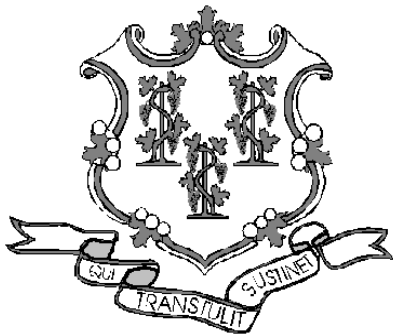




Connecticut Department
of Social Services

Making a Difference

CHC Service Provider Workshop



Presented by

The Department of Social Services
& Hewlett Packard Enterprise



**Hewlett Packard
Enterprise**

CHC Service Provider Workshop

Agenda

➤ **What's New in 2016**

- ✓ Provider Enrollment for New CT Home Care Program Services
- ✓ Elimination of Paper Claims
- ✓ Electronic Visit Verification
 - ✓ Implementation
 - ✓ Online Trainings

➤ **Connecticut Home Care Program Review**

- ✓ Client Eligibility/Resolution

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Agenda

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



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WHAT'S NEW IN 2016 – A REVIEW OF CURRENT CONNECTICUT MEDICAL ASSISTANCE PROGRAM CHANGES

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Program Updates - 2016

➤ **Provider Enrollment for New CT Home Care Program Services**

- Effective July 1, 2015 the following new services were added and billable as of the effective date:

- »1321Z Care Transitions (Access Agencies only)

- »1322Z Bill Payer

- »1333Z Chronic Disease Self- Management

- »1213M Recovery Assistant Agency

- »2040Z Support Broker

- »2030Z Support Broker Individual

* For full service definitions please refer to [Provider Bulletin 2015 - 63 - Provider Enrollment for New CT Home Care Program Services](#)

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Program Updates - 2016

➤ Elimination of Paper Claims

- Effective October 1, 2016, the Department of Social Services (DSS) no longer accepts paper claims for processing.
- Paper claims submitted to Hewlett Packard Enterprise on or after October 1, 2016 will be returned to the provider.
- Out of State providers who currently submit paper claims are excluded from this mandate along with any provider claims that are submitted to Hewlett Packard Enterprise for special handling, such as timely filing overrides.

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Program Updates - 2016

➤ Electronic Visit Verification

- Electronic Visit Verification (EVV) is an in-home visit scheduling, tracking and billing system that employs controls with in the delivery of home based services to ensure client's quality of care. The EVV system will be specifically configured to support DSS HCBS program requirements.
- Implementation dates:
 - Non-medical services - **TBD**
 - Home Health related services - **TBD**

*** Non-medical service providers who fail to implement EVV by **TBD** will experience claim denials for services that are mandated for EVV use.**

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Program Updates - 2016

➤ **Electronic Visit Verification (cont.)**

- **EVV Welcome Kit**

- In order to receive your EVV Welcome Kit, you are required to complete mandated training located on the Learning Management System (LMS) Web site.
- If you have not begun and/or completed the mandatory EVV training, you must enroll in the Learning Management System. LMS is a web-based learning system that will provide the training and documentation needed to request and receive your Welcome Kit. Additional training videos are also available for your convenience
 - LMS enrollment instructions and Web site links can be found on the www.ctdssmap.com Web site > Information > click on “Electronic Visit Verification Implementation” > page 3

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Program Updates - 2016

➤ **Electronic Visit Verification (cont.)**

- Your Welcome Kit email will include:
 - **Getting Started Document:** Includes details on how to access your HIPAA compliant EVV system.
 - **Agency Specific Call Reference Guide:** Includes your agency specific toll-free lines (English and Spanish); EVV telephony instructions can be referenced by your staff during home health encounters.
 - **Agency Specific Getting Started Brochure:** Includes your agency Web URL and administrative login and password.
 - **User Securities and Set up:** Includes the details on setting up your agency's office staff in the Santrax Payer Management (SPM) System.
 - **What to do when you get your SPM Database:** Includes what each agency must do when you have access to your SPM system.
 - **Task List (English/Spanish):** A directory of possible services that may take place during an encounter.

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Program Updates – 2016

➤ **Electronic Visit Verification (cont.)**

Caregiver Preparation

- To provide the caregivers with a better understanding of the EVV Project, Sandata will be providing several videos showing the three methods that a caregiver may use to log their time in the EVV system.
- 1. The **Santrax EVV Telephony** call-in and call-out demonstration video outlines the Santrax calling steps.
- 2. The **Mobile Visit Verification** device check-in and check-out demonstration video outlines the steps when using the mobile device.
- 3. The **Santrax Fixed Visit Verification (FVV)** demonstration video outlines the steps used when a telephone is not available for use during the visit.

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Program Updates – 2016

➤ **Electronic Visit Verification (cont.)**

Care Plan and Eligibility in EVV

**** Note: Care Plan prior authorizations will continue to be viewable via the portal.***

- Access agencies are required to enter a care plan within seven (7) days from the initial assessment. Once an authorization has been created from the care plan, it will be automatically sent to the EVV system. The EVV system will also receive any new or changed authorizations at least daily to ensure the EVV system is up to date.
- Visits often occur prior to the care plan being in the portal. You will want to complete EVV for the visit (Check in and out) and once the authorization is received in the EVV system, the visit can be confirmed. The claim can then be submitted to Hewlett Packard Enterprise via the EVV system once the authorization is received.

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Program Updates – 2016

➤ **Electronic Visit Verification (cont.)**

Care Plan and Eligibility in EVV (cont.)

- Eligibility **must** be verified prior to billing clients.
 - » Just because a client is located in the EVV system does not automatically mean they are eligible.
- If a client is unable to be setup in HPE due to eligibility issues and the caregiver is unable to enter a service authorization:
 - » A check-in/check-out can still occur, however, an exception in the EVV system will occur indicating an unknown client and unscheduled visit occurred. The Community Options 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 HomeandCommunityBasedServices.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, CHC or PCA Waiver Client Eligibility Issue" in the subject line of the email.

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Program Updates – 2016

➤ **Electronic Visit Verification (cont.)**

Additional Information

- Electronic Visit Verification Implementation Important Message
 - ctdssmap.com Web site > Information
 - Revised often with the most up-to-date information
 - Frequently Asked Questions (FAQs)
 - Learning Management System Enrollment Instructions and Web site links
 - Refresher Training videos
 - EVV Service Code Listing
 - EVV publications list
 - Interface Specifications
 - Reason Code/Task lists

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Program Updates – 2016

➤ **Electronic Visit Verification (cont.)**

EVV contacts

- For questions and issues related to prior authorizations, claims and the EVV implementation please send an email to the following e-mail address: ctevv@hpe.com
- For questions and issues related to the Santrax software please send an email to the following email address: ctcustomer@sandata.com
- Sandata CT EVV Customer Care Number (toll free) **1-855-399-8050**
 - » ***Remember to document your call tracking number for both your records and to provide to HPE if you need further assistance.***



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DETERMINING AND RESOLVING ELIGIBILITY ISSUES

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Access to Secure Web Account

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization

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
- Secure Site

Trading Partner

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

Pharmacy

- Pharmacy Information

Email Subscription

- Register/Update Email Subscription





Server:
VM A

Daily Downtime:
12:00 AM - 12:10 AM EST

WELCOME

TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HEWLETT PACKARD ENTERPRISE 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

- [Attention All Providers: New Eligibility System \(Posted 10/12/16\)](#)
- [Hospital Monthly Important Message \(Updated 10/12/16\)](#)
- [Important Electronic Visit Verification \(EVV\) Notice \(Posted 10/7/16\)](#)
- [Electronic Visit Verification Implementation \(Updated 10/6/16\)](#)
- [Revised Provider Manual Chapters \(Updated 10/4/16\)](#)
- [CMAP Addendum B Updated \(9/30/16\)](#)
- [Frequently Asked Questions \(FAQs\) - Provider Bulletin PB16-31 \(Updated 9/16/16\)](#)
- [Important ABI Reminders and Updates](#)
- [Long Acting Reversible Contraception \(LARC\) FAQs](#)
- [ACA Enhanced Provider Enrollment Requirements - Fingerprint Based Criminal Background Checks \(FCBC\)](#)
- [Attention Dental Providers: Adult Reimbursement Rate Issue \(Posted 9/7/16\)](#)
- [CMAP Medicaid Access Monitoring Review Plan \(AMRP\)](#)

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Access to Secure Web Account

The screenshot shows a web browser window with a navigation menu at the top. The menu items are: Home, Information, **Provider**, Trading Partner, Pharmacy Information, home, provider enrollment, provider re-enrollment, provider enrollment tracking, provider matrix, provider services, provider search, drug search, provider fee schedule download, ehr incentive program, oos instructions/information, and **secure site**. Below the menu is a blue header with the word "Login". The main content area contains the following text: "The Connecticut Department of Social Services Medical Assistance Program secure website is intended for providers, clerks and billing agents." followed by "If you have received your Personal Identification Number letter, click on the setup account button." Below this is a blue button labeled "setup account". A red rectangular box highlights the login form, which includes a "User ID*" field, a "Password*" field, and a blue "login" button. Below the login form is the text "If you have forgotten your password please click the reset password button." and a blue "reset password" button.

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Web Access

Eligibility Verification

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

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

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

- Valid Search Combinations
- Client ID + SSN
 - Client ID + Birth Date
 - Birth Date + SSN
 - Full Name + SSN
 - Full Name + Birth Date

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID	<input type="text"/>	last name	DOE	From DOS*	09/01/2014
SSN	666-55-4444	First Name, MI	JOHN	To DOS*	09/30/2014
Birth Date	<input type="text"/>				
Service Type Code 1	<input type="text"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

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

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 are covered under any of the benefit plans indicated in the list below. As long as the client is eligible for one of the plans, there is no change in services covered when the client moves from one plan to another).*
 - ✓ **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

Note: Clients enrolled in a HUSKY A or C benefit plan only are not eligible for non-medical CHC services.

- HUSKY A
- HUSKY C

For more information refer to section **4.4 Provider Secure Web Site Eligibility Verification in the [Chapter 4-Client Eligibility](#) provider manual located at www.ctdssmap.com.

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Determining and Resolving Eligibility Issues

Client Eligibility cont.

✓ Resources:

- Community Options (formerly the Alternate Care Unit) at Department of Social Services (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 HomeandCommunityBasedServices.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 Community Options Unit as noted above. To avoid further claim denial, check eligibility before resubmitting claim.



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VIEWING AND UNDERSTANDING THE CARE PLAN

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Viewing and Understanding the Care Plan – Prior Authorization Inquiry

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

home **account home** account maintenance account setup change password **Prior Authorization Search** hic 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](#)
- [Claim Status Inquiry](#)
- [Client Eligibility Verification](#)
- [Prior Authorization Inquiry](#)
- [Download Remittance Advices](#)
- [ACA Ordering/Prescribing/Referring Provider List](#)

Global Messages
*** No rows found ***

Secure Mailbox
*** No rows found ***

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CHC Service Provider Workshop

Viewing and Understanding the Care Plan – Prior Authorization Inquiry

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

home prior authorization search care plan

Quick Link

- Web Guide - Prior Authorization Search

Provider 008021184 MCD

Prior Authorization Search

Client ID <input type="text"/>	Prior Authorization <input type="text"/>
Client Name	PA Assignment <input type="text"/>
Requested Eff Date <input type="text"/>	PA Assign - Sub <input type="text"/>
Requested End Date <input type="text"/>	Procedure <input type="text"/> Search]
Authorized Eff Date <input type="text"/>	Revenue Code <input type="text"/> [Search]
Authorized End Date <input type="text"/>	Proc/Mod List <input type="text"/>
	Records 20 <input type="text"/>

CHC Service Provider Workshop

Viewing and Understanding the Care Plan

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

Search Results																			
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

CHC Service Provider Workshop

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] COMPANION SERVICE - AGENCY

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List

Procedure Code List

Requested Eff./End Dates*

Requested Units/Dollars*

NDC [Search]

Status Auto Approved for Care

Authorized Units/Dollars 12.000 \$0.00

Authorized Eff./End Dates

Used Units/Dollars \$0.00

Available Units/Dollars \$0.00

Frequency

Notes

*** No rows found ***

CHC Service Provider Workshop

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 ***

CHC Service Provider Workshop

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

Procedure Code List Meals - 1 Time Only

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 ***

CHC Service Provider Workshop

Viewing and Understanding the Care Plan

- 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 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	Revenue Code NDC	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

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

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

CHC Service Provider Workshop

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 [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 AD

Procedure Code List

Requested Eff./End Dates* 04/13/2014 05/03/2014 NDC [Search]

Requested Units/Dollars* 6.000 \$0.00 Status Approved

Authorized Units/Dollars 6.000 \$0.00

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

Used Units/Dollars 0 \$0.00

Available Units/Dollars 6 \$0.00

Frequency 2 Per Calendar Week

Notes

*** No rows found ***

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Viewing and Understanding the Care Plan

- 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

➤ Modifiers used in the Connecticut Home Care Program include:

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

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

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

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Viewing and Understanding the Care Plan

- **Modifiers used in the Connecticut Home Care Program cont.**
 - ✓ Modifier **TT - Subsequent Client** 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 – Prior Authorization Review

➤ **Non-Medical Connecticut Home Care Services may be authorized by:**

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

CHC Service Provider Workshop

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.
- Providers should also refer to the procedure code crosswalk for unit increments which should match back to the number of hours the service was authorized.

CHC Service Provider Workshop

Viewing and Understanding the Care Plan

- **CHCPE 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 Connecticut Home Care Program.
- Providers should access the [CHCPE 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 Beacon Health Options)
 - ✓ Funding Source that covers the service

Home Health Agency Provider Workshop

Claim Submission Points to Remember

- **CHCPE Procedure Code Crosswalk** – can be obtained on the www.ctdssmap.com Web site.
- ✓ From the Home page > publications > provider manuals > chapter 8 CHC Provider Manual > Claim Submission Instructions > field 24d.



CHC Service Provider Workshop

CLAIM SUBMISSION GUIDELINES

CHC Service Provider Workshop

Access to Claim Submission

The screenshot displays the website's navigation bar with the following items: Home, Information, Provider, Trading Partner, Pharmacy Information, Claims, Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. A dropdown menu is open under 'Claims', listing: Claim Inquiry, Professional, Institutional, Dental, Claim History for Specific, and Services. The 'Professional' option is highlighted with a red box. Below the navigation bar, there are sections for '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), and 'Trading Partner' (Trading Partner Enrollment, Trading Partner Documents, Provider Electronic Solutions Billing Instructions). The main content area features a large 'WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM' graphic and a paragraph of introductory text. Below this, four icons represent 'Information' (stack of books), 'Provider' (stethoscope), 'Trading Partner' (key), and 'Pharmacy' (pill bottle). A blue bar at the bottom contains the text 'Important Messages'.

CHC Service Provider Workshop

Access to Claim Submission

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

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	<input type="text" value="1"/>	Status	<input type="text"/>
From DOS*	<input type="text"/>	Emergency Indicator	<input type="text" value="No"/>
To DOS*	<input type="text"/>	Pregnancy	<input type="text" value="Not pregnancy Related"/>
Procedure*	<input type="text"/> [Search]	EPSDT Referral	<input type="text" value="None"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	<input type="text" value="No"/>
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	<input type="text" value="\$0.00"/>
Units*	<input type="text" value="1.00"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	<input type="text" value="\$0.00"/>	Medicare Calc Allowed Amt	<input type="text" value="\$0.00"/>
Rendering Physician*	<input type="text"/> [Search]	Medicare Paid Amount	<input type="text" value="\$0.00"/>
SSN	<input type="text"/>	Medicare Deductible Amount	<input type="text" value="\$0.00"/>
Referring Provider	<input type="text"/> [Search]	Medicare Coinsurance Amount	<input type="text" value="\$0.00"/>
Ordering Provider	<input type="text"/> [Search]	Diagnosis Code Pointer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		National Drug Code	<input type="text"/>
		NDC Quantity	<input type="text" value="0"/>
		NDC Unit of Measurement	<input type="text"/>

- In the Detail Section enter the procedure code, date of service, units of the procedure, total charges for the service. If applicable, enter the rendering provider NPI.
- To enter additional procedures, click on the button within the Detail Panel and enter the required information.
- *Do not click on the button after you've entered the last procedure for the client/date of service.*

CHC Service Provider Workshop

Access to Claim Submission

Diagnosis Panel

Diagnosis					
Diag-Sequence ▲	Diagnosis	Description			
Code Set	ICD 10 ▼				
Principal	<input type="text"/>	[Search]	Other 1	<input type="text"/>	[Search]
			Other 2	<input type="text"/>	[Search]
Other 3	<input type="text"/>	[Search]			

CHC Service Provider Workshop

Access to Claim Submission

TPL Panel

TPL

Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
A 060	BC/BS OF CONNECTICUT	UPX8289514	\$0.00						

Type data below for new record.

Client Carriers: 060 - BC/BS OF CONNECTICUT

Carrier Code: 060 [Search]

Plan Name: BC/BS OF CONNECTICUT

Policy Number: [Search]

Paid Amount*: \$100.00

Paid Date*: 06/01/2016

Relationship: [Search]

Last Name: [Search]


First Name, MI: [Search]

Date of Birth: [Search]

Adjustment Reason Code: [Search] [Search] [Search]

Adjustment Amount: \$0.00 \$0.00 \$0.00

delete add

- Medicaid is always the payer of last resort. If the client has Other Insurance (OI) primary, the provider should bill that carrier first.
- The OI information can be entered in the TPL panel by first clicking on the  button in the TPL panel.
- The required fields are Carrier Code for the OI, Paid Amount and Paid Date.
- The three digit Carrier Code can be found on the client eligibility verification screen under TPL Information, or in the drop down "Client Carriers" field in the TPL panel on the Claim screen.

CHC Service Provider Workshop

Access to Claim Submission

Claim Status Panel

Claim Status Information	
Claim Status	Not Submitted yet

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

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

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

- Claim Status Information Panel shows the status of the claim.
- Once a claim is submitted, it processes in real time and assigns an Internal Control Number (ICN) to the claim. The Claim Status will show if it has been submitted, paid, denied or suspended.
- Claim Status on a paid claim will show the paid amount.
- Claim Status on a processed claim will also show the Explanation of Benefit (EOB) codes that post at the header of the claim and at the details.

CHC Service Provider Workshop

Access to Claim Submission

Claim Status Panel

[Web Claim function buttons](#)

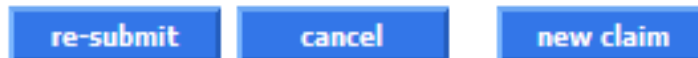
New Claim



Paid claim



Denied claim



Suspended claim



CHC Service Provider Workshop

Access to Claim Submission

Web Claims Submission – Error Messages

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


The following messages were generated:

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

The error message will point to the Panel, the Field and the Row where the error has occurred.

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

Type data below for new record.

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

CHC Service Provider Workshop

Access to Claim Submission

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

- *ICN, From and Through Dates of Service, From and Through Dates of Payment, or check the Pending Claims box.*

The screenshot shows a web application interface for claim submission. At the top, there is a navigation menu with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Claims (highlighted), Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below this is a sub-menu with links: home, claim inquiry (highlighted), professional, institutional, dental, and claim history for specific services. The main content area is titled "Claim Search 008021184 MCD" and contains several input fields and checkboxes. On the left side, there are input fields for ICN, Client ID, TCN, FDOS, TDOS, and Prescription No (Pharmacy Only). On the right side, there are dropdown menus for Claim Type and Status, and input fields for FDate Paid and TDate Paid. Below these are checkboxes for Pending Claims and Exclude Adjusted Claims. At the bottom right, there are "search" and "clear" buttons. A "Records" dropdown menu is set to "20".

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

TCN

FDOS

TDOS

Prescription No (Pharmacy Only)

Claim Type

Status

FDate Paid

TDate Paid

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

Access to Claim Submission

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Medical Care Advisory Committee **Claims** Eligibility Prior Authorization

Hospice Trade Files MAPIR Messages Account

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

Claim Search 16161616 NPI

ICN	<input type="text"/>	Claim Type	<input type="text" value="v"/>
Client ID	<input type="text"/>	Status	<input type="text" value="v"/>
TCN	<input type="text"/>	FDate Paid	<input type="text"/>
FDOS	<input type="text" value="06/01/2016"/>	TDate Paid	<input type="text"/>
TDOS	<input type="text" value="07/07/2016"/>	Pending Claims	<input type="checkbox"/>
Prescription No (Pharmacy Only)	<input type="text"/>	Exclude Adjusted Claims	<input type="checkbox"/>
		Records	<input style="border: 1px solid black; width: 30px;" type="text" value="20"/> <input type="text" value="v"/>

Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Status	Date Paid	Amount Billed	Amount Paid
2216187050005	003411489	DAVE PARKER		06/27/2016	06/27/2016	Paid	07/09/2016	\$200.00	\$184.00
2216188050001	005153371	BOD T AMERICHOICE		06/27/2016	06/27/2016	Paid	07/09/2016	\$200.00	\$156.8
5916187001006	003411489	DAVE PARKER		07/01/2016	07/01/2016	Denied	07/09/2016	\$188.00	\$0.00
5916187001007	003623539	TOM DENT		07/01/2016	07/01/2016	Denied	07/09/2016	\$188.00	\$0.00
2216187050001	003623539	TOM DENT		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	\$188.00	\$51.48
5916187001004	003623539	TOM DENT		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	\$188.00	\$85.28
2216188050003	005153371	BOD T AMERICHOICE		07/06/2016	07/06/2016	Paid	07/09/2016	\$100.00	\$81.00
2216187050002	003411489	DAVE PARKER		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	\$188.00	\$100.00
2216187050003	003623539	TOM DENT		07/05/2016	07/05/2016	Paid	07/09/2016	\$188.00	\$85.28
2216187050004	003411489	DAVE PARKER		07/05/2016	07/05/2016	Paid	07/09/2016	\$188.00	\$146.00
5916188001002	005153371	BOD T AMERICHOICE		07/06/2016	07/06/2016	Denied	07/09/2016	\$100.00	\$0.00
2216188050002	005153371	BOD T AMERICHOICE		07/06/2016	07/06/2016	Adj/Voided	07/09/2016	\$100.00	\$81.00
5916187001005	003411489	DAVE PARKER		07/01/2016	07/01/2016	Adj/Voided	07/09/2016	\$188.00	\$146.00

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 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.*

CHC Service Provider Workshop

CT HOME CARE PROGRAM FOR ELDERS (CHCPE) REVIEW – MONTHLY CLAIMS REPROCESSING

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing

Systematic Monthly Claims Reprocessing:

- 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.

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing cont.

Systematic Monthly Reprocessing

- In the first cycle of each month, HPE 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 HPE will reprocess, deny and/or pay claims posting to the correct PA/PA line detail (Region 24 claims = a new day claim).

For example: **changes made to PAs in May 2016** by the Access Agency will result in claims being **voided** (region 52) and **reprocessed** (region 24) in **the first cycle of July 2016**.

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

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing 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.

CHC Service Provider Workshop

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	EORS
CLIENT NAME: Sally Client												
CLIENT NO.: 0000000000												
1	2200000000000	060314	061214	(116.16)		(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
HEADER EORS: 8236												

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing 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.

CHC Service Provider Workshop

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
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS PAID

Date: 10/15/2014
PAGE: 2

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.:

L	2400000000000	060214 061214	116.16	75.00	0.00	0.00	0.00	0.00	0.00	75.00	0.
---	---------------	---------------	--------	-------	------	------	------	------	------	-------	----

PL	SERV	PROC	CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL	EOBS
						FROM THRU	PROVIDER	AMOUNT	AMOUNT		
	12	1210Z			20	060214 061214	MCD	116.16	75.00		

Header EOB: 8238

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing 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.

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

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing 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.

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing 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

CHC Service Provider Workshop

CHCPE Monthly Claims Reprocessing 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:
 - HPE is requesting providers **stop submitting claim adjustments** that will process against these PAs.



Home Health Agency Provider Workshop

CLAIM DENIALS, RESOLUTION AND RESOURCES

CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Claim Denials due to Client Eligibility

✓ Denial Reasons:

- **EOB code 2003** - Client Ineligible for dates of service
- **EOB code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have 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

- **Claim Denials Related to Care Plan/PA Issues**
 - **EOB code 3015** – CHC Care Plan Required
 - Resolution: A care plan must be created by the Access Agency and uploaded to the HPE system.
 - **EOB code 3016** -Service not Authorized on the CHC Care Plan
 - Resolution: A service denied for not on care plan must be added by the Access Agency to the Care plan.

CHC Service Provider Workshop

Claim Denials, Resolution and Resources

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

- **EOB code 5151** – Units exceed the frequency units authorized on the care plan
 - Resolution: Units of service must be added to the frequency of an existing PA by the Access Agency.
- **EOB code 3003** - Prior Authorization is required for payment of the service (units for the service are exhausted)
 - Resolution: Units of service must be added by the Access Agency to an existing PA that is currently exhausted.

CHC Service Provider Workshop

Claim Denials, Resolution and Resources

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

✓ Resources:

- Care Managers 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 HPE, 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.

CHC Service Provider Workshop

Claim Denials, Resolution and Resources

- Claim Denials Related to Care Plan/PA Issues cont.
 - ✓ Care plans or changes to care plans that are not viewable via the provider's secure Web portal within seven (7) days of issuance may be the result of the Access Agency experiencing an upload issue to HPE due to:
 - Service overlaps
 - ✓ These types of upload issues take time to resolve so it is important to confirm service order requests or changes have been uploaded as soon as possible to avoid unnecessary claim denials or further delay in prior authorization upload.

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

CHC Service Provider Workshop

Claim Denials, Resolution and Resources

➤ Claim Denials Due to Provider Error

✓ Claim denials due to

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

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

✓ Claim denials due to:

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

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

CHC Service Provider Workshop

Claim Denials and Resolution

- EOB code 749 - Modifier U2 not allowed
- 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 Community Options unit immediately with clients who are not eligible for a CHC benefit at HomeandCommunityBasedServices.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 10/3/16 to 10/5/16 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

- **EVV System**
- All claims are validated in the EVV system prior to direct submission
 - Right Client
 - Authorized Services
 - Right Caregiver Type
 - Verified Visit Data
- Only validated claims can be submitted for payment
- EVV Check in and Check out determines visit duration for claim

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 Community Options unit.
- ✓ Submit care plan discrepancies not already addressed to Access Agency.
- ✓ Reconcile RA for the current cycle before receiving next RA to identify problems early to avoid major reimbursement issues.
 - Refer to list of EOB code descriptions at the end of the RA to determine reason(s) for denial.
 - Use Claim Resolution Guide (**Chapter 12** of Provider Manual) to determine the cause of a denial and its resolution.
 - Use Claim Submission **Chapter 8** for CHC Providers to determine claim resolution.
 - Contact the Provider Assistance Center at 1-800-842-8440 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 Web page > Information > click "Click here for Archived Messages" and use the search function to locate the document

CHC Service Provider Workshop

CHC Program Resources

- *CT Medical Assistance **Provider Manual***
 - ✓ *Provider access from the www.ctdssmap.com Homepage > Information > Publications > Provider Manuals.*
 - ✓ The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission.
 - ✓ It is the primary source of information for submitting CMAP claims and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions.

CHC Service Provider Workshop

CHC Program Resources

– Chapter 1 – Introduction

- Provides information on the CT Medical Assistance Program, (CMAP) 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.

CHC Service Provider Workshop

CHC Program Resources

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.

CHC Service Provider Workshop

CHC Program Resources

- **Chapter 7- Regulations/Program Policy**

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

- **Chapter 8 – Billing Instructions**

- Provides information on provider specific billing requirements.
- **CHC Procedure Code Crosswalk** can be found as a link in Chapter 8 of the Home Health Provider manual, Claim Submission Instructions, field 44.

CHC Provider Workshop

CHC Program Resources

– 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.

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)

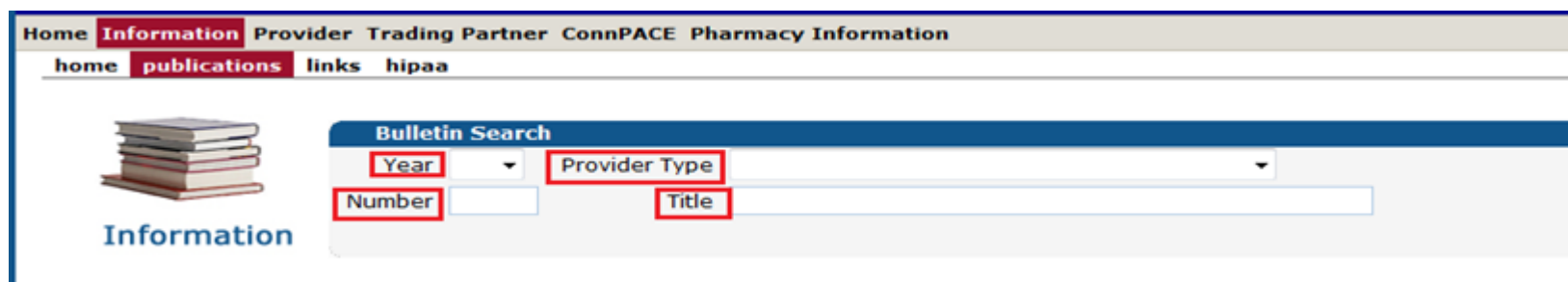
➤ Web Claim Submission Instructions

- ✓ 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** emailed to relevant provider types/specialties **documenting changes or updates** to the CT Medical Assistance Program.
- **Bulletin Search** allows you to search for **specific** bulletins (by year, number, or title) as well as for **all** bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.



The screenshot shows a web application interface with a navigation bar at the top containing links for Home, Information, Provider, Trading Partner, ConnPACE, and Pharmacy Information. Below the navigation bar, there are sub-links for home, publications, 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 a blue header. This section contains four search criteria: "Year" (a dropdown menu), "Provider Type" (a dropdown menu), "Number" (a text input field), and "Title" (a text input field). Red boxes highlight each of these four search fields.

CONTACTS

- **Hewlett Packard Enterprise Provider Assistance Center (PAC)**
 - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays - CTDSSMAP-ProviderEmail@hpe.com
- **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
- **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 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.
- **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.

- **Agency on Aging of South Central CT (AASCC)**
chcbilling@aoascc.org

Companies without secure e-mail, please fax service order inquiries to (203)752-3064. 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

Questions & Answers

