssmap.com -> Information -> Publications then scroll down to the Provider Manuals section and select chapter 12. Chapter 12 has some of the most common EOB reason codes for all provider types and how to resolve them.

If after researching the EOB code you require additional assistance in resolving the claim denial, please contact the DXC Provider Assistance Center at 1-800-842-8440.