

Connecticut Medical Assistance Program



CHC Service Provider Workshop

Presented by:

The Department of Social Services & HP
for Billing Providers

CHC Service Provider Workshop

Agenda

- Program Enhancements – Spring 2014
- Program Enhancements – Upcoming Fall 2014
- Viewing and Understanding a Care Plan
- Changes to Claim Submission
- Claims Resolution
- Important Program Resources
 - Updated Program Resource Contacts
 - Must Have Resource Documentation
- Time for Questions



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Program Enhancements- Implemented Spring 2014

Due to the changes made to the Connecticut Home Care Program for Elders (CHCPE) effective July 1, 2013 DSS has recognized a need for:

➤ Greater flexibility in updating care plans – In Spring 2014 HP Implemented:

✓ **Modifiers for Non-Medical services**

- One Time Only Service Authorization – U2 modifier
- Subsequent Client Service Authorization – TT modifier

✓ **Procedure Code Lists for Non-Medical Services**

- Meals - 970
- Adult Day Care - 971
- Adult Family Living/Foster Care - 972

✓ **Procedure Code/Modifier Lists for Non-Medical Services**

- Meals (one time only) - ML
- Adult Day Care (one time only) - AD
- Adult Family Living/Foster Care – (one time only) - FF



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Program Enhancements- Upcoming Implementation Fall 2014

Changes to be Implemented - Fall 2014:

➤ **Allow retroactive changes to Care Plans when claims are paid against the Prior Authorization (PA)**

- ✓ Access Agencies will be able to make changes to individual care plans without requesting the provider recoup/void claims paid for dates of service on or after the effective date of the change.

Example 1: Client enters hospital on 9/1/14 and is discharged on 9/5/14. On 10/5/14 the Access Agency learns of the admission and must adjust the care plan. The Provider has paid claims against the care plan through 9/30/14.

Currently: The Access Agency would request the provider recoup/void all claims for dates of service on and after 9/1/14 through 9/30/14 and not resubmit until the existing care plan has been end dated and a new one effective with the date of discharge has been added.

Changes: Will allow the Access Agency to end date and restart the care plan without requesting the provider recoup their claims.



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

Example 2: Client receiving homemaker services 12 units 3 x week effective 7/1/14 through 12/31/14. On 10/1/14 the care plan changed to 12 units 4 x week. The provider has paid homemaker services through 10/04/14.

Currently: The Access Agency would request the provider void homemaker claims with dates of service 10/1/14 through 10/04/14, end date the PA for 9/30/14 and restart the PA with the additional services on 10/1/14.

A one time only for 12 units of 1214Z U2 for 10/1-10/4/14 could also be created with a PA end date of 10/4/14 and restart of 10/5/14.

Changes: Will allow the Access Agency to end date and restart the care plan without requesting the provider void their claim or eliminate the need to add a one time only services for 10/1-10/4/14.

Provider Impact: As Providers will no longer be requested to recoup claims and resubmit once changes to the care plan have been made.

- ✓ Less delay in reimbursement and less claim denials



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

Systematic Monthly Claims Reprocessing to:

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



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

Systematic Monthly Reprocessing

- In the first cycle of each month, HP will recoup (void) all paid claims impacted by the Access Agency changes made two months prior (Region 52 claims = a voided claim).
- In the same cycle HP 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 November 2014** by the Access Agency will result in claims being **voided** (region 52) and **reprocessed** (region 24) in **the first cycle of January 2015**.

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



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

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.



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Monthly Claim Reprocessing Due to PA Changes Made by Access 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
 ISSUE DATE 10/15/201
 TAXONOMY -----
 P. AVRS ID

FP	--ICN--	SERVICE DATES		BILLED	ALLOWED	DEDUCT	CO-INS	TPL	CO-PAY	APPLIED	PAID	CLIENT
	--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	INCOME	AMOUNT	CONTR.
		SERVICE DATES RENDERING					BILLED	ALLOWED				
PL SERV	PROC CD	MODIFIERS	UNITS	FROM	THRU	PROVIDER	AMOUNT	AMOUNT	DETAIL	EOBS		

CLIENT NAME: Sally Client

CLIENT NO.: 0000000000

1	2200000000000	060314	061214	(116.16)			(0.00)	(0.00)		(0.00)	(0.00)	(0.00)
					(58.08)		(0.00)	(0.00)			(58.08)	
1	5200000000000	060314	061214	116.16			0.00	0.00		0.00	0.00	0.00
					0.00		0.00	0.00		0.00	0.00	0.00

HEADER EOBS: 8236



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

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.



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

FP	--ICN--	SERVICE DATES	BILLED	ALLOWED	DEDUCT	CO-INS	TPL	CO-PAY	APPLIED	PAID	CLIENT
	--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	INCOME	AMOUNT	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											
	SERVICE DATES RENDERING	BILLED	ALLOWED								
	AMOUNT	AMOUNT	DETAIL EOB								
PL SERV PROC CD MODIFIERS	UNITS	FROM THRU	PROVIDER								
12 1210Z	20	060214 061214	MCD	116.16	75.00						



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

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.



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

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 Access Agency.



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

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

- A PA may show negative units available, if the changes made by the Access Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.
- For example:
 - PA authorized for 20 units per week for 4 weeks = 80 units authorized and available.
 - Claims are paid against the PA = 40 units used
 - Access Agency changes the PA to 10 units a week for 2 weeks = 20 units authorized and available.
 - Until claims are recouped and reprocessed, the PA will show 20 units available – 40 used = (20) negative units



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Program Enhancements- Upcoming Implementation Fall 2014 cont.

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

- Negative units indicate potential detail/claim denial when claims are voided and reprocessed, unless another service order is created that will allow the claims to be paid.

- To reduce the denial of claims processing against a PA with negative units, during the implementation of these changes:
 - HP is requesting providers **stop submitting claim adjustments** until **January 1, 2015**.



Viewing and Understanding the Care Plan

CHC PROVIDER WORKSHOP

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Viewing and Understanding the Care Plan – Prior Authorization Inquiry

CONNECTICUT DEPARTMENT
OF SOCIAL SERVICES

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Friday, March 28, 2014

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WELCOME

TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HP ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.



Information



Provider



Trading Partner



Pharmacy

Important Messages

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Viewing and Understanding the Care Plan – Prior Authorization Inquiry

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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.

[setup account](#)

User ID*

Password*

[login](#)

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

[reset password](#)



CHC Service Provider Workshop

Viewing and Understanding the Care Plan – Prior Authorization Inquiry

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Friday, March 28, 2014

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

home **account home** account maintenance account setup change password **Prior Authorization Search** profile maintenance reset password log out

Care Plan

Welcome, P008021184

Provider ID: 008021184 MCD

Provider AVRS ID: 008021184

Zip Code: 06032 - 1254

Your R.A.s, or 835 transactions, are being sent to:

Your download page in the Trade Files menu option.

Quick Link

- [Check E-messages](#)
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Viewing and Understanding the Care Plan – Prior Authorization Inquiry

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Help
Monday, March 31, 2014

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home **prior authorization search** care plan

Quick Link

- Web Guide - Prior Authorization Search

Provider 008021184 MCD

Prior Authorization Search

Client ID

Client Name

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assign - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Records 20



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Viewing and Understanding the Care Plan

The search results by client shows multiple PAs and services authorized.

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

Search Results

Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Authorized 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
2014084034	01	04/04/2014	04/04/2014	12	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1210Z	U2	TT							12 Per Calendar Week
2014084038	01	04/13/2014	05/03/2014	15	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial									970	5 Per Calendar Week
2014084040	01	04/13/2014	05/03/2014	6	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial								AD		2 Per Calendar Week
2014084036	01	04/01/2014	04/12/2014	6	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial								ML		3 Per Calendar Week
2014084032	01	04/01/2014	04/12/2014	80	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1210Z									40 Per Calendar Week
2014084039	01	04/13/2014	05/03/2014	15	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial									971	5 Per Calendar Week
2014084041	01	04/13/2014	05/03/2014	15	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial								ML		5 Per Calendar Week
2014084033	01	04/03/2014	04/03/2014	8	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1210Z	U2								8 Per Calendar Week
2014084035	01	04/01/2014	04/12/2014	10	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1220Z									5 Per Calendar Week

Authorized Meals include: Proc/Mod List ML = 1218Z U2 + 1220Z U2 + 1221Z U2
 Procedure Code List 970 = 1218Z + 1220Z + 1221Z

Authorized Adult Day Care include: Proc/Mod List AD = 1200Z U2 + 1201Z U2 + 1202Z U2
 Procedure Code List 971 = 1200Z + 1201Z + 1202Z



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Viewing and Understanding the Care Plan/

❑ Adding the use of Modifiers

- One Time Only Services – Modifier **U2** can be used to authorize:
 - Additional units needed on a day service is provided
 - Another day of service in an existing care plan
 - An additional frequency to an existing service
- The U2 Modifier can be authorized for all **non-medical services** except:
 - Highly Skilled Chore
 - PERS Service Installation
 - Assistive Technologies
 - Minor Home Modifications
 - Two-way PERS-ongoing service
 - Care Management



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Claim Submission Changes - 2014

Adding the use of Modifiers cont.

- Subsequent Client – Modifier **TT** can be used to authorize:
 - Service for an additional client residing in the home of a client already receiving the same service.
 - No procedure code restrictions
 - If authorized:
 - The **TT** modifier must be associated to the procedure code on the care plan/PA



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Viewing and Understanding the Care Plan

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

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

Type changes below.

Line Item 01

Service Type Code* Procedure Code [Search]

Procedure Code [Search] [Search]

Mod 1 [Search] [Search]

Mod 2 [Search] [Search]

Mod 3 [Search] [Search]

Mod 4 [Search] [Search]

Revenue Code/List [Search] [Search] [Search]

Proc/Mod List

Procedure Code List

Requested Eff./End Dates* NDC [Search]

Requested Units/Dollars* Status

Authorized Eff./End Dates

Used Units/Dollars

Available Units/Dollars

Frequency

Notes

*** No rows found ***



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Program Enhancements – April 2014 cont.

The following **procedure code list** and **procedure code/modifier list** have been added for **meal services**. A “**list code**,” when **authorized** will appear on the **PA**. However, Providers **must bill** the **procedure code or procedure code/modifier** for the service provided. **Reminder:** Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.

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



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Viewing and Understanding the Care Plan

This PA for meal service is authorized with **Procedure Code list 970** which includes billing procedure codes **1218Z, 1220Z and 1221Z**. The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

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
01	15.000	\$0.00	15.000	\$0.00	Approved						970			

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List

Procedure Code List 970 Meals -CHC

Requested Eff./End Dates* 04/13/2014 05/03/2014

Requested Units/Dollars* 15.000 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates 04/13/2014 05/03/2014

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

NDC [Search]

Status Approved

Notes

*** No rows found ***



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Viewing and Understanding the Care Plan

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

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
01	15.000	\$0.00	15.000	\$0.00	Approved							ML		

Type changes below.

Line Item 01

Service Type Code* Procedure/Mod List

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List ML

Meals - 1 Time Only

Procedure Code List

Requested Eff./End Dates* 04/13/2014 05/03/2014

Requested Units/Dollars* 15.000 \$0.00

NDC [Search]

Status Approved

Authorized Units/Dollars	15.000	\$0.00
Authorized Eff./End Dates	04/13/2014	05/03/2014
Used Units/Dollars	0	\$0.00
Available Units/Dollars	15	\$0.00
Frequency	5 Per Calendar Week	

Notes

*** No rows found ***



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Program Enhancements – April 2014 cont.

The following **procedure code list** and **procedure code/modifier list** have been added for **Adult Day Care services**. A “**list code,**” when **authorized** will appear **on the care plan**. However, Providers **must bill the procedure code or procedure code/modifier** for the service provided. **Reminder: Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.**

Adult Day Care	List Code = 971 (on care plan)
Description of Service	Procedure Code (on claim)
Full Day - Non-Medical	1200Z
Full Day - Medical	1201Z
Half Day	1202Z
Adult Day Care - One Time Only	List Code = AD (on care plan)
Description of Service	Procedure Code/Modifier (on claim)
Full Day - Non-Medical One Time Only	1200Z U2
Full Day - Medical One Time Only	1201Z U2
Half Day – One - Time Only	1202Z U2



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Viewing and Understanding the Care Plan

This PA authorizes Adult Day Care services using **Procedure Code List 971**, which includes procedure codes **1200Z, 1201Z and 1202Z**. Services relating to these codes can be provided interchangeably up to the units authorized of **5 per week from 4/13-5/3/2014**, unless otherwise indicated in the notes by the care manager.

Line Item															
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	NDC	Revenue Code	Revenue Code List
01	15.000	\$0.00	15.000	\$0.00	Approved						971				

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List 971 Adult Day Care - CHC

Requested Eff./End Dates* 04/13/2014 05/03/2014

Requested Units/Dollars* 15.000 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates 04/13/2014 05/03/2014

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

NDC [Search]

Status Approved



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Viewing and Understanding the Care Plan

Note the components of this PA for one time only Adult Day Care services authorized under **Proc/Mod list AD**. This Proc/Mod list includes the same procedure codes as in **list code 971** with an added U2 modifier designating the service as one time only. The services relating to these codes can be provided interchangeably up to **2 units** allowed per week between **4/13-5/3/2014**, unless otherwise indicated in the care plan notes.

Line Item																		
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	NDC	Revenue Code	Revenue Code List			
01	6.000	\$0.00	6.000	\$0.00	Approved							AD						
Type changes below.																		
Line Item	01																	
Service Type Code*	Procedure/Mod List											Tooth	<input type="checkbox"/>	[Search]	Authorized Units/Dollars	6.000	\$0.00	
Procedure Code	<input type="text"/>	[Search]	<input type="text"/>													Authorized Eff./End Dates	04/13/2014	05/03/2014
Mod 1	<input type="checkbox"/>	[Search]														Used Units/Dollars	0	\$0.00
Mod 2	<input type="checkbox"/>	[Search]														Available Units/Dollars	6	\$0.00
Mod 3	<input type="checkbox"/>	[Search]														Frequency	2 Per Calendar Week	
Mod 4	<input type="checkbox"/>	[Search]																
Revenue Code/List	<input type="text"/>	[Search]	<input type="text"/>	[Search]														
Proc/Mod List	AD Adult Day Care - 1 Time Only																	
Procedure Code List																		
Requested Eff./End Dates*	04/13/2014	05/03/2014														NDC	<input type="text"/>	[Search]
Requested Units/Dollars*	6.000	\$0.00														Status	Approved	
Notes																		
*** No rows found ***																		



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Viewing and Understanding the 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 paper service order or
 - ✓ the service order noted in the notes section of the PA on your secure Web account (Access Agency Upload of Service Orders)

Note: Discrepancies should be reported to the Access Agency



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Viewing and Understanding the Care Plan – PA Inquiry cont.

- **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.
 - If the procedure code on the service order is of a lesser 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.



2014 Claim Submission Changes

CHC PROVIDER WORKSHOP

CHC Service Provider Workshop

Claim Submission Changes in 2014

- The use of modifiers for non-medical services are introduced into the CT Home Care Program:
 - ✓ U2 Modifier for one time only services
 - ✓ TT Modifier for subsequent (additional client(s) in the home receiving the same service during the same visit as the primary (first) client.
- When authorized, the **U2** or TT modifiers will be associated to a procedure code on the care plan. Both the **procedure code** and **modifier(s)** **must be billed on the claim.**



CHC Service Provider Workshop

Program Enhancements – April 2014 cont.

Adult Family Living/Foster Care

- **Adult Family Living/Foster Care services were added to the CHCPE effective July 1, 2013.**
 - ✓ Providers interested in providing these services should refer to the following Provider Bulletins:
 - **PB 2014-16** – Adult Family Living/Foster Care Credentialing/Enrollment and Claim Submission Guidelines.
 - **PB 2013-50** – CT Home Care Program for Elders – Adult Family Living for service guidelines.
- The following procedure code list and procedure code/modifier list have been added for Adult Family Living/Foster Care services. A **“list code,”** when authorized will appear **on** the **care plan**. However, Providers **must bill** the **procedure code** for the service provided. **Reminder:** **Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.**



CHC Service Provider Workshop

Program Enhancements – April 2014 cont.

Adult Family Living/Foster Care Procedure Code list and Procedure Code/Modifier Code List.

Adult Family Living/Foster Care		List Code = 972 (on care plan)
Description of Service		Procedure Code (on claim)
Level 1		S5140
Level 2		5140X
Level 3		5140Y
Level 4		5140Z
Adult Family Living/Foster Care – One Time Only		List Code = FF (on care plan)
Description of Service		Procedure Code (on claim)
Level 1 - One Time Only		S5140 U2
Level 2 - One Time Only		5140X U2
Level 3 - One Time Only		5140Y U2
Level 4 - One Time Only		5140Z U2



CHC Service Provider Workshop

Access to Claim Submission

The screenshot shows the homepage of the Connecticut Department of Social Services. The header includes the department name and logo, the date 'Monday, March 31, 2014', and a 'Help' link. A navigation bar contains links for Home, Information, Provider, Trading Partner, Pharmacy Information, Claims, Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. The 'Claims' link is highlighted with a red box, and a dropdown menu is open, with 'Professional' also highlighted in red. The main content area features a large 'WELCOME' message and a list of categories: Information, Provider, Trading Partner, and Pharmacy, each with an icon and a list of sub-links. The 'Information' category includes links for Publications, Links, Important Information, RA Banner Announcements, HIPAA, and Regional Office Locations. The 'Provider' category includes links for Provider Services, Provider Search, Provider Enrollment, EHR Incentive Program, OOS Instructions/Information, and Secure Site. The 'Trading Partner' category includes links for Trading Partner Enrollment, Trading Partner Documents, and Provider Electronic Solutions Billing Instructions. The 'Pharmacy' category includes a link for Pharmacy Information. The footer contains an 'Important Messages' section.

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --

Help
Monday, March 31, 2014

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

home site map about us

Information

- Publications
- Links
- Important Information
- RA Banner Announcements
- HIPAA
- Regional Office Locations

Provider

- Provider Services
- Provider Search
- Provider Enrollment
- EHR Incentive Program
- OOS Instructions/Information
- Secure Site

Trading Partner

- Trading Partner Enrollment
- Trading Partner Documents
- Provider Electronic Solutions Billing Instructions

Pharmacy

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HP ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.

Information Provider Trading Partner Pharmacy

Important Messages



CHC Service Provider Workshop

Access to Claim Submission

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --

Monday, March 31, 2014

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

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

Quick Links

- Internet Claims Submission FAQ
- Instructions for submitting Professional claims
- Claim Resolution Guide

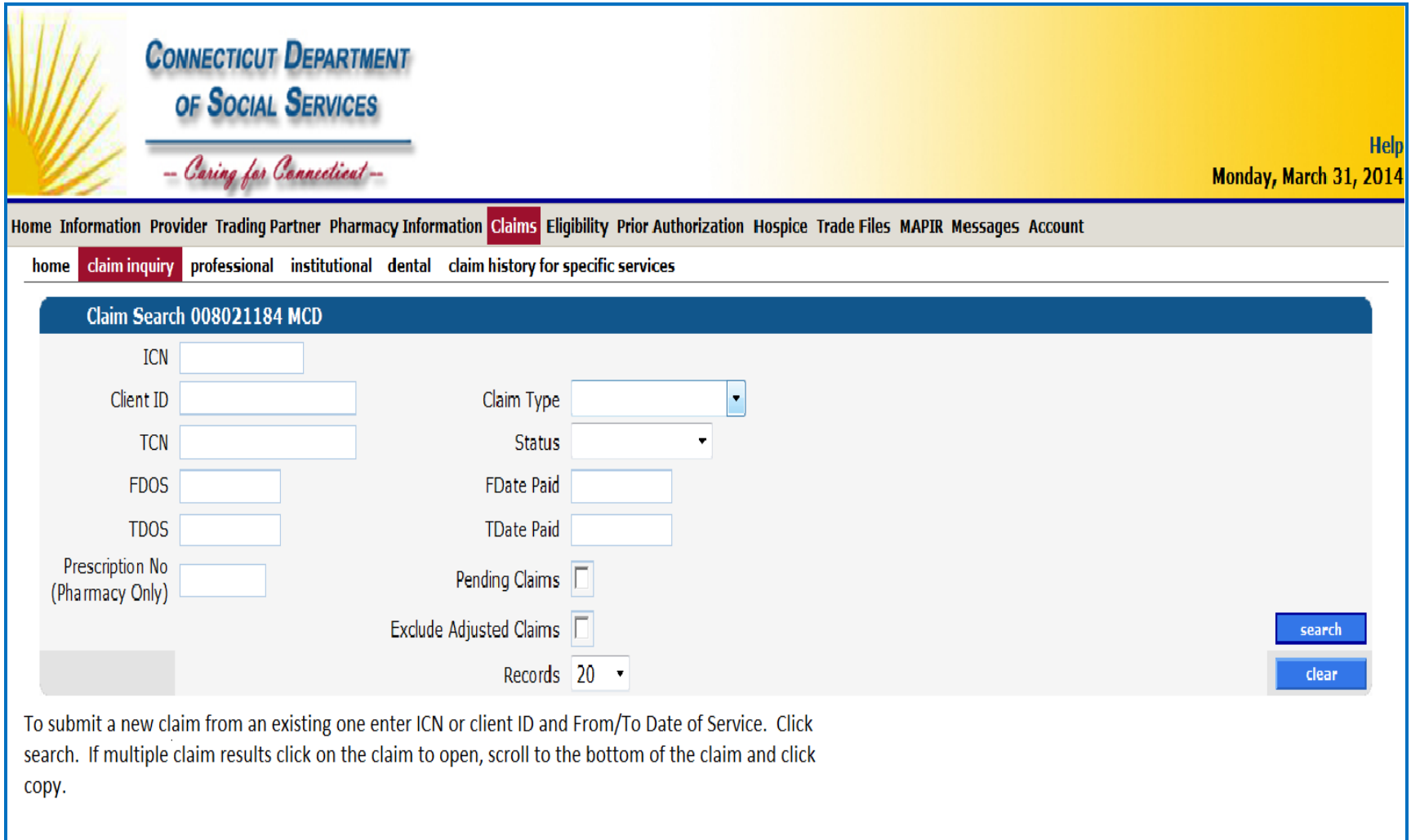
Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	008021184 MCD	To Date	<input type="text"/>
AVRS ID	008021184	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	\$0.00
First Name, MI	<input type="text"/>	Total Paid	\$0.00
Date of Birth	<input type="text"/>	TPL Amount	\$0.00
Patient Account #	<input type="text"/>	CoPay Amount	\$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	No
Referring Physician	<input type="text"/> [Search]	837 Version	5010
Accident Related	No	Accident Date	<input type="text"/>



CHC Service Provider Workshop

Access to Claim Submission



CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --

Help
Monday, March 31, 2014

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

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

Claim Search 008021184 MCD

ICN
Client ID Claim Type
TCN Status
FDOS FDate Paid
TDOS TDate Paid
Prescription No (Pharmacy Only) Pending Claims
Exclude Adjusted Claims
Records 20

To submit a new claim from an existing one enter ICN or client ID and From/To Date of Service. Click search. If multiple claim results click on the claim to open, scroll to the bottom of the claim and click copy.



CHC Service Provider Workshop

Claim Submission Points to Remember

❑ Accessing claims for inquiry or new submission

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



CHC Service Provider Workshop

Claim Submission

Prior Authorization ^A	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084032	01	04/01/2014	04/12/2014	80	1210Z									40 Per Calendar Week
2014084033	01	04/03/2014	04/03/2014	8	1210Z	U2								8 Per Calendar Week
2014084034	01	04/04/2014	04/04/2014	12	1210Z	U2	TT							12 Per Calendar Week

Detail								
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount	
A	1	04/01/2014	04/03/2014	1210Z	40.00	\$160.00	\$0.00	
A	2	04/03/2014	04/03/2014	1210Z U2	8.00	\$32.00	\$0.00	
A	3	04/04/2014	04/04/2014	1210Z U2 TT	12.00	\$48.00	\$0.00	

Type data below for new record.

Item Status

From DOS* Emergency Indicator

To DOS* Pregnancy

Procedure* [Search] EPSDT Referral

Modifiers [Search] [Search] Family Planning

Units* Allowed Amount

CoPay Amount

Facility Type Code* [Search] Medicare Paid Date

Charges* Medicare Calc Allowed Amt

Rendering Physician* [Search] Medicare Paid Amount

Referring Provider [Search] Medicare Deductible Amount

Ordering Provider [Search] Medicare Coinsurance Amount

Diagnosis Code Pointer

National Drug Code

NDC Quantity

NDC Unit of Measurement



CHC Service Provider Workshop

Submission

Claim

Prior Authorization ^A	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084035	01	04/01/2014	04/12/2014	10	1220Z									5 Per Calendar Week
2014084036	01	04/01/2014	04/12/2014	6								ML		3 Per Calendar Week

Detail

Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A 1	04/01/2014	04/03/2014	1220Z	3.00	\$27.00		\$0.00
A 2	04/04/2014	04/04/2014	1218Z	1.00	\$5.00		\$0.00
A 3	04/05/2014	04/05/2014	1220Z	1.00	\$9.00		\$0.00

Type data below for new record.

Item: 2

From DOS*: 04/04/2014

To DOS*: 04/04/2014

Procedure*: 1218Z [Search]

Modifiers: U2 [Search] [Search] [Search]

Units*: 1.00

Facility Type Code*: 12 [Search]

Charges*: \$5.00

Rendering Physician*: [Search]

Referring Provider: [Search]

Ordering Provider: [Search]

Diagnosis Code Pointer: [] [] [] []

National Drug Code: []

NDC Quantity: 0.000

NDC Unit of Measurement: []

Status: []

Emergency Indicator: No

Pregnancy: Not pregnancy Related

EPSDT Referral: None

Family Planning: No

Allowed Amount: \$0.00

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

When a list code is authorized, refer to the Procedure Code Crosswalk for codes that may be billed, based on the service provided.

delete add



CHC Service Provider Workshop

Claim Submission

Prior Authorization ^A	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084039	01	04/13/2014	05/03/2014	15									971	5 Per Calendar Week
2014084040	01	04/13/2014	05/03/2014	6								AD		2 Per Calendar Week

Detail

Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A 1	04/13/2014	04/13/2014	1201Z U2	1.00	\$75.00		\$0.00
							AD Proc/Mod 1 of 2 units authorized
A 2	04/14/2014	04/15/2014	1201Z	2.00	\$150.00		\$0.00
A 3	04/16/2014	04/16/2014	1202Z U2	1.00	\$75.00		\$0.00
							AD Proc/Mod 2 of 2 units authorized
A 4	04/17/2014	04/18/2014	1201Z	2.00	\$150.00		\$0.00

Type data below for new record.

Item	4	Status	
From DOS*	04/17/2014	Emergency Indicator	No
To DOS*	04/18/2014	Pregnancy	Not pregnancy Related
Procedure*	1201Z [Search]	EPSDT Referral	None
Modifiers	[Search] [Search]	Family Planning	No
Units*	2.00	Allowed Amount	\$0.00
Facility Type Code*	99 [Search]	CoPay Amount	\$0.00
Charges*	\$150.00	Medicare Paid Date	
Rendering Physician*	[Search]	Medicare Calc Allowed Amt	\$0.00
Referring Provider	[Search]	Medicare Paid Amount	\$0.00
Ordering Provider	[Search]	Medicare Deductible Amount	\$0.00
Diagnosis Code Pointer	[] [] [] []	Medicare Coinsurance Amount	\$0.00
National Drug Code			
NDC Quantity	0.000		
NDC Unit of Measurement			

delete add

When a list code is authorized, refer to the Procedure Code Crosswalk for codes that may be billed, based on the service provided.



CHC Service Provider Workshop

Claim Submission Points to Remember

➤ Procedure Codes

- The **Code billed** must be on the PA and must be the **same** as what is **on the paper service order or notes section on the PA**, when service is authorized by procedure code or procedure code with Modifier
 - ❖ Example: If service authorized is **1214Z U2** then **1214Z U2** must be billed on the claim.

➤ Procedure Code List or Procedure Code Modifier List

- The **List code** on the PA should not be submitted on the claim. Submit a procedure code associated with the list code for the service provided on the claim. Refer to the Procedure Code Crosswalk for codes associated to the code list on the PA.
 - ❖ Example: If **list code 970** is on the care plan, then **1218Z**, **1220Z** or **1221Z** may be billed, depending on the service provided.
 - ❖ Example: If **list code ML** is on the care plan, then **1218Z U2**, **1220Z U2** or **1221Z U2** may be billed, depending on the service provided.

Reminder: Alpha characters are case sensitive and must be submitted in upper case on both the care plan and on the claim.



CHC Service Provider Workshop

Claim Submission – Spanning Dates

Dates of service can only be **spanned** for non-medical services submitted in the professional claim format when service is provided on **consecutive dates** which span the **from and through** dates of service on the claim detail.

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

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



Claim Denials, Resolution and
Resources

CHC PROVIDER WORKSHOP

CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Claim Denials due to Client Eligibility

✓ Denial Reasons:

- **EOB 2003** - Client Ineligible for dates of service
- **EOB 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 CHC. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021).

✓ Resolution:

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



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

Client Eligibility cont.

✓ Resources:

- The Alternate Care 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 "CHC Client Eligibility Issue" in the subject line of the email.

- Providers who identify an eligibility issue upon claim denial should contact the DSS Alternate Care Unit as noted above, if the eligibility is not resolved within one month of claim denial as the DSS Alternate Care Unit receives a monthly CHC claim denial report due to client eligibility. To avoid further claim denial, check eligibility before resubmitting claim.



ELIGIBILITY VERIFICATION

Benefit Plans eligible for CHC coverage with services required to be in the Care Plan:

➤ **CHC Waiver Benefit Plans** – *(Medical and non-medical services for elder and disabled clients in the CHC Program).*

- ✓ **1915C** CHC 1915i Case Managed Clients
- ✓ **1915S** CHC 1915i Self Directed Clients
- ✓ **CBCMD** CHC Program for Disabled Adults Community Based
- ✓ **CBCMF** CHC Community Based Case Managed Waiver
- ✓ **CBCMS** CHC Community Based Case Managed State Funded
- ✓ **SDIRF** CHC Self Directed Waiver
- ✓ **SDIRS** CHC Self Directed State Funded

The following HUSKY clients may also be eligible for one of the above CHC Waiver benefit plans, but non-medical services won't be covered:

- HUSKY A
- HUSKY C

****For more information refer to section 4.4 Internet Web Site Portal Eligibility in the Chapter 4-Client Eligibility provider manual located at www.ctdssmap.com.****



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Claim Denials Related to Care Plan/PA Issues

✓ Denial Reasons:

- **EOB 3015** – CHC Care Plan Required
- **EOB 3016** -Service not Authorized on the CHC Care Plan
- **EOB 5015** - Units exceed the frequency units authorized on the care plan
- **EOB 3003** -Prior Authorization is required for payment of the service (units for the service are exhausted)



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Care Plan/PA Issues cont.

✓ Resolution:

- **EOB 3015** - A care plan must be created by the Access Agency and uploaded to the HP system.
- **EOB 3016** - A service denied for not on care plan must be added by the Access Agency to the Care plan.
- **EOB 5151** - Units of service must be added to the frequency of an existing PA by the Access Agency.
- **EOB 3003** - Units of service must be added by the Access Agency to an existing PA that is currently exhausted.



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Care Plan/PA Issues cont.

✓ Resources:

- Care Mangers create service orders and enter them in the Access Agencies Care Management System.
- The Access Agency is responsible for uploading initial care plans and changes to care plans to HP, 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 Access Agency as noted in the following contact information:



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

Access Agency Contact Information

- **Connecticut Community Care Inc. (CCCI)** has communicated a special e-mail address to their service providers. Providers with care plan issues, who service clients with service orders from CCCI, are encouraged to submit their issues to the following e-mail address:

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 HP, from and to dates of service, the type of service (SNV, homemaker, MOW, 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.



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

Access Agency Contact Information

- **Western Connecticut Area on Aging (WCAA)** - Providers with care plan issues who service clients with service orders from WCAA should contact WCAA directly at **(203)465-1000**.
- ✓ **Please have the following information available when contacting WCAA:** client name, the client EMS number, the type of service (SNV, homemaker, MOW, etc.), the dates of service, the frequency of service and the number of units or hours per visit.



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

Access Agency Contact Information

➤ **South Western Connecticut Area on Aging (SWCAA)** - Providers with care plan issues who service clients with service orders from SWCCA should contact SWCAA Operations at SWCAABillings@swcaa.org.

✓ **Please have the following information available when contacting SWCAA:** client name, the client EMS number, the type of service (SNV, homemaker, MOW, etc.), the dates of service, the frequency of service and the number of units or hours per visit.



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

Access Agency Contact Information

Agency on Aging of South Central Connecticut (AASCC) - has communicated via e-mail to their service providers that they have set up a special contact e-mail address and telephone number. Providers who service clients with service orders from AASCC who have questions can direct their inquiries to: **pcaldwell@aoascc.org**.

For those companies that do not have secure e-mail, please fax your service order inquiries to (203)752-3064, Attention: Peggy Caldwell or contact her directly at (203)752-2947. Due to the high volume of inquiries AASCC requests your primary source of communication to them be by e-mail or fax.



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

Department of Social Services Contact Information

- **Department of Social Services (DSS)** – For Self Directed clients on the CHCPE Program, please **contact Amy Dumont directly via e-mail at amy.dumont@ct.gov.**



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Care Plan/PA Issues cont.

- Care plans or changes to care plans that are not viewable via the provider's secure Web portal within seven (7) days of issuance may be the result of the Access Agency experiencing an upload issue to HP due to:
 - Service overlaps
 - Claims paid against a PA for dates of service on or after a required service order change. (Hospital Admission)
- These types of upload issues take time to resolve so it is important to confirm service order requests or changes have been uploaded as soon as possible to avoid unnecessary claim denials or further delay in prior authorization upload.



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Claim Denials Due to Provider Error

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



CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Provider Error cont.

✓ Claim denials due to:

- **EOB 3003**- Prior Authorization is required for payment of this service or

- **EOB 5151**- Units exceed frequency units on CHC care plan

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

✓ Claim denials due to:

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

May be the result of submitting non-medical services under the provider's Home Health provider number.



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 749 - Modifier U2 not allowed (New Edit)

Cause:

If the claim is submitted with a U2 modifier for one of the following services:

Highly Skilled Chore

Minor Home Modifications

PERS Service Installation

Two-way PERS-ongoing service

Assistive Technologies

Care Management

Resolution:

Claim must be resubmitted without the U2 modifier.



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

- **Check client eligibility on clients coming on service.**
 - Contact DSS Alternate Care unit immediately with clients who are not eligible for a CHC benefit at AlternateCare.dss@ct.gov.
 - Be sure to include requested data to expedite the process
 - Set up a periodic check system to determine when the client is eligible so claims may be submitted, if applicable.
 - Note: most issues of client ineligibility are resolved within a few days of notification.



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

- **Check the client's care plan (PA)** to be sure the services you have been requested to provide have been authorized.
 - ✓ Review the care plan carefully to ensure all services to be provided are on the initial care plan/PA.
 - ✓ Report discrepancies to the appropriate Access Agency 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.



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

➤ Claim submission review

- Prior to submitting claims be sure services provided match service authorized and services to be billed.
- ✓ Identify discrepancies early to avoid over service or potential billing errors which may cause claims to deny such as:
 - Exceeding units on a claim frequency.
 - Omission of a modifier on a claim detail(s).
 - Spanning dates of service across frequencies or PA line details.



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

➤ **Claim submission review**

- Submit claims electronically and/or via the web rather than on paper to:
 - Minimize claim submission time by:
 - ✓ Copying a prior paid claim, especially when billing for like services, minimizes changes needed for resubmission
 - ✓ Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces key strokes and the number of details on a claim.

Example: a homemaker service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 10/7/14 to 10/9/14 1214Z for 30 units.

- Maximize reimbursement time
- Reduce claim errors due to poorly aligned claim data fields



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

➤ 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 Alternate Care unit.
- ✓ Submit care plan discrepancies not already addressed to Access Agency.
- ✓ Reconcile RA for the current cycle before receiving next RA to identify problems early to avoid major reimbursement issues.
 - Refer to list of EOB code descriptions at the end of the RA to determine reason(s) for denial.
 - Use Claim Resolution Guide (**Chapter 12** of Provider Manual) to determine the cause of a denial and its resolution.
 - Use Claim Submission **Chapter 8** for CHC Providers to determine claim resolution.
 - Contact HP Call Center with issues you cannot resolve.



CHC Service Provider Workshop

PROGRAM RESOURCES

CHC Service Provider Workshop

CHC Program Resources

➤ CHC Procedure Code Crosswalk

- ✓ Contains authorized codes and associated billing codes
- ✓ Service descriptions
- ✓ Unit increments
- ✓ Billing Provider (Allied or CHC Service Provider)
- ✓ If spanning code is allowed
- ✓ Valid frequency (which can be used by Access Agency to authorize the service)

This document can be found as a link in Chapter 8 of the CHC Provider manual in the modifier section of the claim submission instructions.

This document can also be found in the “Welcome to the CT Home Care Implementation” Important Message located on the www.ctdssmap.com Home page.



CHC Service Provider Workshop

CHC Program Resources

➤ **Provider Manual (Important CHC Chapters)**

- ✓ Chapter 7 (CHC Policy)
- ✓ Chapter 8 (Claim Submission Instructions)
- ✓ Chapter 12 (Claim Resolution Guide)
 - This chapter is also a link on the provider secure Web portal. Click on claims then on professional.
- ✓ Chapter 10 (Web Portal)

➤ **Web Claim Submission Instructions**

- ✓ Located on secure web account
- ✓ Under claims select professional
- ✓ Click on the claim submission instructions link in the upper left portion of the screen.
- CHC Important Message – Welcome to the CT Home Care Program Implementation located on the www.ctdssmap.com Web site.

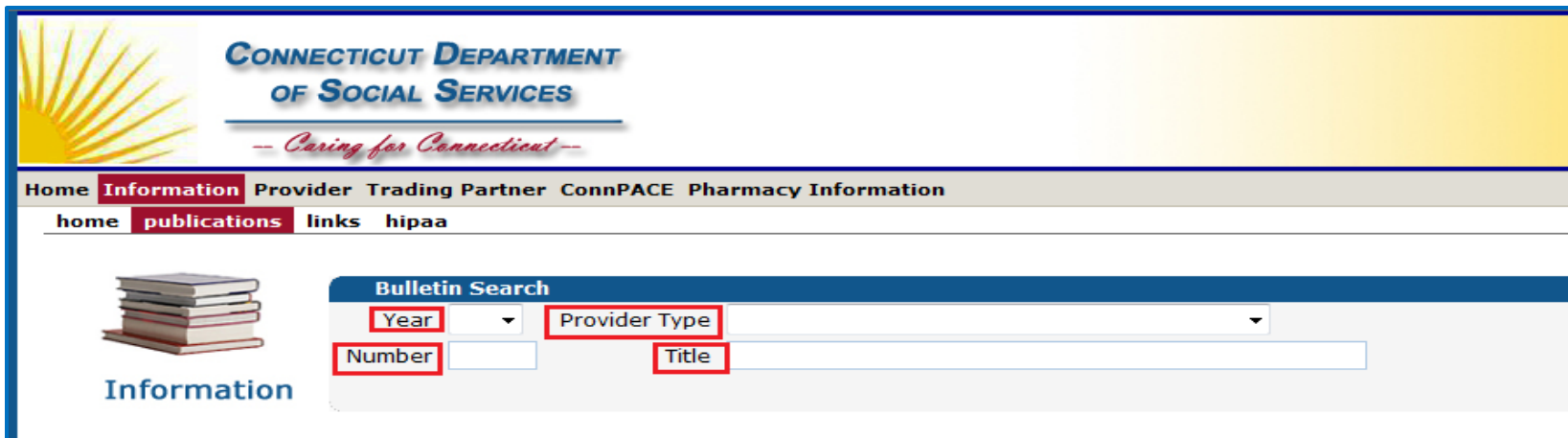


INFORMATION-PROVIDER BULLETINS

➤ Provider Bulletins:

Publications mailed 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.



The screenshot displays the website for the Connecticut Department of Social Services. At the top left is a logo with a sunburst and the text "CONNECTICUT DEPARTMENT OF SOCIAL SERVICES" and the tagline "-- Caring for Connecticut --". Below this is a navigation menu with links: Home, Information (highlighted), Provider, Trading Partner, ConnPACE, and Pharmacy Information. Under the "Information" link, there are sub-links: home, publications (highlighted), links, and hipaa. On the left side, there is an icon of a stack of books and the word "Information". The main content area features a "Bulletin Search" section with four input fields: "Year" (a dropdown menu), "Provider Type" (a dropdown menu), "Number" (a text input field), and "Title" (a text input field). Each of these four fields is highlighted with a red rectangular box.

INFORMATION – PROVIDER MANUAL

[\(Provider Manual\) Homepage > Information > Publications > Provider Manuals at **www.ctdssmap.com**.](#)

- The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission.
- It is the primary source of information for submitting CMAP claims and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions.
- 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 – PROVIDER MANUAL

Chapter 1 – Introduction

- Provides information on the CT Medical Assistance Program, (CMAP) the Department of Social Services' and Hewlett-Packards' 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.



INFORMATION – PROVIDER MANUAL

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 Remittance Advice.

Chapter 7- Regulations/Program Policy

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

Chapter 8 – Billing Instructions

- Provides information on provider specific billing requirements.



INFORMATION – PROVIDER MANUAL

Chapter 9 – Prior Authorization

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

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

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

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.



CONTACTS

- **HP Provider Assistance Center (PAC)**
 - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
 - CTDSSMAP-ProviderEmail@hp.com
- **HP Electronic Data Interchange (EDI) Help Desk**
 - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
- **Connecticut Community Care (CCI)- serviceauthissues@ctcommunitycare.org.**

Providers must include the following information when submitting service authorization issues to CCI: provider name, client name, client EMS number, CCI number, EOB code on rejecting claim at HP, from and to dates of service, the type of service (SNV, homemaker, MOW, etc.), the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCI service order number, if available and any comments the provider wishes to communicate to CCI.
- **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, the type of service (SNV, homemaker, MOW, etc.), the dates of service, the frequency of service and the number of units or hours per visit.



CONTACTS

- **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 (SNV, homemaker, MOW, etc.), the dates of service, the frequency of service and the number of units or hours per visit.
- **South Central Connecticut Area on Aging (SCCAA)- pcaldwell@aoascc.org. Companies without secure e-mail, please fax service order inquiries to (203)752-3064, Attention Peggy Caldwell or contact her directly at (203)752-2947.** Due to the high volume of inquiries AASCC requests your primary source of communication to them be by e-mail or fax.
- **Department of Social Services (DSS) – For Self Directed clients on the CHCPE Program, please contact Amy Dumont directly via e-mail at amy.dumont@ct.gov.**
- **www.ctdssmap.com**



CHC Service Provider Workshop

Time for questions